AMA

AMA POSITION STATEMENT

HEALTH AND WELLBEING OF DOCTORS AND MEDICAL STUDENTS 2020

AMA

Health and Wellbeing of Doctors 2020

CONTENTS

1. PREAMBLE

A healthy medical profession is integral to optimising patient safety and quality of care and the sustainability of the medical workforce [1]. Systemic pressures are threatening doctor well-being as well as the health and effectiveness of the organisations in which they practice [2]. Staff burnout and dissatisfaction is increasingly recognised as a consequence of poor organisational culture, leading to costly staff turnover, patient dissatisfaction, increased medico-legal risk and significant financial costs. Ensuring doctor wellness should be seen as promoting quality in the Australian health-care system, furthering competency, reducing the frequency of medical errors and, in turn, improving health system cost-effectiveness [3].

To care effectively for patients, doctors and medical students must maintain good health and wellbeing. This position statement addresses structural and individual barriers to wellbeing and acknowledges that physical and mental health are interrelated. This supports the World Health Organisation definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

There has been increased awareness of doctors' health issues in recent years. While certain initiatives have been implemented to improve the ability of doctors to withstand pressure, fundamentally many of the modifiable risk factors for poor mental health and wellbeing have not been addressed. In addition, the evidence base for such interventions is poor. Amongst the underlying risk factors is the detrimental effect of poor professional and workplace culture on wellbeing. Cultural change will require strong leadership if it is to effectively advance improvements in wellbeing.

Doctors perform at their best to deliver high quality health care to their patients and community when their experience of medicine is rewarding and satisfying. The responsibility for facilitating this lies with all involved. This position statement analyses the risk factors for poor health, barriers to accessing treatment, and available interventions from the perspective of individuals, teams, and systems. The World Medical Association's Declaration of Geneva (2017) calls upon doctors to "attend to (their) own health, well-being, and abilities in order to provide care of the highest standard". Creating systems that enable doctors to fulfil this must be a high priority

2. SUMMARY OF RECOMMENDATIONS

KEY POINTS:

Doctors and medical students should:

- Take responsibility for their own physical and psychological health and explore strategies that work for them personally.
- Establish a continuing therapeutic relationship with a general practitioner outside of their work setting to promote help seeking, discourage self-prescription, ensure preventative health needs are met, and address concerns about confidentiality and privacy within the workplace.
- Incorporate regular leave, good nutrition, exercise, leisure, spirituality and family time into a healthy and balanced lifestyle.
- Maintain collegial connectedness that supports the wellbeing of the profession.
- Support colleagues in maintaining their wellbeing and encourage them to seek help when unwell.
- Be aware of the precise application of current mandatory reporting requirements surrounding impairment as a treating practitioner and as a doctor-patient.
- Strongly consider having appropriate insurances in place to support them through illness.

Treating clinicians should:

- Provide treatment to doctors and medical students with the same skill and professionalism provided to all other patients, with particular emphasis on confidentiality.
- Be aware of the stigma surrounding health-seeking and prioritise confidentiality, including investigating alternative mechanisms of providing support
- Facilitate, where possible, telehealth appointments for rural and remote doctors, and access to psychologists and psychiatrists in a setting not influenced by pre-existing relationships.

Hospitals, healthcare services and employers should:

- Prioritise employee wellbeing and follow established guidelines for creating mentally healthy workplaces.
- Hospital management and senior members of the profession must take a leadership role and make it clear that discrimination, bullying and harassment is unacceptable.
- Implement and regularly review systems and reporting structures to support a zero-tolerance approach to bullying and harassment.
- Support initiatives that promote a positive workplace and professional culture.
- Establish and fund a Chief Wellness Officer or equivalent position who can cater specifically to the needs of doctors, particularly doctors in training or transitional phases of career. This role should be based on existing published guidelines and not play a role in determining training progression.
- Consider the effect of implementing new technologies on the wellbeing of their staff. including funded strategies for documenting the impact on wellbeing and addressing these issues.
- Provide appropriate management and leadership training to those in leadership or supervisory roles.
- Take measures to prevent burnout which include promoting a civil and respectful workplace culture, consider providing resilience training, and to provide flexible work arrangements.
- Provide adequate facilities, for example, common rooms and sleeping facilities, for those working shift work and on call.
- Recognise the importance of physical health in wellbeing and provide healthy food options and exercise facilities.

- Adhere to award working hour requirements and encourage doctors to claim overtime where worked
- Ensure clinicians working overtime are properly remunerated.
- Minimise unsocial and unsafe rostering practices (e.g. long runs of night and on-call shifts) and consider the effects of these on staff wellbeing.
- Ensure their employees have access to sick, personal and other forms of leave (that meet the standards for public sector employees where applicable); and that adequate relief is available for doctors to take emergent sick, personal and other forms of leave, both planned and unplanned.
- Involve clinicians in high-level decision-making around organisational structure to improve clinician autonomy and reduce levels of burnout.
- Objectively evaluate all initiatives and policies that promote the health and wellbeing of doctors.
- Promote initiatives aimed at reducing stigma surrounding all doctors' health issues including mental health issues amongst the medical profession.
- Ensure appropriate programs, services, and policies are developed and are in place to support access to treatment and facilitate both return to work and continuance of training while carefully protecting individual confidentiality and privacy.

Medical schools should:

- Ensure medical students are educated to enable them to effectively maintain their health and wellbeing and create lifelong healthy practices.
- Have strategies in places for the early identification of struggling students and systems to alleviate modifiable stressors.
- Enhance the capacity of medical students to identify and address barriers to health and wellbeing by including evidence-based strategies in the curriculum.
- Enhance access to independent confidential care.

Specialty training colleges should:

- Include skills in leadership, mentoring and management in the curriculum for doctors in training and medical students and offer these as continuing professional development courses for fellows.
- Develop training programs where wellbeing and health of the trainee is a core principle, considering issues such as requirements for entry into training, training requirements, flexibility in training, return to work practices, performance management, exam failure and stress.
- Actively collaborate with employers to implement more flexible training structures to facilitate healthy work-life balance among their trainees while ensuring training quality is upheld.

The Australian Health Practitioner Regulatory Agency (AHPRA) and the Medical Board of Australia (MBA) should:

- Continue to fund profession-funded national confidential doctors' health programs in all states and territories to improve and promote the health and wellbeing of the medical profession.
- Acknowledge the impact of regulatory issues on doctors, ensure transparency in processes, and that doctors have access to support during the regulatory process.
- Further educate clinicians as to mandatory reporting and the thresholds for reporting.
- Work to reduce stigma associated with mental ill health.

The Australian Medical Council should:

- Ensure that the standards for the accreditation of primary education, internship, prevocational and vocational training require medical education and training providers and settings to provide an environment that supports doctor and medical student health and wellbeing.
- Strengthen accreditation standards to require all training programs to include doctor health and wellbeing as part of their curriculum, and health and wellness programs and initiatives should be regularly evaluated.

Commonwealth, state and territory governments should:

- Make doctors' and medical student health and wellbeing a national priority.
- Consider implementing strategies to enable the maintenance of the health and wellbeing of doctors and medical students when engaging in workforce planning.
- Commit to funding the implementation of the national framework to guide coordinated action on the mental health of doctors and medical students to improve the health and wellbeing of the medical profession.
- Amend the Health Practitioner Regulation National Law to exempt treating practitioners from mandatorily notifying their health practitioner patients, in line with the current law in Western Australia.
- Fund further research into system-wide interventions to address the wellbeing of doctors and medical students and provide funding to establish a national doctor suicide registry.

3. INDIVIDUALS

Most doctors have an above average physical health status. They are less likely than the general population to suffer lifestyle-related illnesses, such as heart and smoking-related disease. However, there is evidence that doctors are at greater risk of psychological distress and stress-related problems [4].

Some sub-groups of doctors may be at greater risk of poorer health and wellbeing because of their professional circumstances. These include, but are not limited to:

- doctors working in rural and remote areas with inadequate resources and professional support,
- doctors who work excessive hours and/or are unable to access sufficient leave,
- international medical students and graduates and doctors from non-English speaking backgrounds,
- doctors who work shift work,
- Aboriginal and Torres Strait Islander doctors and other minority groups,
- those exposed to blood-borne diseases and other specific occupational risks,
- doctors who are the subject of medico-legal process such as lawsuits, complaints and inquiries, and
- senior doctors dealing with stress can be made more difficult by professional isolation, especially for those in private practice without access to institutional support.

3.1. National Mental Health Survey of Doctors and Medical Students

The National Mental Health Survey of Doctors and Medical Students conducted by Beyond Blue in 2013, provided data demonstrating poor mental health and psychological distress amongst doctors and medical students in Australia. It found that doctors have higher levels of very high psychological distress [(3.4% than the general population (2.6%) and other professionals (0.7%)] [4]. Particular groups are at significantly greater risk; medical students and females reported higher rates of psychological distress and mental health problems than males and older doctors. Female doctors also have a higher suicide rate than for women in other occupations, whereas for male doctors the rate is similar [5].

3.2. What are the risk factors?

The risk factors for mental ill health and poor wellbeing vary with career stage. For medical students, demands of study and examinations (58.4%), university workload (50.4%), conflict between personal responsibilities/ family and study (35.2%), keeping up to date with knowledge (34.2%), fear of making a mistake (34%) were the most common stressors. Notably, medical students were more likely to seek treatment for depression and anxiety than doctors [4].

Barriers to medical students seeking help included embarrassment (50.3%), fear of lack of privacy/confidentiality (49.9%), reticence to ask for help from others/self-reliance (47.7%) lack of time (40.6%), and concerns about career development and progression (37%) [4]. Amongst university students, medical students face additional stressors including relocation for rural placements, and balancing employment with irregular placement hours. Given these risk factors, medical schools should educate medical students to effectively maintain their health and wellbeing and create lifelong healthy practices.

Medical schools must have specific strategies in place for the early identification of struggling students and systems to alleviate modifiable stressors.

Doctors in Training (DiTs) face particular stressors at the start of their career, and over seventy percent of DiTs express concerns about their physical or mental health [6] Doctors in training, compared with other doctors, are more concerned about career development and progression (BB survey). **Governments should consider implementing strategies to enable the maintenance of the health and wellbeing of doctors and medical students when engaging in workforce planning.**

3.3. The CV arms race

Psychological distress surrounding the availability of specialist training places has intensified since the rapid expansion of medical student places in the early 2000s. This has led to what has been termed a 'CV arms race', with DiTs incurring significant financial costs on additional courses to increase their chances of being accepted onto a specialist training program. Examinations, both prior to entering a training program, and while undergoing specialist training, are particularly stressful events for doctors in training, and inadequate access to leave and the absence of a supportive workplace when undergoing exams, can worsen psychological distress.

3.4. Trainees in unaccredited positions are vulnerable

Despite increasing awareness, safe working hours continues to be a concern from both a patient safety and a doctors' health perspective [7]. This is of particular importance amongst unaccredited registrars, who are currently unaccounted for in national workforce data sets. Conditions, including access to education, are relatively protected in internship due to accreditation requirements [8].

From postgraduate year two onwards, this curriculum framework and structure is absent for many doctors who are yet to enrol in vocational or specialist training. Doctors working in prevocational 'unaccredited' or 'service registrar' roles often report to supervising consultants whom they also rely on for references to apply to their chosen specialty [9]. This creates a significant power imbalance and may leave this cohort vulnerable to exploitation, work-related stress, and workplace harassment and bullying. Furthermore, increasing competition for a limited number of training positions compounds the strain on mental wellbeing by prolonging the time spent in these prevocational or service provision roles [10,11].

3.5. Professional isolation

Rural and regional doctors face challenges from professional isolation, poor accessibility to an independent general practitioner and taxing on call requirements [12]. Finally, doctors who have established careers, including those in private practice, are not immune from risk factors for poor health, and professional isolation is a prominent concern [13]. Medicolegal risk and the impact of patient complaints and regulatory investigations are also of concern.

Older doctors also face increasing incidence of chronic disease and disability which may impact on their physical and mental health and professional identity [14].

3.6. Barriers to accessing care

There is a strong community expectation that doctors will seek appropriate medical care from another doctor when they are unwell. **The AMA believes that all doctors should take responsibility for their own physical and psychological health.** However, the reality is that there are significant barriers, real and perceived, that prevent some doctors and students from seeking healthcare [15]. These include a range of well documented systemic barriers, confidentiality concerns, embarrassment, stigma, concerns about career development, and concerns surrounding mandatory notification of impairment [16]. In addition, access barriers, such as time, geographic isolation, and lack of experienced personnel, are common.

These barriers can result in doctors engaging in inappropriate practices including inadequate preventative care, self-diagnosis, self-treatment, and delayed presentation to other practitioners. Students and doctors are often reluctant to have a general practitioner for independent medical advice. Similarly, they may not adhere to routine preventative health measures, such as screening tests and vaccinations. Doctors may also be unable to correctly identify the early warning signs of mental illness and burnout.

In Australia, doctors feel least comfortable seeking help from Employee Assistance Providers [4]. This is due to a lack of confidence about the confidentiality of such services, and that the advice they need is not provided by the counsellors available through these services, such as advice on career pathways or on medico-legal issues [17].

3.7. Establishing a relationship with a general practitioner

The reluctance of doctors to consult a general practitioner about their medical problems, and ready access to medical knowledge and medications can facilitate self-treatment and self-prescribing. Self-treatment can also include informal pathways of care such as 'corridor' consultations and self-referring to a specialist. The important role that a general practitioner can play in the health and wellbeing of doctors and medical students is recognised throughout the literature [4, 18]. **All doctors and medical students should have a general practitioner outside of their work setting to promote help seeking, discourage self-prescription, ensure preventative health needs are met, and address concerns about confidentiality and privacy.**

The role of doctors in treating other doctors is often overlooked, and further education for doctors who treat doctors and when doctors find themselves as patients is required. **All doctors should provide treatment to doctors and medical students with the same skill and professionalism provided to all other patients, with particular emphasis on confidentiality.**

Treating practitioners need to be aware of the stigma surrounding health-seeking and prioritise confidentiality, including investigating alternative mechanisms for providing support. This could include facilitating, where possible, telehealth appointments for rural and remote doctors, and access to psychologists and psychiatrists in a setting not influenced by pre-existing relationships. With new technology, avenues such as telehealth, especially tele mental health provided by a broad number of healthcare workers, including psychiatrists, psychologists, and general practitioners, represent a new and proven modality of care and support for mental health [19].

3.8. Doctors' Health Advisory Services play a key role

Further to seeking help from a general practitioner, state-based doctors' health advisory services provide assistance to doctors and students and provide a contact with which they can discuss concerns and advice in a non-judgemental, confidential manner. These services are funded by the Medical Board of Australia and provide vital advice and support when a GP may not be accessible. Additionally, they play an important role in educating the profession about doctor's health. **The AMA supports ongoing funding for profession-funded national confidential doctors' health programs in all states and territories to improve and promote the health and wellbeing of the medical profession.**

3.9. Individual strategies

At an individual level, there are evidence-based strategies that doctors can use to reduce stress-related ill health. **The AMA encourages doctors to explore strategies that work for them personally.** There is significant evidence to support the use of Mindfulness-Based Stress Reduction, and its inclusion in medical school curricula, with studies suggesting that it can lead to reductions in stress, anxiety, psychological distress, self-doubt and burnout, along with increased self-awareness, empathy and a positive affect [20,21]. **The AMA calls on medical schools to enhance the capacity of medical students to identify and address barriers to health and wellbeing by including evidence-based strategies in the curriculum. This includes enhancing access to independent confidential care.**

Studies have demonstrated the effectiveness of self-care activities including nourishment, hygiene, sleep-hygiene, intellectual and creative health, physical activity, spiritual care, balance and relaxation, time for loved ones, big picture goals, pleasure and outside activities, and hobbies [22]. Other initiatives previously implemented by hospital departments to help facilitate self-care include on-site gyms, Schwartz rounds, Balint groups, and leadership coaching. **All doctors and medical students should incorporate regular leave, good nutrition, exercise, leisure, spirituality, and family time into a healthy and balanced lifestyle. Additionally, they should strongly consider having appropriate insurances in place to support them through illness.**

4. TEAMS

4.1. Healthy workplaces

Evidence suggests that positive workplace cultures are associated with positive patient and practitioner outcomes [23]. Despite growing awareness amongst clinicians there are still many embedded cultural trends within the profession that act as barriers to physician wellness. Negative team culture can be a key contributor to burnout - this is particularly in relation to attitudes towards prioritising self-care, intergenerational expectations, and cynicism about value of work. **The AMA calls on all hospitals and health services to prioritise staff wellbeing and follow established guidelines for creating mentally healthy workplaces** [24].

4.2. Zero tolerance for bullying and harassment

Bullying and harassment within the medical profession plays a significant role in mentally unhealthy workplaces. This is covered extensively in the AMA's Position Statement on Workplace Bullying and Harassment 2019 [25]. There is a strong hierarchical model of training in medicine and this has led to a workplace environment where those in power can abuse their position with minimal repercussions. This structure also makes it very difficult for doctors to seek help when unwell. Doctors fear their career will be jeopardised because of the strong stigma associated with needing help, particularly with regards to mental health concerns [26,27].

Changing the workplace culture must start with hospital management and senior members of the medical profession making it clear that discrimination, bullying and harassment is unacceptable. Policies and processes to eliminate discrimination, bullying and harassment must be strengthened, including commitment at senior levels to tackling problem behaviour, and specific training for all staff including how to deal with situations of discrimination, bullying and harassment.

There must be clearly articulated policies and process on the management of discrimination, bullying and harassment to engender confidence that complaints will be treated seriously and fairly.

Processes must offer a 'safe space' for complainants so that they can raise issues of discrimination, bullying and harassment, free of shame, stigma, or repercussions. Employers need to have good performance management processes in place to avoid reasonable management actions escalating into harassment complaints.

Employers should implement and regularly review systems and reporting structures to support a zero-tolerance approach to bullying and harassment.

4.3. Creating a positive workplace culture

In addition to issues with bullying and harassment, and a fear of seeking help when unwell, a sense of collegiality may conversely increase pressure on doctors to not take care of their own health. Many doctors report being unable to take a sick day or holiday leave because they did not want to let their colleagues down and that there is an expectation to still come to work even when sick [28].**The AMA encourages all doctors and medical students to support their colleagues in maintaining their wellbeing and encourage them to seek help when unwell.**

A number of significant grassroots initiatives that promote positive professional culture have evolved in recent years. Groups such as WRaP EM (Wellness, Resilience and Performance in Emergency Medicine) [4] promote wellbeing by providing resources (how to guides) and organising events (Wellness Week). Further to this, following the lead of individual health services, a large number of pilot interventions, particularly at the junior doctor level, are now in place e.g. in New South Wales as part of the JMO Wellbeing and Support Plan. Evidence as to the effectiveness of such programs is emerging. **The AMA supports initiatives that promote a positive workplace and professional culture and encourages hospitals and health departments to support them.**

4.4. The role of the Chief Wellness Officer

More formalised initiatives include the role of a Chief Wellness Officer. This has been recognised widely in the United States of America, primarily stemming from programs at Stanford University. In Health Affairs a Chief Wellness Officer is broadly defined as "a strategist, leader, and change agent in driving system-level transformation to a culture of well-being" [26]. This is a deliberately broad definition as one of the key aspects of this position is tailoring the approach by effectively engaging with clinicians [26,29]. Research into the cost-effectiveness of a chief wellness officer has indicated that every dollar investment into clinician wellness produces a $2-3 saving in both medical costs and absenteeism [30].

Published guides for the role of the Chief Wellness Officer make some key points which include points on practical implementation which include reporting to senior leadership to enable positive organisational change and reasonable minimum resources to implement programs [29,31]. In addition to this, if senior clinicians fill this position they should be independent from assessment of juniors to maintain impartiality. There are also important guidelines for the role itself including strategic vision and direction on improving wellness, creating a culture of change, monitoring on outcomes of interventions and appropriate engagement with mental health leaders [29].

The launch of a specific Doctor's Wellbeing Officer at the Royal Perth Hospital saw far more engagement than broader employee assistance programs, with 57% of interns using the program in the first nine months [32]. Aside from the usual stressors, there is significant published evidence around the additional stressors associated with transitions (medical student to doctor, resident to registrar, registrar to consultant) and specifically addressing these to improve wellness [33-35]. **The AMA believes that hospitals should establish and fund a Chief Wellness Officer or equivalent position who can cater specifically to the needs of doctors, particularly doctors in training or transitional phases of career. This role should be based on existing published guidelines and not play a role in determining training progression.**

4.5. The impact of technology

In an increasingly technology driven society, technological advances have a complex impact on doctors' health. Significant changes in work practices and workflow arising from the implementation of such technologies can affect doctor health and wellbeing if done poorly [36] . Enhanced clinical stewardship may help to address and prevent any unintended consequences on health and wellbeing as a result of workplace changes.

The use of technology to communicate can also significantly impact on doctors' interactions with each other. Examples of this include the ability to study alone during exam periods rather than congregating in groups for support, or instant messaging team members rather than conducting in person 'paper rounds'. Counterintuitively, by having technology readily available doctors may risk becoming increasingly isolated and this is particularly true of those in at risk groups including General Practitioners, Rural doctors and those in private practice [37,38]. **When implementing new technologies, hospitals and health systems should consider their effect on staff wellbeing including funded strategies for documenting the impact on wellbeing and addressing these issues.**

5. ORGANISATIONS AND SYSTEMS

5.1. A national priority

The AMA recognises that systemic factors are the major drivers of doctors' health and wellbeing. Poor clinician wellness can affect health-care provision, and therefore **doctors' and medical student health and wellbeing should be a national priority for the health and wellbeing of all Australians.**

In 2017, the Commonwealth government funded the development of a national framework to guide coordinated action on the mental health of doctors and medical students (the framework).

The AMA supports a national framework and is committed to working in a consistent, coordinated, supportive and inclusive manner to collaboratively implement the national framework, and address the factors that will enhance the physical and mental health of doctors and medical students. **The AMA calls on the Commonwealth Government to commit to funding the implementation of the national framework to guide coordinated action on the mental health of doctors and medical students to improve the health and well-being of the medical profession.**

5.2. Leadership

Hospitals, health care organisations and management can show leadership and commitment to providing a safe working environment by developing and communicating a clear statement that articulates the organisation's commitment to a safe workplace, that they value the health and safety of their employees, and acknowledge the potential for unsafe work environments to impact on wellbeing, care quality, safety and access [39].

While managers or supervisors have a responsibility to manage the performance of an employee or trainee professionally and constructively, many individuals are placed in leadership or supervisory roles with little or no training or support. Poor performance management of doctors, medical students and doctors in training can have a direct impact on health and wellbeing, professional confidence, career progression and satisfaction.

Appropriate management and leadership training must be provided and should be a requirement for those in leadership or supervisory roles. This includes education on performance management, providing constructive feedback, communicating about difficult issues, and effective complaint management to prevent issues escalating where possible.

Skills in leadership, mentoring and management should be included in the curriculum for medical students and doctors in training and offered as continuing professional development courses for fellows. This is part of developing the qualities of professionalism and leadership in doctors and is consistent with the attributes outlined in Good Medical Practice: A Code of Conduct for Doctors in Australia.

5.3. Preventing fatigue and burnout

For doctors working in a hospital environment, long working hours, unpredictable rosters, overtime, on-call, and night shifts are important systemic barriers to the maintenance of physical and mental health and wellbeing [40-43]. International evidence suggests a linear relationship between working more hours and having higher rates of anxiety, depression, and psychological distress [40]. Similarly, Australian junior doctors identify number of hours at work, long shifts, late and inflexible rostering as key barriers to supporting mental health and wellbeing [17,44].

High workloads and disrupted schedules contribute to insufficient sleep, mood changes and lack of time for nutrition/exercise. Over time, this can manifest as significant work-life balance conflict, increasing the risk of burnout and practitioner fatigability. Fatigue in doctors is an important risk factor for use of prescription medicine for sleep, road traffic accidents, needle stick injuries, and medical errors [41,44].

Burnout is defined as individuals experiencing emotional exhaustion, depersonalisation and reduced personal accomplishment [45]. Globally, rates of clinician burnout have been reported ranging from 25-75% [46], with Australian levels averaging higher at 65-75% [47]. Burnout may affect doctors at all stages in their career and is an important contributor to psychological stress among doctors and medical students.

Rates of burnout are increasing amongst Australian doctors and there is a need to evaluate what role health services and organisations can play in preventing and correcting burnout [48]. This includes considering rates of burnout in workforce planning and ensuring appropriate staffing levels in facilities with high rates of burnout. There is some evidence for resilience training preventing burnout, however this is not conclusive and depends on the circumstance in which it is implemented [49]. **All hospital and health services should take measures to prevent burnout which include promoting a civil and respectful workplace culture, providing flexible work arrangements, and providing good health and wellbeing initiatives to all staff. To facilitate this, they should also provide adequate facilities, for example, common rooms and sleeping facilities, for those working shift work and on call.**

Healthy eating is a prerequisite for general good health, and there are numerous barriers to healthy eating amongst health professionals which include limited hospital cafeteria opening times, lack of selection for healthy food, and lack of meal breaks [50]. Healthy food options in hospital cafeterias, access to food preparation areas in private practice and clean designated food storage is a basic essential but often overlooked. New innovations such as salad robot dispensers, and fresh fruit vending machines extend health options to night shift staff. **Hospitals should recognise the importance of physical health in wellbeing and provide healthy food options and exercise facilities.**

Solutions with regards to rostering need to not only aim for a sustainable working week, but will need to look at all elements of employment agreements, innovative shift work solutions and flexible rostering – currently these rigid organisational structures and inflexible work hours are a leading cause of doctors' mental ill health [22]. **All employers of doctors should adhere to award working hour requirements, encourage doctors to claim overtime where worked, and ensure clinicians working overtime are properly remunerated. Additionally, employers should minimise unsocial and unsafe rostering practices (e.g. long runs of night and on-call shifts) and consider the effects of these on staff wellbeing.**

5.4. Access to leave

Furthermore, organisational culture has been identified as a barrier to safe working conditions including overarching expectations for doctors to finish late, work unpaid overtime, not take sick leave and not utilise meal breaks [17,44]. Examinations during career progression can be exceptionally stressful periods of time and employers should prioritise support and access to quarantined study leave at the time they require this leave [51].

All hospitals and health services should ensure their employees have access to sick, personal and other forms of leave that meet the standards for public sector employees; and that adequate relief is available for doctors to take emergent sick, personal and other forms of leave, both planned and unplanned.

5.5. The role of the Specialty training colleges

Specialty training colleges play a crucial role in the wellbeing of their members. Inflexible workplace arrangements during training years is a key issue for many current and future trainees. In 2015, 16.2 percent of advanced trainees were undertaking part time work. Part-time training was more common in sexual health medicine, addiction medicine and general practice. Notably, several specialties with significant trainee numbers had very low rates of part-time training [11]. Frequent relocation of trainees to meet college requirements may also contribute stress and negatively impact wellbeing [52].

The 2014 AMA Specialist Trainee Survey revealed that while trainees felt optimistic about access to flexible training options, policies on flexible employment arrangements were not always widely publicised. It recommended that Colleges should promote and explore further options for flexible training posts, such as flexible full time, job-share and part-time positions, with the option to pilot flexible training positions. **Specialty training colleges should ensure their training programs place the wellbeing and health of the trainee as a core principle, considering issues such as requirements for entry into training, training requirements, flexibility in training, performance management, exam failure and stress.**

Colleges must also actively collaborate with employers to implement more flexible training structures to facilitate healthy work-life balance among their trainees while ensuring training quality is upheld.

5.6. Flexible work arrangements

Changes in the demographics and composition of the medical workforce and in societal attitudes towards work life balance are driving changes towards greater flexibility in work arrangements. The AMA National Code of Practice on National Code of Practice - Flexible Work and Training Practices provides guidance on implementing best practice flexible work and training policy and arrangements to support doctors and employers achieve a balance between family, work and other responsibilities in life [53]. This will not only benefit doctors and employers but also the quality of care provided to patients and the wider community.

5.7. Engaging clinicians in decisions that affect them

As the nature of healthcare and service delivery continues to evolve so do the daily tasks of a clinician. There is increasing evidence to suggest that reduced physician autonomy, organisational bureaucracy and compassion fatigue are contributing significantly to burnout and clinician unwellness [46]. The solutions to these are necessarily organisational; structural and cultural change is required.

A significant cause for these high rates of stress and burnout amongst doctors is that time at work is often frustrating and unrewarding. There are many factors contributing to this which are identified in the literature, and include institutional failure, increasing administrative burden, a bureaucratic professional regulatory system, rigid organisational structure, and systems of governance that lead to a loss of clinician autonomy [5,28,54,55].

Doctors spending more time on administration have been found to have lower career satisfaction, even after controlling for income and other factors [56]. Implementation of electronic health systems and increasing administrative tasks for doctors removes practitioners from the bedside.

Studies modelling the causes of work stress identify that jobs are stressful when there is a high demand but no power to alter the situation, a circumstance very common for doctors who are working under immense pressure in a resource poor setting. It will be important when looking at methods to maintain doctors' wellbeing, that healthcare systems continue to strive for manageable workload and clinician satisfaction when at work.

Removing sources of frustration and inefficiency can lead to increased productivity and decreased levels of burnout. Initiatives to redesign care processes, minimise unnecessary paperwork and reduce tick box activities may lead to increased work satisfaction in medical workplaces [57]. Investing in streamlining technologies such as mobile EHR devices, voice recognition software and meaningful optimisation focusing on user experience of EHRs will make some progress towards this [58].

When considering such initiatives, the literature suggests that top-down approaches are unsuccessful because there is minimal engagement from frontline doctors and there exists no bottom-up feedback mechanism for discussing healthcare delivery and decision making. Therefore organisation-directed interventions should engage on a meaningful level with doctors and incorporate clinicians into leadership positions and policy development roles [59]. All initiatives and policies that promote the health and wellbeing of doctors should also be objectively evaluated.

5.8. Mandatory reporting requirements

Medical professionals who experience mental ill-health and suicidal behaviour can and do provide quality patient care. Mandatory notification under the National Law refers to the requirement, under each state's respective Health Practitioner National Law Act, for doctors to report other health professionals who place the public at substantial risk of harm because the practitioner has an impairment (such legislation also mandates reporting for intoxication, sexual misconduct, and departure from professional standards; while these may be identified in doctors who are unwell, these are not considered here). This is necessarily a high threshold for a notification to occur, however many doctors are fearful of being reported due to the significant stigma associated with notifications within the medical community [60]. **All doctors should be aware of the precise application of current mandatory reporting requirements for treating practitioners and for doctor-patients. Employers should also be aware of these requirements.**

The literature is clear in that doctors find mandatory reporting a barrier to them seeking help when unwell [61,62]. 34% of respondents in the Beyond Blue survey described concerns about notification to AHPRA as a significant barrier to seeking treatment when concerned for their mental health [4]. **AHPRA should acknowledge the impact of regulatory issues on doctors, ensure transparency in processes, and that doctors have access to support during the regulatory process. Further, they should continue to further educate clinicians as to mandatory reporting thresholds and work to reduce stigma associated with mental ill health.**

The AMA continues to support changes to the Mandatory Reporting law. Australia's medical practitioners desperately need legislation that does not actively discourage them from seeking medical treatment when they need it. Practitioners are also patients, and should have equal rights to their patients, in that their access to medical treatment should be equal to all other Australians.

The unintended consequences from the operation of the current law are far reaching, with doctors and their families suffering, and a less safe system for patients. For the treating practitioner it has a detrimental impact on the confidentiality of the doctor-patient relationship. The provisions in the law in Western Australia (WA) provide a suitable and tested model. There is no evidence to suggest diminished patient safety in WA. Adoption of the WA model would also provide much needed national consistency. **The AMA calls on all jurisdictions, with the exception of WA, to amend their respective laws to reflect the exemptions in place under the Western Australian model.**

In addition to mandatory reporting, medicolegal issues, notifications, and complaints to regulatory bodies in general have a significant detrimental effect on doctors. The medical landscape is becoming increasingly litigious with a 50% increase in complaints to AHPRA from 2010 to 2018 [63]. Complaints provoke anxiety amongst doctors as their abilities are scrutinized and their practices questioned; this promotes feelings of anger and frustration leading to distress [64]. Studies have shown that 30-40% of doctors considered retirement or leaving medicine entirely after receiving a complaint and one of the strongest predictors for psychiatric illness amongst doctors is exposure to a current legal matter [46,65]. Research suggests that even after the exposure there are changes in practice and changes in personal behaviours such as increased alcohol use that persist.

Given the effect of notifications and complaints in causing psychological distress, regulatory bodies should ensure medicolegal processes are transparent and efficient.

5.9. Combating stigma

There is a significant stigma surrounding mental health conditions within the medical profession and this prevents clinicians from seeking help [61]. Research into various programs has shown that improving education, correcting attitudes and improving communication can help to reduce this stigma [62]. A large number of awareness-raising initiatives exist, including staff wellbeing days, R U Ok day, the BPT-OK program, AMSA's Blue Week and Crazy Socs for Docs day [63] and these have successfully brought doctors' wellbeing to the forefront.

Hospitals and health services should promote initiatives aimed at reducing stigma surrounding all doctors' health issues including mental health issues amongst the medical profession.

5.10. Supporting return to work

Doctors who face challenges from physical or mental ill health should be supported by their workplaces. Return to work programs following breaks for physical or mental health reasons, or upon return from parental or other leave, are distinctly lacking in health service environments. Having to be away from work is a major challenge to self-worth and sense of self, which is compounded by difficulty in returning. Delays also create CV gaps that may impact on future employment. Customised stay-at-work and return-to-work plans enable those who live with mental ill health to continue to contribute to the health workforce [57]. All hospitals and health services should ensure appropriate programs, services, and policies are developed and are in place to support access to treatment and facilitate both return to work and continuance of training while carefully protecting individual confidentiality and privacy. This will help the institution manage risk more effectively.

5.11. Strengthening accreditation standards

Accreditation bodies such as the Australian Medical Council and postgraduate medical councils ensure the standard of teaching and training for doctors in Australia. The provision of standards that relate to the health and wellbeing of doctors and medical students varies across agencies and programs. Accreditation bodies should require accredited bodies to report against these standards, demonstrating how they ensure the health and wellbeing of doctors and medical students.

The AMA calls for the Australian Medical Council to ensure that the standards for the accreditation of primary education, internship, prevocational and vocational training require medical education and training providers and settings to provide an environment that supports doctor and medical student health and wellbeing. Furthermore, accreditation standards should require all training programs to include doctor health and wellbeing as part of their curriculum and health and wellness programs and initiatives should be regularly evaluated.

5.12. Funding for research

Knowledge as to risk factors, barriers, and attitudes in relation to doctors' and medical students' health has increased greatly in recent years. Interventions to address this, however, are either emerging or yet to be effectively evaluated. Many of the interventions that are currently supported by the literature focus on the effectiveness of programs promoting resilience and mindfulness. Further research is required into primary prevention of burnout and reducing work-related stress at an organisational level. Evaluation should not only focus on participant feedback but include other objective measures. The AMA calls on government and other healthcare and educational institutions to fund further research into system-wide interventions, to address the wellbeing of doctors and medical students, and for funding to establish a national doctor suicide registry.

6. SUPPORT SERVICES FOR DOCTORS' HEALTH

DRS4DRS www.drs4drs.com.au/

The state-based services are listed as follows:

- AMA Tasmania Peer Support Service: 1300 853 338 (8am to 11pm)
- Doctors Health Advisory Service Australian Capital Territory and New South Wales: 02 9437 6552
- Doctors Health Advisory Service Western Australia: 08 9321 3098
- Doctors Health South Australia (also covers Northern Territory): 08 8366 0250
- Queensland Doctors' Health Programme: 07 3833 4352
- Victorian Doctors' Health Program (also covers Tasmania): 03 9280 8712

Crisis support

Support for a crisis is available from the following providers, or may be accessed through attendance at an Emergency Department depending on the nature of the crisis.

- Lifeline: 13 11 14
- BeyondBlue: 1300 22 46 36
- Suicide Call Back Service: 1300 659 467

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