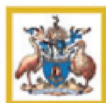
Tri-nation Alliance

The Royal Australian & New Zealand College of Psychiatrists



The Royal Australasian College of Physicians

EXPLORING MENTAL HEALTH FOR PATIENT AND DOCTOR WELLNESS

A report from the International Medical Education Leaders – South East Asia Forum. Sydney, Australia. March 2018.

Royal Australia and New Zealand College of Psychiatrists, Australia and New Zealand

Royal Australasian College of Physicians, Australia and New Zealand

Australian and New Zealand College of Anaesthetists, Australia and New Zealand

Royal College of Physicians and Surgeons of Canada, Canada

IMELF INTERNATIONAL MEDICAL EDUCATION LEADERS FORUM

Keynote speakers:

Dr Murray Wright

Dr Murray Wright is a clinical psychiatrist, the Clinical Director of the North Shore Ryde Mental Health Service and New South Wales' Chief Psychiatrist, appointed by the NSW Ministry of Health.

Dedicated to the education of aspiring young psychiatrists, Dr Wright is involved in the University of Sydney Undergraduate Medicine teaching program as a Clinical Senior Lecturer in Psychiatry at the Northern Clinical School. He also leads the Psychiatry State Training Committee at the Clinical Education and Training Institute (CETI). Dr Wright has 20 years of experience in clinical psychiatry and has held senior executive management positions in mental health, and drug and alcohol units in both metropolitan and rural services.

Dr Kim Jenkins

Dr Jenkins is the current President of the Royal Australian and New Zealand College of Psychiatrists. Dr Jenkins has held a range of roles as a Consultant Psychiatrist in both the public and private sectors. She has a clinical and academic interest in the health and welfare of the medical profession and has spent the last 10 years in the role of Medical Director of the Victorian Doctors Health Program. Dr Jenkins has had extensive involvement in psychiatry-related medical education, both within the RANZCP and externally. She was also involved in the planning and development of the (competency-based) Fellowship program since its inception and has chairs several of its working parties.

Dr Caroline Gérin-Lajoie

Dr Caroline Gérin-Lajoie is a psychiatrist and Assistant Professor at the University of Ottawa, Faculty of Medicine. Dr Gérin-Lajoie has presented provincially, nationally and internationally on topics related to psychological oncology, physician health and disruptive behaviour. In collaboration with her colleagues at The Ottawa Hospital, she has been working on implementing resiliency initiatives for physicians, trainees and staff. This work has results in a 2 year grant from the Mach-Gaensslen Foundation to evaluate a resiliency pilot that could ultimately leady to the development of a corporate health plan at The Ottawa Hospital.

The growing awareness of mental illness and its impact on population health

By Dr Murray Wright, New South Wales Chief Psychiatrist

Lecture

Brief overview

Provided a brief description of the facts and statistics related to mental health at an Australian population health level. Then explored:

- What these statistics tell us about our system of care for patients with mental illness
- The relevance of stigma as an important cultural influence on our system of care and subsequent treatment outcomes of patients with mental illness
- How stigma impacts detection and treatment of medical professionals who experience mental illness.

Population health and mental illness

- 1 in 5 Australians experience Mental Illness each year
- Globally, 70 per cent with Mental Illness will receive no health service
- Mental illness is associated with the lowest likelihood of labour force participation
    - Understanding of mental health is siloed – mental health and other health
- Data linkages study
    - Relative risk for mortality high for those with mental illness
    - Comorbid medical conditions contribute to excess mortality after mental health admission
        - These outcomes are stubbornly resistant to traditional treatment
        - Needs to be collaboration between mental health, physicians and education

The population health data is largely Australian based, however, literature suggests that the Australian experience with mental illness is not isolated and is consistent with other top 20 Organisation for Economic Co-operation and Development (OECD) nations with similar economies and health systems.

The headline statistics quoted are that 1 in 5 Australians will experience mental illness each year, up to 75% homeless adults have mental illness and serious mental illness is associated with life expectancy reduction between 10-20 years (Australian Bureau of Statistics, 2009). Another major statistic are that mental illness initially generally present between mid-teens and mid 20's. These statistics were reinforced by economic and social impact of mental illness, with 70% of those with mental illness receive no health service (not just mental health service) (Thornicroft, 2007: 807-808). The Australian Productivity Commission has commissioned reports, showing how this can impact economic outcomes. The Commission is concerned with the 6 major chronic illnesses and its economic impact. The Commission notes that mental illness associated with the lowest likelihood with being in the workforce, which has a knock on effect not only for the patient, but the societal system as a whole.

Another issue is siloing of information of those with mental illness, and the broader health information of the patient, especially between primary health care and hospitals. Relative risk to the

patient is higher in mental illness than other chronic illnesses. Policy and investment is starting to gain interest, but the figures haven't shifted.

Root cause - Stigma

What about stigma?

  - Perceived negative attributes that causes someone to devalue or think less of the whole person
- Unmet need
  - Health literacy → if you don't understand it how can you identify it
    - We need to become more comfortable with talking about
  - Prejudice
  - Discrimination
- Consequences of Stigma
  - Marginalisation/exclusion
    - Developing countries→ greater family unit so more support.

There are many causes of mental illness, at a macro level, with stigma of mental illness being a key part of the lack of progress in health outcomes for those with mental illness. This could be due to a lack of understanding what a mental illness is, how to identify key signs and voice that. However, maturity and understanding around mental illness is increasing.

There are different types of stigma, where it can be exhibited in the person who has the stigma, or can be the person perceived to be causing it. Observations show outright prejudice against people with mental illness and discrimination as a consequence of having a mental illness. This is compounded by large consequences across large sections of society. Research has shown, however, mental illness consequences are less prominent in developing countries due to family and community ties, compared to developed countries, where these ties are not as strong.

Systems level: Consequences of stigma

  - Diagnostic and treatment error
    - Failure to diagnose
    - Failure to provide appropriate treatment
    - Failure to detect deterioration
    - Physical symptoms are misattributed to a comorbid mental illness
    - Patients with Mental Illness and diabetes less likely to be admitted to hospital than those with diabetes alone
    - Admitted patients with schizophrenia experience increased rates of infection etc.
  - Stigma surrounding psychiatry from a professional view.
    - Stigma within medical profession as a career.
- Medical students → psychiatry and general practice - ^ % of negative comments → impacting career choices
- Care seeking by health professional

- Delays in seeking help still an issue
- Beyond blue survey of Drs and med students
- Drs reported increased rates of psych distress and attempted suicide.
  - Stigmatising attitudes regarding professionalism of medical practitioners with mental illness
  - As a result, medical practitioners are terrified to see a psychiatrist – may impact career
    - Reluctant to see a psychiatrist off their own bat
  - What about the health community?
    - Nothing of the same calibre as public health initiative

Evidence suggests there is significant stigma within the medical profession on those who want to work in mental health, especially psychiatry. Psychiatry and General Practice are the two medical professions that have the largest stigma placed on their profession by their academics and peers (BJ Psych Bulletin 2016, 40, 97-102).

Delays in medical professional seeking help is still a major issue. Doctors have a higher rate of mental illness compared to the Australian population as a whole. Stigma of medical professionals with mental illness is also an issue, where performance of medical professionals is challenged as result of mental illness diagnosis. Stigmatising attitudes regarding the performance of medical practitioners with mental illness persist, which leads to them being perceived to be less competent, with knock-on effects on career prospects.

- Culture and Leadership
  - Review of seclusion, restraint etc.
    - Key issues were in culture and leadership (deficiencies)
  - Mental health patients often ignored by nursing staff – seen as the role of security.
- Health professionals spoke disparagingly about mental health consumers and staff
  - Leadership ignored this 'casual discrimination'

The culture and leadership in medical community plays a large part in playing into this stigma, but also will be the main driving force behind changing the stigma around medical professionals with mental illness. This leadership can have broader impacts on the community's view of mental illness.

- Integration of mental health services
  - Mainstreaming in 1990 mental health was meant to be 'mainstreamed' within 5 years.
  - Silos (not just organisational) persist in 2018
    - Thinking
    - Strategic → different policies
    - Funding (operational)

- Do we have educational silos? And are they a problem?
- Stalled mainstreaming
    - Ambivalence – on both sides
        - Unproductive
    - Persisting influence of mind-body dualism
    - ‘virtual’ asylums
        - Not separated physically but through attitudes
- Reducing stigma in health
    - Efforts mainly based in community

The healthcare industry can help in the promotion of mental illness and while public health programs such as beyondblue and headspace are having a big impact on changing community stigma, the biggest room for improvement is within the health system and professionals itself.

There are multiple options available to organisations and governments alike, in combating mental illness, including the stigma that is attached to having a mental illness and to the clinicians treating mental illness. The three main areas Dr Wright spoke about were advocacy, research and education.

Advocacy issues and opportunities include:

- The need for subtle, strategic advocacy, as opposed to megaphone approach
- Consistency in the vision, which is communicated well. This is has been proved to be most effective when trying to change the culture in a health service
- Leadership at every level, in every profession to change culture
- Consulting consumers in the redesign of mental health services, as the outcomes are for them and the group that health services are Accountable to.

Topics raised when discussing Research options:

- Implementation research as opposed to theoretical research was raised as a large gap in the current literature.
- Quality improvement in practice and outcomes and involving medical professionals to improve patient safety
- Collaborative research across health service, involving a holistic approach to research as opposed to the siloed approach that currently exists.

Educational issues and opportunities:

- Better integration into specialist medical education of mental illness issues, and acknowledging and educating about current stigma of mental illness. Educating new medical professionals about reversing the stigma involved with mental illness.
- Understanding and influence the change the attitude of mental health and mental illness, as leaders in medical professionals and in the community as a whole.

Health outcomes could be improved significantly if the above issues are addressed and acted on. Currently, there is still a gap between treatment and identifying mental illness as well as a blinkered approach to mental health, where other medical issues are being missed/misdiagnosed.

Other issues raised include violence and mental illness, especially where the US stigmatises the mass shooters as having a mental illness. Violent patients are more frequent now, however it's also a sign of misdiagnosis of mental illness, where better treatment would reduce the violent instances within hospitals and health services as well as in the community.

<u>Roundtable discussion outcomes</u>

1. What is the relevance of stigma patients and profession towards mental illness in the organisation you represent?

It's always been there and hard to change without institutional and cultural change.

Stigma is mostly preconceived and ingrained. Words/language and actions are very important.

Consistency in approach, rather than responding to events. Crisis tends to allow for people to relinquish a little for a greater purpose. Need to be more proactive, as opposed to being reactive.

Medical professionals face professional stigma, along with other stigma, as there are career and regulatory issues that can create doubt in seeking medical help.

There is a gap in understanding differences between illness, behaviours and other types of actions.

International medical graduates face similar stigma to their Australian graduate colleagues, however racial and competence stigmas are compound existing stigma when talking about mental illness.

2. How would you measure the success of efforts to reduce stigma?

Open and public discussion about mental illness, with suitable mechanisms in place, where self-reporting are encouraged and supported right through to return to work plans.

Depression admission/treatment rate, where stigma would be being addressed if the treatment rate of depression in medical professionals would exceed normal rates in the population. Same with other medical services. False positives going to get medical help, would help with those with a false negative who wouldn't necessarily get help, unless the stigma falls away and people are being referred at the first instance.

Medical insurers/insurance companies are at the forefront of stigma of mental illness in their assessments. Mental illness can be insignificant as one instance to continued hospitalisation due to incapacitation, where medical insurers

Improving the Mandatory reporting mechanism through the Australian Health Practitioners Regulatory Authority (AHPRA), which has been misreported. This only has to do patient safety, however medical professionals are worried their professional careers will be impacted if they do see a medical professional about a mental illness.

3. **Nominate 3 initiatives (excluding 'more resources' or 'more research') in the undergraduate/postgrad education environments that could improve mental health outcomes for patients**

Work/life balance, wellness/mindfulness programs and working with GPs regarding mental health

Combining wellness and mental health, as opposed to the siloing that occurs currently.

Putting into the curriculum regarding wellness and personal mental health. Reinforcing this issue at undergraduate level, that medical careers will be stressful and that doctor's wellness is a key part to patient safety.

Integration of mental health into all medical education, both at undergrad and post grad level. Medical Sexual Assault Clinicians Aotearoa (MEDSAC) is also changing cultures across the medical schools. The issue may not be in the formal curriculum but in the hidden curriculum of the perceptions and stigma.

Beyondblue junior doctor report is an important report that should be further studied, with questions such as is stigma something that isn't discussed enough in our junior doctor conversations explored?

Advocacy, through celebrity/prominent endorsement/conversation.

Resilience training, which also reinforces the stereotype that doctors will just need to deal with it, as opposed to a systematic approach to treatment and management.

Experience can reinforce/change stigma more than most other factors. Being in an ED can give you a rose coloured view of what mental illness can be, whereas in private practice can be quite mundane and management of MI can be much more rewarding/outcome based, as opposed to a hospital/ED setting.

Substance dependency in patients and doctors: a crisis for healthcare

Dr Kym Jenkins, President, RANZCP

Lecture

Brief overview

- What is addiction?
- Addiction in patients
- Doctors and substance abuse
- Other addictions
- Implication for medical education

What is addiction?

- Addiction is taught as substance use disorders. These are three kinds of addiction - misuse, abuse, and dependence.
- Substance misuse → more prevalent for medical practitioners.
- Alcohol → most common drug of concern for specialized visits.

Substance abuse cannot be brought to a single factor, as with the general population. Secrecy and isolation is a major issue for doctors not reporting substance abuse.

Abuse can also be a factor for stigma, where it's more self-stigma, where immunity to common human issues don't apply to doctors. Alcohol is the leading drug of abuse/dependence.

1 in 4 Australians are drinking alcohol at risky levels, with 10-15% of emergency department presentations are alcohol-related. 25% of all frontline police officers' time is taken by alcohol-related crime. The leading cause of drug-related death - more than 5,500 deaths estimated to be attributed to alcohol in any year. Alcohol is the most common drug of concern for people accessing specialist treatment in 2015-16 accounting for 32% of episodes (National Alcohol Strategy)

Addiction in patients

- RACP and RANZCP alcohol policy (2016): Alcohol and other drug related harm places a high burden on Australia and the community.
- 134,000 clients – under represented the need for alcohol and drug related services
- Need is greater in rural areas

According to the RACP-RANZCP Alcohol Policy (2006), alcohol is world's third largest risk factor for disease burden after childhood underweight and unsafe sex, accounting for 4.5 per cent of global Disability Adjusted Life Years (DALYs). Alcohol use is eighth largest risk factor for deaths, accounting for 3.8 per cent of global deaths. In high income countries, it is the second largest risk factor after tobacco, accounting for 6.7 per cent of DALYs.

The National Alcohol and Other Drug Workforce Development Strategy 2015-2018 states Alcohol and other drug-related harm places a high burden on the Australian community. The cost of harmful alcohol, tobacco and other drug use in 2004–05 was estimated at $56.1 billion, of which:

Tobacco accounted for 56%;

Alcohol accounted for 27.3%; and

Illegal drugs accounted for 14.6% (Collins & Lapsley, 2008).

The Alcohol and other drug services (AOD) report published by the Australian Institute of Health and Welfare noted these key points:

- Australian Government and state and territory governments fund both government and non-government organisations to provide a range of AOD treatment services
- Services delivered in residential and non-residential settings, include detoxification, rehabilitation, counselling, and pharmacotherapy
- 2015–16, about 796 alcohol and other drug treatment services in Australia provided just over 206,600 treatment episodes to an estimated 134,000 clients
- Nearly 3 in 5 (57%) of these agencies were non-government, more than half (54%) of agencies were located in Major cities
- Top 4 drugs that led clients to seek treatment were alcohol (32% of treatment episodes), cannabis (23%), amphetamines (23%), and heroin (6%)
- Proportion of episodes where clients were receiving treatment for amphetamines risen over 5 years, from 12% of treatment episodes in 2011–12 to 23% in 2015–16
- median age of clients in AOD treatment services rising, from 31 in 2006–07 to 33 in 2015–16
- Of all clients receiving treatment, around 2 in 3 (67%) were male, and around 1 in 7 (14%).

Frank case study shows how dependency can impact not just the professional but the practice and community as a whole. Case management of Doctors can be incredibly helpful in coordinating the care and eventual return to work (along with other consideration).

<u>Doctors and substance abuse</u>

- Within medical profession alcohol is the most prevalent, however incidence and prevalence rates unknown
- Prognosis for physicians who get help is better than the general population → recovery rates vary from 73%-91%
- Alcohol abuse and dependency in doctors
    - Common 8-10% - that we know about
    - Affects family life then social life
    - Only affects work at an advanced stage
    - Denial is a key feature
    - Intervention saves careers and lives
    - Emphasis on confidentiality
- Substance use problems in medical profession cannot be reduced to a single factor
- Doctors using can be very vulnerable and very isolated. Support groups provide relief that they’re not alone.
- Strong work identity where illness is equated with incompetence. Self-identity results in self stigma.

The lifetime prevalence of substance abuse in Australian doctors has been estimated to be approximately 8% (Khong, E., Sim, MG. & Hulse, G., 2002; Hulse, G., Sim, MG. & Khong, E., 2004)

If impaired practitioners remain untreated, the community may be deprived of years of service of highly trained and experienced professionals. One aim of physician health programs is to ensure that doctors with substance use issues comply with appropriate treatment, remain abstinent, and receive close monitoring so they can safely return to medical practice (Marshall, JE., 2008; Knight, JR., et al., 2007; McLellan, TA., Skipper, GS., Campbell, M. & DuPont, RL., 2008)

Given potential public health and safety problems that can be caused by addiction among physicians, the care and supervision provided by these programs is imperative, with emphasis on the need for confidentiality, long-term supervision and the membership of self-help groups (Marshall, JE., 2008).

Research shows such a comprehensive approach to assisting doctors is associated with recovery rates between 75% and 85% (Knight et al., 2013; Wile, C., Frei, M. & Jenkins, K., 2011; Brewster, J., Kaufmann, I., Huitchison, S. & MacWilliam, C., 2008). As with any population group that has substance use problems, its cause cannot be reduced to a single factor; anxiety, depression, personality problems, stress at work, family stress, long hours, time pressure and resources and high expectations can all contribute to the development of substance use issues (Marshall, JE., 2008; Khong, E., Sim, MG. & Hulse, G., 2002; Hulse, G., Sim, MG. & Khong, E., 2004). Because a doctor's addiction is associated with secrecy and solitude, many report relief on discovering that they are not alone (Marshall, JE., 2008; Fayne, M. and Silvan, M., 1999).

- Societal expectations of doctors that they're immune from these issues
- Case Studies
    - *Case study 1* – Late career medical specialist, who joined the program after being reported to the Medical Board.
    - *Case study 2* – Surgeon who denied he had a problem despite being obviously intoxicated before surgery. Colleagues/employer obliged to Mandatory Report.
    - *Case study 3* – Trainee. Young trainee whose mentor was concerned. Intense self-loathing manifesting in binge drinking and bulimia. Committed suicide.
    - *Case study 4* – internet addiction. Medical student. What will we do to help him?

- VDHP – Victorian Doctors Health Program
    - Formed in 2001
    - Only health program that includes case management
    - It is the only full-time physician health program of its kind in Australia
    - Like physician health programs in other jurisdictions, a significant proportion of VDHP's work is the care of doctors with substance use issues
    - Tailored to each individual practitioners needs

- Caduceus – facilitated support group
    - Solely for medical practice
    - Peer based support
    - Known only those attending
    - Able to address issues specific to work in medical professions
    - Able to address specific issues relating to shame with not living up to the Doctor ideal
    - Most participants were well established in their careers before they were noticed
    - Substance of choice was alcohol (50%)
    - Many participants stated that Caduceus was crucial for their recovery. They valued the therapeutic aspects of the group. Perceived as supportive, safe, unique and non-judgemental.
    - Female doctors did not feel accepted in the caduceus group.

Caduceus is a facilitated support group for medical professionals. Confidential location. Offers peers based support group for substance abuse. Doctors only as this allows for more tailored support in the medical professional, including the issue of doctor-patient, be the care-receiver, when the norm is care-giver. Coming to the group had positive impacts on doctors MH, perceived as supported, safe and non-judgemental. Women felt less welcomed than men, that the group catered more to male issues.

Anaesthetists - historically abused: Pethidine, Fentanyl, and Propofol.

- Belief that they can manage it (Propofol)
- U.S 30% of Propofol abuse in doctors results in death

Propofol is a major issue, especially for anaesthetists, where ease of access provides opportunity and the risks not taken seriously by medical professionals.

Amber case study shows issues outside of work, where nothing reported at work. Anorexia and bulimia also present. Self-loathing was presented clearly. Amber committed suicide since the case study has been written.

The Thomas case study showed a registrar who has an internet addiction, which mostly surrounds porn sites. The effects of this were a lack of sleep and systemic study due to addiction.

- “Addictions” take home messages:
    - More widespread than you care to imagine
    - Generally something else going on too
    - Behind the substance use
    - Stress and mental health problems
- Common themes for unhappy doctors
    - Tough jobs
    - Idealism

- Arrogance and pride
  - Relationship problems
  - Financial naiveté
  - Dealing with colleagues
  - Being a good doctor and success professionally doesn't equate to being happy

Addictions are far more widespread than imaged, especially in the medical profession. Main challenge is getting professionals into care, and convincing professionals that care will be helpful.

A lot of common themes resonate with issues in the wider population, but specially around being a good doctor and how that impacts their personal life (what they are giving up to being a good doctor).

- Why doctors get sick: consider – what we do; who we are etc.
  - Burden of international medical students who are carrying a huge burden
- Approach to management – no one size fits all
  - Core elements
  - Systems approach
  - Interventions need to be earlier down the chain of events.
  - Comprehensive approach
  - Awareness of stressors
  - Awareness of risk
  - Create culture where it is ok to get help

Why do doctors get sick?

- Perfectionists, greatest strength and greatest risk to the community.
- Social prestige and altruism.
- International medical graduates are carrying a far greater burden through their medical education career and then into training and work life.

Doctors can help by being aware, and observe any changes in mood/behaviour. It's not easy identifying an issue in a colleague. Enlist professional help, don't be the treating doctor if your colleague is struggling. Be a friend and refer them to a professional outside of the relationship that can provide objective care. Doctors can help themselves by being proactive and identifying help options before a crisis comes on. Always think beyond the addiction and see the whole person. Addiction is not just substances, but extends to the internet, gambling and gaming.

<u>Roundtable discussion outcomes</u>

1. **How is (or how should be) 'Addiction' adequately represented in the training curricular of your organisation? How well equipped is your organisation to identify and support a medical professional who may have an addictive disorder?**

Within the RACP, there is a Chapter of Addiction Medicine, which represents the area's professionals and advises on issues relating to addiction in the training curricular. There is also a post graduate qualification that can be done via RACP in Australia and New Zealand. ANZCA has a resource around health and wellbeing, but it has limited references to addiction. ANZCA do have it in the training curriculum – sits in different places in the curriculum.

Most organisations agreed that addiction was represented in respective training curricular, however how it's presented is more prominent than others (ACEM, RACP, RANZCP have dedicated sections, whereas others it's incorporated more generally).

Differentiating between internal and external addiction medicine → what about integral? In terms of recognising it in oneself. Some focus on health and wellbeing but not in the curriculum.

There an issue with putting the cart before the horse. Drug use by anaesthetists into the exams which drove trainee behaviour (which is also experienced in Canada). Self-care under the role of medical professional. Loss of career is a major driving factor behind doctors not reporting, or underreporting substance abuse.

Practical skills in the curriculum, such as self-care and mental health in health workforce. Would also need to look into focusing on specific drugs, for example, but not limited to, in anaesthesia. Skills training in terms of self-care not yet part of what is covered in training curriculum.

2. **How does/would your organisation facilitate the 'return to work' of a medical practitioner who has a substance use disorder?**

ANZCA have a back to work strategy → varies across jurisdictions → dependent on knowledge of resources. Dependent on knowing individual psychology and addiction type. ANZCA has a return to work framework. With regards to Propofol there was debate as to whether an anaesthetist could return to a place where it is readily available?

Returning to work in the private sector – easy to have a supervised return to work practice in a hospital. In the private sector that is more difficult as they are siloed → may be working in different hospitals etc. achievable but fraught with organisational difficulties. Workplace monitor or a graduated return to work.

Within remote practice, a return to work plan can be challenging to implement as there are limited resources.

If there is not a widely known return to work plan, this can lead to 'underground' operations, without the proper support mechanisms in place.

Return to work for trainees – trainees are the only ones we know about, where in reality, trainee information about consultants is not shared. In the future this may change?

Drug and alcohol testing of medical professionals – non-medical professionals (Such as pilots and high risk construction workers) surprised that all doctors don't have to deal with this - should doctors be tested?

Medical Council of New Zealand has a health committee on health of doctors. It aims to foster a rehabilitative approach, with support doctors to return to work or withdraw if they need to.

Involve the right people, which can lead to conditions on practice but these trainees tend to go for voluntary agreements when discussing return to work. This, anecdotally, has resulted in a high reporting rate, with self-reporting in some instances. If we get 'return to work' strategies in place and people know it's possible then it may result in more people reaching out for help.

Strategies and system change to mitigate doctor burnout

Dr Caroline Gérin-Lajoie, University of Ottawa, Canada

Lecture

General Overview

- Review wellness and burnout in current landscape
- To discuss the importance of Doctor Wellness and Burnout in the present medical landscape
- To review individual, organizational and system strategies to mitigate Burnout (resiliency models)
- To share wellness initiatives from a large Canadian academic tertiary care centre (The Ottawa Hospital – "TOH")

Looking at strategies on medical professional wellness, wellbeing and burnout

Challenged, thriving and successful in work and personal lives.

Doctor wellness is looking at not just trainees but the whole doctor career cycle. Burnout typically presents its self in Year 2 medical school, residency/internship year(s) and mid-career.

2 major research articles on doctor wellness started the research area, propelling an increasing recognition over the last 2 decades, with an even greater awareness in the past few years of the positive effect wellness can have. There have been a lot more studies conducted in recent times into the effectiveness and viability of wellness programs for medical professionals.

Doctor Wellness and Burnout in the present medical landscape

Main themes

- Context – the speed of change is so fast.
- Confluence in healthcare:
  - increased complexity
  - Technology
  - Budget cuts
- What are the impacts?
- Wellness goes beyond absence of distress and includes being challenged, thriving, and achieving success in various aspects of personal and professional life
- Spike of burnout: 2nd year, junior year and residency.
- Burnout – the environment needs to be considered.
- Doctor Burnout – impact studies over the last 10 years
- Burnout – Maslach Burnout Inventory

Maslach Burnout Inventory is viewed as the gold standard measuring tool, presenting as Impersonal attitude (depersonalization, detachment, and/or cynicism), perceived lack of accomplishment and emotional exhaustion. Burnout rate is about 50% of all medical professionals across the various lifecycle stage. This impact transfers to patient through lack of empathy and detaching from the patient. Burnout is not a clinical diagnosis, nor viewed as clinical depression, but viewed as treatable.

Sources of burnout include:

- Individual: personality traits, coping strategies, loss of meaning, difficulty with work-life integration, female gender
- Medical Profession: hidden curriculum, conspiracy of silence, blame culture of medicine, tendency to ignore distress
- Health Care Organization: overcrowding and flow, high work load, inefficient processes, burden of EMR, changing work environment, poor leadership, loss of autonomy (Lemaire and Wallace, 2017)

There is also a hidden curriculum to burnout, through the conspiracy of silence, the shame and blame culture that is attributed to burnout in the medical profession. Burnout data is limited, however, the measured data in the United States shows a clear trend of increasing burnout in the medical profession, with the highest recorded areas being in the acute care areas (i.e. ER, Internal Medicine, Family Medicine, also in Oncologists, Neurologists, and Gynaecologists).

Organisational factors that may lead to Burnout:

- Overload
- Lack of control
- Insufficient reward
- Lack of community
- Lack of fairness
- Conflicting values

Decreasing burnout means that engagement needs to be increased. Key drivers of burnout and engagement. If around 20% of work is meaningful that makes a big difference. Burnout is the opposite of engagement when describing doctor welfare in the workplace. Not enough emphasis is being placed on engaging with the workforce to ensure they are performing at their best, and when this doesn't happen, burnout can become a state of mind for parts of the workforce.

Doctor burnout can have a range of consequences, on the medical professional itself, the patient, the organisation and the wider health system. Some of these include:

Personal:

- Lower work satisfaction
- Link to cardiovascular disease and significantly shorter life expectancy
- Link to problematic substance use and abuse
- Link to broken relationships
- Link to depression and suicide

Healthcare organisation and systems:

- Intensified oversight of doctor health by professional (regulatory) bodies
- Risk-management strategies (organizational psychology and occupational medicine to change behaviour)
- Associated with unprofessional behaviour
- Lower quality of care
- Decreased patient satisfaction
- Problems with patient safety (increased medical errors)
- Associated with high job turnover (impact on recruitment and retention, early retirement)

- Lost revenue from decreased productivity and efficiency

These are large knock-on effects, especially in an environment where healthcare funding is politically fraught, and healthcare systems are tasked with providing higher levels of care with less funding. Previous lack of awareness of the economic cost associated to burnout and uncertainty about what can be done to address the issue. The Canadian estimate of the cost of burnout is over $200 million, so this now becomes not only a health issues, but an economic issue for both health care providers and governments alike.

Strategies to mitigate doctor burnout

- Resiliency – bounce back in face of adversity – thrive/go beyond.
  - Individual needs to work on themselves first.
- Recipe for resiliency – no on right answer.

You need to assist yourself first, before you can help others. There is no one right answer to be resilient to the stress of a medical professional's life. The need for sleep and eating properly is crucial and finding a GP/family physician is key to ensuring ongoing health monitoring.

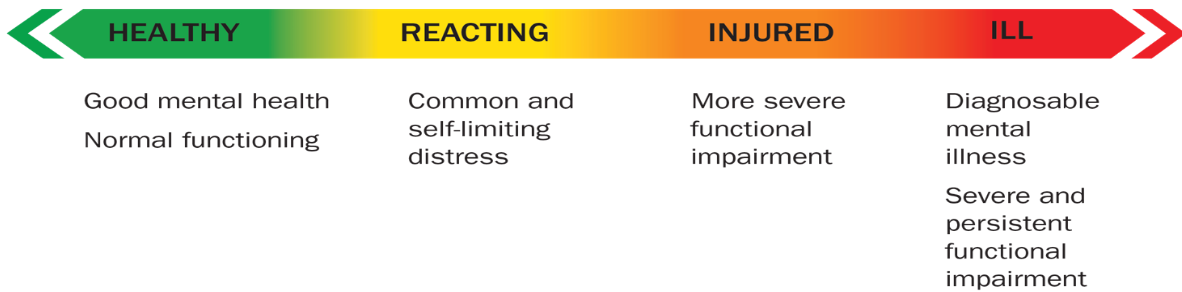
- Individual strategies for resiliency – the Basics. Body Affect Social Intellect Community Spirituality

The five fundamentals look at a more positive model, which looks at the importance of the positive approach to wellness. This is particularly present in sports psychology where wellness programs are used in preparation, performance, coping skills and strategies and recovery. It captures the physical, mental and emotional state of sportspeople, examining not only the individual but also the environment they are in (physical and emotional). This has been piloted in the University of Manitoba, Faculty of Medicine, with results still pending.

The model that Dr Gerin-Lajoie uses at the University of Ottawa and discusses at length is the Canadian Armed Forces "Road to Mental Readiness" or (R2MR), which aims to improve the resilience of Canadian Armed Forces members and increase mental health literacy through evidence based mental health education and training.

The Mental Health Continuum Model is horizontal scale of healthy to ill, with colour coding to signify mental wellness. The model provides for a reduced stigmatised way of talking about mental illness and wellness within the military, which has now been replicated with the University of Ottawa. Each colour has specific strategies attached to it, with the ultimate goal of moving people back to the healthy green section.

The model is below:



Dr Gerin-Lajoie discussed other examples of strategies, including the "the Big Four" and "Positive Psychology: Elements of Well-Being", which both target issues such as goal setting and achievement, visualisation and meaning and the importance of positive relationships.

The change management within an organisation can be difficult, especially in large organisations such as hospitals and allied healthcare organisations. Reinforcing what works can assist in making change palatable for employers and employees alike.

Recent meta-analysis of multiple studies showed some individual targeted interventions resulted in small reductions in burnout. Mindfulness, stress reduction techniques, education around communication skills, exercise and building self-confidence were some of the techniques used in reducing doctor burnout. The research showed that individual interventions worked better when in combination with organisational interventions (rescheduling shifts, reducing workload, enhancing teamwork and leadership) (Panagioti M., et al., 2017).

Instilling a culture change can be achieved by fostering leadership and support, addressing toxic aspects, promoting professionalism, acknowledging and addressing perfectionistic expectations and mitigating excessive job demands (Lemaire and Wallace, 2017).

Engaging in organizational and professional recognition of wellbeing is integral to the profession and central to patient care. Wellbeing is currently recognised as a missing quality indicator for all health care systems, which if measured and recognised, could optimize health system performance (Lemaire and Wallace, 2017).

Further progress in doctor wellbeing can be achieved through internationally coordinated research effort, with the aim of identifying evidence based strategies to address burnout (Lemaire and Wallace, 2017).

- Cultivate community space, allowing communication and connection.
- Rewarding and encouraged in the workplace
- Work life integration and flexibility in your work

- Strengthen culture around wellness
- Providing resources, as it should be a group effort and not an individual responsibility

Shanafelt et al. (2016) have published 9 organisations strategies, as part of a wider research paper on burnout and satisfaction with work-life balance in medical professionals and the general population. The research used the Maslach Burnout Inventory to measure levels of burnout when comparing physicians to the general population. Their conclusion was "burnout and satisfaction with work-life balance in US physicians worsened from 2011 to 2014. More than half of US physicians are now experiencing professional burnout".

- 9 org strategies necessary for individual change
  - Acknowledge and assess the problem
  - Harness the power of leadership
  - Develop and implement targeted 'work unit interventions'
  - Cultivate community at work
  - Use rewards and incentives (could just be recognition and praise)
  - Align our values
  - Promoting flexibility and work life integration
  - Provide resources to promote resiliency and self-care
  - Facilitate and fund organisation science

Dr Gerin-Lajoie presented to the group the progress of The Ottawa Hospital Doctor Wellness program. The program is designed to deliver a fully funded, supported and implemented wellness program within a large scale hospital. The Ottawa Hospital employs the "PALS" framework, which consists of:

- **Physician:** self-aware, authentic, values-driven
- **Advocacy** and Relationship between TOH Physicians and Administration
- **Leadership** and Professional Development/Communication
- **Support** and Physician Connections

Some of the successes of this program so far has been advocacy for better working conditions, including available food for staff, childcare services and access to a gym onsite. Other successes are the "Creation of a "Family Physician on Site Service" for Doctors and their families and access to an "Employee and Family Assistance Program" for free, short-term individual or couple counselling".

Other resources that have been created following the implementation of the Ottawa model are Training in R2MR (Resiliency Model), Video and face-to-face sessions on resiliency, a grant for a pilot in "Resiliency for Doctors and Trainees (Mach-Gaensslen Foundation)", "Wellness Consultations" in Departments and various other physical and intellectual resources.

Uptake and progress has been significant, with surveys showing a greater awareness of wellness support within the Ottawa Hospital (Aon Hewitt Engagement Survey).

Roundtable discussion outcomes

1. **Should we focus on doctor resiliency, or creating a healthier environment? Is it possible to have an environment in healthcare that doesn't require resiliency?**

Consensus on tables is that they go hand in hand with each other, because while healthier environments will inevitably assist, some form of resilience will need be instilled in doctors, as the nature of the job requires.

The word 'resilience' and its use in its current lexicon is contentious at the moment, that debate is still ongoing on the relevance of the word 'resilience'

- Is it a tainted word now? Similar problem with the word burnout.
- Different burnout for different levels?

Burnout within a team is contagious on team dynamics. Resilience is a quality (seen on multiple levels), not a product but can also be termed as a skill or approach to managing stress.

NSW health – pressure in any in terms of competing for entry into training programs → trying to juggle so much is it necessary? Pressure from Colleges (on trainees) – especially selection, is an area where Medical Colleges can assist in creating that healthier environment for trainees.

2. **If you were tasked with creating a doctor wellness strategic plan in your environment, what would be your top priorities? Where would you get started?**

Budget admin support needed up front to facilitate the advocacy and academic work. It also needs to be on leadership community agendas to drive change from the top.

Issues to tackle in strategic plan – what do the people in that org want and having engaged consultation. Start with the Low hanging fruit and move on, as this shows progress. Easy to do, in the scheme of things and is cost effective but needs to be conceptualised.

NSW Health is currently planning and implementing junior doctor wellbeing programs and support, after a series of trainee suicides. Rostering practices for junior doctors can done at a state level. There are number of actions, which are state-wide and high level, but it would be coordination between the State Health Department and local hospitals on how it would be implemented

RACS - building respect program is a behavioural and cultural level to change the work environment within hospitals, especially with trainees. How do we change culture? Lot of hospitals signed up to the cognitive institute program, which is linked to Vanderbilt approach.

Lost community of practice in hospitals, where loss of spaces for connection within health professionals. This is not just physical spaces, but time and opportunity to engage with health colleagues.

Service based funding and support – the medical professionals need to be champions of trying to form that change, as the current funding is focussed on service and not quality and patient safety issue. It can also be framed as an economic issue, with regards to not only doctor productivity and outcomes but also for patient health outcomes and the impact that can have on the economy.

Rostering – junior doctor level – fund for wellness. We need to look at rostering for service, rostering for welfare and rostering for education. Delegated authority to rostering to workforce units, who will not understand the key requirements for wellness. Money, both in funding and lack of understanding of cost to budget is a barrier to wellness.

3. **Can linkages be created between institutions or organisations to better advocate, and provide support for Dr Wellness? What levers may be synergistic to improving doctor wellness?**

Pan-collegial engagement and coordination shows it is important for both Colleges and other medical organisation to work together, in forums such as IMELF to discuss and agree on action plans to take back to our organisations and health departments to promote greater focus on wellness of our medical professionals, particularly trainees.

Action plans – coming out of these types of forums to not only discuss but also go away with strategies to implement. One low hanging fruit that is achievable is determining a baseline measurement, to assist in advocacy but also context of the issue facing healthcare organisations.

Need to get to interventional strategies now, as a lot of research has been on measurement and defining the issue around wellness. The next research area is evidence based interventions, which is where the networking at forums such as IMELF is so important, to discuss those inventions.

There is large potential in learning from other industries, such as aviation, the military and other emergency industries. Comparing industries is fraught, as the differences far outweigh the similarities, however these industries have becoming incredibly resilient when faced with stressful situations. Research needs to focus on how to treat people well and optimising their performance through human behaviour. Employing safeguards to identify harmful situations and behaviours and build in mechanism to correct a situation before it becomes a critical threat to human safety (such as limiting work hours as seen in aviation).

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Attendees:

Participant name	Participant organisation
Dr David Andrews	The Royal Australian and New Zealand College of Ophthalmologists
Mr John Batten	The Royal Australasian College of Surgeons
Mr John Biviano	Royal Australasian College of Surgeons
Dr Claire Blizard	Health Education and Training Institute
Dr Ian Bowmer	Royal College of Physicians and Surgeons of Canada
Ms Robyn Burley	NSW Ministry of Health
Dr Craig Campbell	Royal College of Physicians and Surgeons of Canada
Dr Damian Castanelli	Monash Health
Dr Adam Castricum	Australian College of Sport and Exercise Physicians
Dr Francoise Chagnon	Royal College of Physicians and Surgeons of Canada
Prof Arthur Conigrave	University of Sydney
Mr Adrian Cosenza	Australian Orthopaedic Association
Dr Ian Curran	Duke-NUS Medical School
Mr Benjamin Cusick	Royal Australian and New Zealand College of Psychiatrists
Prof Paul Dagg	University of British Columbia
Prof Richard Doherty	The Royal Australasian College of Physicians
Dr Jason Frank	Royal College of Physicians and Surgeons of Canada
Dr Caroline Gerin-Lajoie	Royal College of Physicians and Surgeons of Canada
Dr Genevieve Goulding	The Australian and New Zealand College of Anaesthetists
Dr Ian Graham	Australian and New Zealand College of Anaesthetists
Dr Debra Graves	The Royal College of Pathologists of Australasia
Ms Elaine Halley	Royal Australian and New Zealand College of Psychiatrists
Dr Kenneth Harris	Royal College of Physicians and Surgeons of Canada
Prof William Hart	Curtin Medical School
Dr John Ilott	Australia and New Zealand College of Anaesthetists
Dr Ian Incoll	Australian Orthopaedic Association
Dr Kym Jenkins	Royal Australian and New Zealand College of Psychiatrists
Ms Lyn Johnson	Australasian College for Emergency Medicine
Mr Olly Jones	The Australian and New Zealand College of Anaesthetists
Ms Callie Kalimniou	Royal Australian and New Zealand College of Psychiatrists
Ms Nathasha Kugenthiran	The Royal Australasian College of Physicians
Dr Sally Langley	The Royal Australasian College of Surgeons
Dr Lynette Lee	The Royal Australian College of Medical Administrators
Dr Kiki Maoate	Pasifika Medical Association
Prof Geoff McColl	University of Melbourne
Dr Rod Mitchell	The Australian and New Zealand College of Anaesthetists
Dr Kate More	The Royal Australasian College of Physicians
Dr Viren Naik	The Royal College of Physicians and Surgeons of Canada
Dr Nick O'Connor	Royal Australian and New Zealand College of Psychiatrists

Dr Andrew Padmos	Royal College of Physicians and Surgeons of Canada
Dr Lindy Roberts	The Australian and New Zealand College of Anaesthetists
Prof David A Scott	The Australian and New Zealand College of Anaesthetists
Mrs Joan Simeon	Medical Council of New Zealand
Ms Linda Smith	The Royal Australasian College of Physicians
Mrs Debbie Sorensen	Pasifika Medical Association
Ms Pamela Spoors	The Royal Australian and New Zealand College of Radiologists
Ms Sarah Taber	Royal College of Physicians and Surgeons of Canada
A/Prof Stephen Tobin	The Royal Australasian College of Surgeons
Dr Leona Wilson	The Australian and New Zealand College of Anaesthetists
Dr Murray Wright	Royal Australian and New Zealand College of Psychiatrists
Dr Catherine Yelland	The Royal Australasian College of Physicians