As we immerse ourselves into this wonderful account of our work and challenges as doctors, and reflect upon our personal lives as well as our physical and mental health, we appreciate more and more that everyone should have a family doctor. Michael and Leanne are indeed the best family doctors to author Every Doctor because they have demonstrated in this book how much they understand about us as medical practitioners, as leaders and advocates, and about our journeys and our future. They share precious experience and offer precious advice.

Dr Donald Li (Hong Kong, China), President, World Organisation of Family Doctors (WONCA), 2018–2020

I am delighted that Drs Rowe and Kidd have written another golden book for doctors on mental well-being and cultural change. Once again, they have used their considerable expertise to hit the mark. It will join their first book on my bookshelf and I suggest other doctors do the same.

Dr Geoffrey Toogood, Cardiologist, Mental Health Advocate and Founder of #crazysocks4docs

Every Doctor spoke to me deeply and personally – listening to its wisdom, touching me in areas of meaning and significance in my life as a physician, medical leader and human being. Emphasizing how important it is to care for each other as we face the challenges of 21st-century medical practice, I felt cared for, much like I do when visiting my personal family doctor. Every Doctor will speak to you as well.

Associate Professor Sandy Buchman, Family Physician Practising in Palliative Care, President-Elect of the Canadian Medical Association

If you ever feel like giving up medicine – and all of us have those sorts of days – then this remarkable, courageous and joyful book is the one for you.

Dr Iona Heath CBE, President, Royal College of General Practitioners (2009–2012)
Congratulations to the respected authors in another vital string to their bows to support us doctor colleagues on how to not ignore ourselves. Doctors’ own health continues to gain priority globally recognising the most important tool in our workplace is the Doctor. The World Medical Association’s ‘modern Hippocratic Oath’, the Declaration of Geneva, now recognises this. This book is a must to take time out of the busy unrelenting day to address and plan and ACT to keep that instrument sharp! Physician heal thy self is not enough.

Dr Mukesh Haikerwal AC, President of the Australian Medical Association (2005–2007) and Chair of the Council of the World Medical Association (2011–2015)

Sometimes we read to escape from the demands of our daily lives – and sometimes we read in order to refresh our practice; to gain renewed understanding and take new opportunities. This book will challenge, question and support us to be more aware of both the risks we run as doctors, and how we can deal with them effectively and fruitfully. Read it alone, or with colleagues, and then discuss – it will be worth it.

Professor Amanda Howe OBE, President, World Organisation of Family Doctors (WONCA), 2016–2018

With intelligence and keen insight based on extensive clinical, organisational and life experience, Drs Leanne Rowe and Michael Kidd deliver a powerful wake-up call to doctors. Writing with warmth and empathy but no holds barred, they ask us to ‘get our own house in order’ for the benefit of all involved. I believe that doctors throughout the world will appreciate their efforts and resonate with the quality and character of the work.

Professor David Bennett, Senior Staff Specialist in Adolescent Medicine, Sydney Children’s Hospital Network, Australia

As implicit in the title the book reaches out to every doctor from recent graduates to the experienced – general practitioner and specialist. The message is universal, timeless and challenging.

Emeritus Professor John Murtagh, Department of General Practice, School of Primary Health Care, Faculty of Medicine Nursing and Health Sciences, Monash University, Australia
EVERY DOCTOR
WONCA Family Medicine

ABOUT THE SERIES

The WONCA Family Medicine series is a collection of books written by worldwide experts and practitioners of family medicine, in collaboration with *The World Organization of Family Doctors* (WONCA).

WONCA is a not-for-profit organisation and was founded in 1972 by member organisations in 18 countries. It now has 118 Member Organisations in 131 countries and territories with membership of about 500,000 family doctors, serving more than 90 percent of the world’s population.

The Contribution of Family Medicine to Improving Health Systems: A Guidebook from the World Organization of Family Doctors

*Michael Kidd*

International Perspectives on Primary Care Research

*Felicity Goodyear-Smith, Bob Mash*

Family Medicine: The Classic Papers

*Michael Kidd, Iona Heath, Amanda Howe*

For more information about this series, please visit: https://www.crcpress.com/WONCA-Family-Medicine/book-series/WONCA
EVERY DOCTOR
HEALTHIER DOCTORS = HEALTHIER PATIENTS

Leanne Rowe
Clinical Professor and Deputy Chancellor
Monash University, Australia

Michael Kidd
Professor and Chair of the Department of Family and Community Medicine
University of Toronto, Canada
Professorial Fellow
Murdoch Children’s Research Institute, Australia
Professor of Global Primary Care
Southgate Institute for Health, Equity and Society, Flinders University, Australia
To our husbands, Alastair McEwin and Peter Jasek
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‘Every Doctor’ forms a trilogy in the Leanne Rowe – Michael Kidd authored series of publications. Readers who have enjoyed and appreciated the writings of these authors, particularly through their previous books, ‘First do no harm’ and ‘Save your life and the lives of those you love: your GP’s 6 step guide to staying healthier longer’ will find ‘Every Doctor’ an extension of an interesting and challenging manifestation of the authors blueprint for optimising one's vocational journey through medicine and for a healthy practice.

Familiar topics that have been expanded include leadership, environmental protection, mental health covering common psychiatric and behavioural conditions and also practical advice for stress management, grief management and healthy lifestyle. There are myriads of good tips for coping mechanisms, which are presented as helpful checklists.

As in First Do No Harm, a series of appropriately chosen quotations ranging from famous figureheads to relatively obscure but significant acquaintances form a type of literary framework to develop the book’s thesis. This is reminiscent of the relevant quote of Rudyard Kipling ‘he wrapped himself in quotations – as a beggar would enfold himself in the purple of emperors’. Kipling also famously said ‘I am, by calling, a dealer in words and words are, of course, the most powerful drug used by mankind’. The authors use words in a masterly plain language and this, of course, renders ‘Every Doctor’ very readable.

The book follows several themes, which include ‘be kind to yourself and enjoy your work’, ‘develop a workplace culture of positivity, happiness, caring and love’, ‘promote optimal standards of patient care’ and ‘cultivate positive change in your workplace’.

There is an interesting pervasive philosophy that is reminiscent of Aldous Huxley’s Brave New World, with yet another relevant quote ‘Words can be like X-rays if you use them properly – they’ll go through anything’.

Michael bravely provides insight into how he confronted and coped with many personal challenges in his life – a fact that earned the respect and admiration of his colleagues. It is a most interesting highlight. Likewise, Leanne shares her innermost distracting human feelings that impact her life as a general practitioner in a rural community while maintaining a caring, diplomatic and brave persona.
As implicit in the title, the book reaches out to every doctor from recent graduates to the experienced – general practitioner and specialist. The message is universal, timeless and challenging.

Emeritus Professor John Murtagh AM
Department of General Practice
School of Primary Health Care
Faculty of Medicine Nursing and Health Sciences
Monash University, Australia
Authors

Leanne Rowe is a family doctor and clinical professor at Monash University, Australia, who has cared for other doctors as patients for many years. She is a past Chairman of the Royal Australian College of General Practitioners, Deputy Chancellor of Monash University and non-Executive Director of beyondblue: the national depression initiative in Australia. Among her many awards are the Rose Hunt Medal from the Royal Australian College of General Practitioners, the ‘Best Individual Contribution to Health Care in Australia’ award from the Australian Medical Association and a Doctor of Laws (Honoris Causa) from Monash University for her service to the university. In 2007, she was made a member of the Order of Australia for services to medicine and education.

Michael Kidd is a family doctor, current Professor and Chair of the Department of Family and Community Medicine at the University of Toronto in Canada, Professorial Fellow with the Murdoch Children’s Research Institute in Melbourne and Honorary Professor of Global Primary Care with the Southgate Institute for Health, Equity and Society at Flinders University in Adelaide. He is a past President of the World Organisation of Family Doctors (WONCA), past president of the Royal Australian College of General Practitioners and former Executive Dean of the Faculty of Medicine, Nursing and Health Sciences at Flinders University. He has served as a consultant to the World Health Organization on primary care, family medicine, health workforce training and mental health. In 2009, he was made a member of the Order of Australia for services to medicine and education.

Website: www.everydoctor.org
Disclaimer: The information in this book is based on the research and personal and professional experiences of the authors. It is not intended as a substitute for consulting with your own physician or other healthcare provider. Medicine is an ever-changing science. The authors, editors and publisher of this book have checked all information with sources believed to be reliable, in keeping with the standards accepted at the time of publication. However, readers are encouraged to continually update their knowledge particularly in relation to medical assessments and treatments in accordance with current evidence-based guidelines.
Introduction

The life so short, the craft so long to learn.

Hippocrates

As medical practitioners of all specialties, we are a diverse, global group of women and men bound by long traditions, deep insights into life and a common purpose to care for people and communities.

Together, we work in complex, changing environments and we are witnessing transformational advances in medical, surgical and Health technologies, particularly in the last decade. In the next decade, further subspecialisation of medicine and disruption of our unsustainable health systems are inevitable. In the near future, some specialties currently regarded with high status will no longer exist, which is both exciting and threatening.

There are immense challenges facing the 21st-century doctor – stress, burnout, mental illness, suicide, substance abuse, bullying, harassment, discrimination, patient-initiated anger and violence, and medical litigation – all of which result from and often contribute to a negative medical culture and which can interfere with the quality of our patient care.

There is a mountain of commercial wellness books on work/life balance, positive psychology, stress management, communication skills and sleep hygiene, but many doctors find that generic self-help strategies don’t work in medicine because of the excessive pressures in our daily lives. For example, the competitive nature of our training programmes, exhaustion due to long working hours and broken sleep, chronic exposure to patient misery, trauma and death, and threats of medico-legal action or deregistration can all weigh heavily on even the most resilient doctor. Information about healthy nutrition, exercise, meditation and mindfulness is everywhere, but how do we find the time to prioritise self-care when just getting through each day can be a challenge in itself, particularly where there are health workforce shortages?

As doctors, we carry an enormous sense of obligation and commitment to our patients. For this reason, the medical profession has had a long and admirable, but often unhealthy tradition of self-sacrifice and selflessness at work. The culture of the medical profession is such that the signs of burnout are often
worn as badges of honour. It’s time to change the mindset that being a worn-out medical practitioner is the sign of a dedicated doctor.

The tendency to strive to be a perfectionist, self-critical and risk-averse person are traits that can make us great doctors but can also make it difficult to work and live with us. When we raise the bar too high, we can become worn out by our impossible expectations. How many of us are surviving or enduring, rather than thriving and experiencing joy in life and medicine?

While our medical organisations advise us to seek professional support and balance between our work and life, our medical culture is rarely conducive to doing so. In reality, medical workplaces can be harsh, cold environments, and there is very little understanding for doctors who are perceived to not be carrying their weight or ‘not up to it’.

On the other hand, if you are one of the fortunate among us who thrive in medicine and have not yet experienced burnout first hand, this book is also for you. We would challenge you to be proactive in protecting yourself and others, and encourage you to open your eyes to the stigma preventing your colleagues from seeking your support.

There are solutions to these complex problems.

**Who is this book for?** As audacious as it sounds, this book is for *every doctor* – doctors of all specialties at all career stages, including medical students, recent graduates, doctors in training, experienced doctors and those approaching or beyond retirement, because exemplary care of our patients, our peers, our profession, our community – and ourselves is a life journey.

**Why this book?** Our starting point is excellence in patient care. Clearly, to provide consistent high-quality patient care, we must care for our own health and for the health of our colleagues.

**What is this book about?** This book is different from generic self-help and mental health books in that it discusses practical strategies that work in medicine, based both on the medical literature and the wisdom of experienced doctors.

First, it is about treating ourselves well – finding our ‘mighty purpose’ and creating our legacy; discovering and rediscovering great joy and beauty in medicine; transcending common stressors in medicine; taking back control of our time while maintaining our duty of patient care; building stronger relationships with our colleagues; responding constructively to inevitable criticism, conflict and complaints; strengthening our personal resilience; caring for our own physical and mental health as priorities; dealing with extraordinary crises and trauma; and seeking support, regular debriefing and professional help from other practitioners.
It’s about collaborative medical leadership in everyday practice through caring for our colleagues, strengthening our clinical teams and changing our medical culture. These are major challenges in themselves because the focus of our care is often on our individual patients in the solitude of our consulting rooms, rather than creating a healthy environment in which we can all flourish.

To summarise, there are three themes underpinning this book, which we hope will begin a new conversation about our individual and collective fortitude and common humanity at a time of immense change and challenge. By collaborating, every doctor can rediscover joy in medicine by

- Improving our physical and mental health to provide patient care of the highest standard.
- Creating a healthier and happier medical culture.
- Leading and influencing positive changes in our workplaces every day.

Most of all, we want feedback from every doctor about ways we can do things better and what works best for us in practice. We are all still learning.

**Leanne Rowe and Michael Kidd**

There’s a way to do it better. Find it.¹

Thomas Alva Edison

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¹ Thomas Alva Edison (1847–1931) was an American inventor and businessman, described as America’s greatest inventor.
SECTION 1

Every Doctor Can Improve Their Physical and Mental Health to Provide Patient Care of the Highest Standard

Wherever the art of medicine is loved, there is also a love of humanity.

Hippocrates

Every doctor awakes each working day or night with the desire to provide excellence in patient care. By the very nature of our work, our care for our patients sometimes happens at the expense of our self-care and our enjoyment of life. A medical career is challenging and requires fortitude, courage and humility.

Section 1 of this book discusses practical ways for every doctor to become mentally and physically healthy by

- Discovering our ‘mighty purpose’.
- Experiencing joy and beauty in medicine.
- Taking control of our time.
- Strengthening our personal resilience.
- Nurturing strong relationships at home.
- Trusting our own doctor.
• Prioritising our wellness and physical health.
• Dealing with immense stress.
• Living with loss, grief and serious illness.
• Seeking help for mental health problems early.

The most important takeaway message from this section is for all doctors to have their own trusted doctor, a family physician or general practitioner, for regular comprehensive preventive health checks, including mental health screening, routine debriefing, best practice management of mental health problems and crisis intervention or postvention, especially following exposure to trauma or suicide. Every doctor deserves the same standard of care that we give to our own patients.

A medical career is not to be endured – it is to be enjoyed.

When a medical student must be converted into a physiologist, a physicist, a chemist, a biologist, a pharmacologist and an electrician, there is no time to make a physician of him (or her)…That will only happen after he (or she) has gone out in the world of sickness and suffering.¹

Sir Andrew MacPhail

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¹ Sir Andrew MacPhail (1864–1938) was a Canadian physician, author, soldier and professor of medicine.
CHAPTER 1

Discovering Our ‘Mighty Purpose’

This is the true joy in life, being used for a purpose recognized by yourself as a mighty one: being a force of nature instead of a feverish, selfish little clod of ailments and grievances, complaining that the world will not devote itself to making you happy.¹

George Bernard Shaw

INSPIRATIONAL ROLE MODELS

We all have our medical heroes, our role models. One of our shared heroes is Dr Catherine Hamlin.

Gynaecologists Catherine Hamlin and her husband Reg left Australia in 1959 to travel to Ethiopia where they established the Addis Ababa Fistula Hospital. They have successfully operated on tens of thousands of women in Ethiopia. They have also advocated for improving the access of women of all backgrounds for fistula repair and safe maternal care at an international level.

Since Dr Reg Hamlin passed away in 1993, Dr Catherine Hamlin has continued to pioneer and teach procedures for obstetric fistula repair to surgeons from around the world. Many of her accomplishments have been achieved during times of war in Ethiopia. In a tribute to her late husband, Catherine Hamlin said:

Reg was terribly touched by the plight of these poor women. He called them the fistula pilgrims on account of the tremendous journeys they undertook to get to the capital. He would hear how they had suffered and been rejected, and of their struggle to get to the hospital, how they perhaps had to sell an animal or beg to raise the money, and often, as he listened to their stories, he would have tears in his eyes. If fistula sufferers turned up at outpatients, the other women would push them to the end of the line because they were

¹ George Bernard Shaw (1856–1950) was an Irish playwright, awarded the Nobel Prize in Literature in 1925. Acknowledgement: The Society of Authors, on behalf of the Estate of Bernard Shaw.
so offensive to be near. Reg would go to them and put his arms around them and say, ‘You’re the most important patient to me today. I’m going to see you first.’ With the fistula pilgrims, he found the great cause he had been seeking. He was drawn to them because he loved them. We found that looking after them was never a hardship and never once did we feel we wanted to do something else.

In her book, *The Hospital by the River*, republished in 2005, Catherine Hamlin reflected on her motivation to continue her work:

As I look back over my life with Reg and our work with the women of Ethiopia it surprises me sometimes to realize that I am 77 years old. Never for a moment have I felt like retiring, or wanted to change my life or my work. I still operate several times a week, and my hands are as steady as ever. Although my life has been spent working for fistula patients, the fascination and appeal has never paled.

Dr Catherine Hamlin has been made a Companion of the Order of Australia, was awarded the ANZAC Peace Prize, received the Gold Medal from the Royal College of Surgeons and was nominated for the Nobel Peace Prize.

Few of us can contribute like Catherine Hamlin. However, it is worth noting in her tribute to her late husband, Catherine Hamlin highlights her admiration for his enduring compassion for his patients, ahead of his innovative surgical techniques, his dedication to teaching and his international advocacy for women. In pursuing her ‘great cause’, she endured the trauma of being exposed to poverty and war, and continues to create a legacy, now aged in her 90s, which is an inspiring example for us all.

Medicine is inherently a ‘great cause’ or a ‘mighty purpose’ because of our potential to make a difference to people’s lives as compassionate, dedicated doctors, whatever our specialty and wherever in the world we practice. Whether we work as a solo doctor in a remote indigenous community, as a member of a team of clinicians in a city clinic or hospital, or lead a global medical organisation with thousands of members, our legacy can be equally profound. This is not about a crusade or a single-minded quest for martyrdom. Rather, it is about identifying a meaningful purpose with specific goals relevant to the stage of our
career and our professional and personal circumstances, to help us persevere through challenges.

I am only one, but I am still one. I cannot do everything, but still I can do something. And because I cannot do everything I will not refuse to do the something that I can do.³

Helen Keller

GOALS AND PRIORITIES

For some of us, during our medical training, our all-consuming goal will be to pass our exams. There seems to be very little time for anything else. When we complete our specialty training, our focus may be on obtaining a preferred position or setting up a medical practice. After we have established our medical career, we may flounder if we do not have broader goals beyond our work that change over time. We may recognise that although our achievements are admirable, our limited medical career goals do not sustain us through the inevitable everyday setbacks or major crises of our lives. Throughout this demanding journey, we also have to juggle the expectations of our families and friends.

For these reasons, it can help to develop goals across different dimensions of our lives beyond our medical careers.

Try this exercise:
You may find it helpful to consider some of the following questions when trying to determine your own goals and priorities:

**Your spiritual life.** What is most important in your life? What do you find uplifting and are you pursuing this? What are your values and are you living them? How are you caring for your soul? Who inspires you and why?

**Your relationships with other people.** Which relationships are most important to you? What qualities do you seek in your relationships?

³ Helen Keller (1880–1968) was deaf and blind from the age of 19 months following scarlet fever, learned to read (in several languages) and speak, eventually graduating with honours from Radcliffe College, and went on to author 13 books.
Are you spending enough time with people you love and who provide you with support?

**Your mental health.** Are you experiencing joy in your life? How are you being proactive in protecting your own mental health?

**Your physical health.** Are you taking care of your physical health as well as you advise your own patients to do the same? How can you fit more exercise into your everyday schedule? When did you last see your own doctor for a comprehensive preventive health check-up?

**Your social and personal life.** What leisure activities energise you and give you the greatest pleasure? Are you doing them? Have you planned regular periods of leave from your work?

**Your security.** Financial security is an important goal, but has money become too prominent in your life? How much money is enough? Have you taken the time to seek competent financial and legal advice?

**Your legacy.** In your retirement, what will you be most proud of? What legacy will you leave and why is this important to you?

What are your specific realistic goals in the next few months, and in the next 5–10 years? At times, your main goal will be just to get through each day. At other times, you will find you can transcend the challenges of each day by focussing on the bigger picture of your life.

Here are some further questions to help you define your priorities:

What is most important to you in your life and in medicine?
What are the three best and three worst things about your work?
If you could, what would you most change at work and home? What are the ways to make this happen?
Are there things you would like to be doing that you are not doing?
Why, how and where are you spending your time? What would you like to do more often?
What can you do now to improve your work and life balance?
What can you delegate, safely avoid or defer?
What advice would you give to a new colleague or a son or daughter about to enter into medical training or practice? Are you taking your own advice?

By doing this exercise, you may be able to identify what is most important in your life and medicine.
Tell me, what is it you plan to do with your one wild and precious life?[^4]

Mary Oliver

Consider keeping a journal or diary to help you maintain your focus on your big picture goals. It may include your own observations, your insights into humanity, letters from your patients and your reflections on your mentors, your teachers and your work. Over time, it will become a priceless personal collection of your individual contribution as an extraordinary doctor.

The first few years of practice one is caught up in mastering the technical aspects of the discipline. You may forget what you don’t write down, and recalling the stories of individuals you meet over the years will be a source of pleasure, perhaps of research, and a testament to your vocation.^[5]

Professor Ruth Wilson

**IN SUMMARY**

The power of a ‘mighty purpose’ is exemplified by Dr Catherine Hamlin and her late husband Dr Reg Hamlin and their work to improve the lives of women in Ethiopia; unmoved by the physical dangers of their environment and bound by the great cause of providing compassionate care.

Like the Hamlins, discovering ‘our mighty purpose’ is about the profound value of developing and realising our own ‘great cause’, through the contributions each of us makes in medicine. A focus on big goals in different aspects of our lives can provide a sense of resolve where daily setbacks are common and may be a source of inspiration in times of temporary disappointment. By underpinning our belief in the big impact of our work, this unifying goal can provide some much-needed clarity in navigating the challenges of our own medical specialty.

[^4]: Mary Oliver (born 1935) is an American poet and winner of the National Book Award and the Pulitzer Prize.

[^5]: Professor Ruth Wilson is a Canadian family physician, educator and professor of family medicine at Queen’s University, and was also an appointed Member of the Order of Canada in 2015.
CHAPTER 2

Experiencing Joy and Beauty in Medicine

A HUGE AND HUMBLING PRIVILEGE

If we remember our first day in the dissecting room clearly, we also remember our first day in labour ward. Being present at childbirth is to share in a huge joy – there is so much joy to go around, a little spills over into all but the most jaded heart. It is always, as if for the first time, to experience a thrilling shock – for there is something shocking, and dislocating, in the final emergence of that new small slippery being. The image in the film Alien, as the pupal-stage alien bursts from the chest of the host human, captures some of the weird other-worldly shock of the first childbirth I ever saw.

Paradoxically, as a doctor, I find my greatest satisfaction now comes from the treatment of, or more accurately the offering of assistance to, the dying. Satisfaction may seem an odd word for this work, which is often emotionally harrowing – but its satisfactions are deeply nourishing. Palliative care, in the argot, has recently, and not before time, become a growth specialty. Being present at death – death at home, among loved ones, from which pain has been banished, and in which the dying person has been granted time and space to come to terms with the fact – to be part of this, in however small and peripheral way, is a huge and humbling privilege. To write about it is near-impossible: firstly, to decide if you have the right, secondly, to tread the fine line between mawkish sentimentality, and too-clinical distance.

Several times I’ve used a female doctor persona to represent the ‘feminine’ side of these feelings: the caring side. Its opposite, the objective ‘masculine’ practitioner, has variously been transformed into a pedantic Latin scholar, and, more recently, a mathematician, obsessed by that purest of the sciences, a world free from any human contamination.

In part such representations are another exorcism, and no doubt somewhere between the two is an ideal narrator: a narrator who can handle all the stories of horror, squalor, stupidity, death – and occasional transcendent courage, or love – for which I can’t yet find a proper focus, or tone.
Of course, death is not easily house-trained; it is rarely so amenable to human management and control – to the schedules of an idealised Good Death. It’s more often sudden, or violent, or cruel, or painful, or terrifying. And its world, and the stories from that world, are almost unfathomable.

Dr Peter Goldsworthy

As described by our colleague, Dr Peter Goldsworthy, a medical career is a huge and humbling privilege. We develop unique insights into life, frequently witness love, inspiration and courage, form close connections to extraordinary people, gain deep satisfaction from helping a diverse range of people, and are learning about amazing advances in medicine, every day.

While we are not always successful with our first choice of specialty, we can have many opportunities and develop many special interests throughout our careers. We can do clinical work, teaching, research and seek leadership roles. We can be powerful advocates for healthcare reform and health equity. All of these experiences can give us a sense of deep satisfaction, fulfilment and joy.

There are also many dimensions of medicine, which can be deeply painful. We can be exposed to misery, trauma, injustice, anger, bullying, violence and death on a daily basis. We can see firsthand the impact of poverty, child abuse, violence, and drug and alcohol abuse on our patients and their families.

Medicine, like any work which involves contact with a lot of human misery – and human stupidity – tends to shrivel the heart.

Dr Peter Goldsworthy

When we accumulate negative memories as our medical careers progress, we can develop a negative cognitive bias where we become overly risk averse, continually watching out for anything that may go wrong, unconsciously and constantly scanning the world for threats, and sometimes assuming the worst-case scenario without proper evidence. We can also fall for the trap of being hyper-vigilant when we no longer need to be or when it is no longer helpful. If we try, we can always find something to worry about and we can forget to seek joy and beauty in our everyday experiences.

There are a number of formal psychological approaches, which can help us understand and address our negative biases. Cognitive behavioural techniques

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1 Dr Peter Goldsworthy is an Australian writer and medical practitioner, who has received numerous awards for his many short stories, poems, novels and opera libretti.
challenge our unhelpful beliefs and common faulty thinking patterns, which predispose us to feeling negative or sad. Acceptance therapy encourages us to accept the things we cannot change or influence and let go of our attachment to the negative with a healthy dissociation.

Positive psychology encourages us to pursue a meaningful life, with focussed attention on nurturing positive relationships and simple pleasures. It encourages regular mindfulness, meditation, relaxation and the practice of gratitude, kindness and forgiveness. It helps us recognise and develop our inner strength, and gain a sense of accomplishment, pride and optimism. We can also use positive psychology techniques to make sense of some contradictory feelings we may experience about the deep satisfaction and enormous responsibility of our work.

You become a doctor for what you imagine to be the satisfaction of the work, and that turns out to be the satisfaction of competence. It is a deep satisfaction very much like the one that a carpenter experiences in restoring a fragile and tea chest, or that a science teacher experiences in bringing a fifth grader to that sudden, mind shifting recognition of what atoms are. It comes partly from being helpful to others. But it also comes from being technically skilled and able to solve difficult, intricate problems. Your competence gives you a sense of identity. For a clinician, therefore, nothing is more threatening to who you think you are than a patient with a problem you cannot solve.²

Professor Atul Gawande

American psychologist and author Professor Martin Seligman has written extensively on positive psychology and describes three belief patterns that commonly apply to doctors and may predispose us to negative thinking:

- **Personalisation** – We may inappropriately assume responsibility for a clinical incident we did not cause, and experience self-doubt. It is often the system of healthcare, funding shortfalls and workforce shortages, which directly result in many adverse events rather than individual error, and we should not always blame ourselves.

² Professor Atul Gawande is a surgeon, public health researcher and writer having published four New York Times bestsellers including *Complications, Better, The Checklist Manifesto* and *Being Mortal*. He practices general and endocrine surgery at Brigham and Women’s Hospital in the United States. He is Professor in the Department of Health Policy and Management at the Harvard TH Chan School of Public Health and the Samuel O Thier Professor of Surgery at Harvard Medical School.
• Permanence – An error in thinking that the effect of the event (for example, a dispute with a colleague, a complaint from a patient or a clinical error) will be lifelong. Doctors learn with experience that negative experiences fade and we will feel better in time.

• Pervasiveness – We may hold the belief that an event (or a period of heavy workload) will affect all areas of our lives and is insoluble. This is rarely the case, and we can try to cultivate positives in other dimensions of our lives to counteract inevitable challenges. In addition to being doctors, we are partners, parents, children and grandchildren, siblings and friends.

We can practice positive psychology in small ways and find joy and beauty in medicine every day by recognising what we often take for granted. We can listen fully to our patients and colleagues with kindness. We can significantly influence junior doctors and medical students by modelling positive behaviours. We can learn from inspirational stories of our patients’ courage through adversity. We can take time every day to feel gratitude for our own health, our family and our ability to enjoy simple pleasures in life. We can experience deep satisfaction by persevering and caring.

It is trust, not gratitude or worship, that animates the physician. To palm a fevered brow, to feel a thin wavering pulse at the wrist, to draw down a pale lower lid – these simple acts cause a doctor’s heart to expand … Add to this the possibility of the grace of healing, and there is no human contact more beautiful.3

Dr Richard Selzer

THE JOY OF MEDICINE

My country rotation as a medical student was overshadowed by a heated argument between the general practitioner and his wife. She was sacrificing her life in this ‘hole of a place’ and angrily stormed out to visit her children in boarding school in the city. Decades later, I now understand the frustration and challenges of rural general practice for a doctor, who is also a mother.

Being ignored in the street by the sister of someone I reported for child abuse. Remaining professional when my child was victimized at school by one of my young patients. Being called out to a cardiac arrest in the middle of lunch with best friends, and leaving them to babysit my children.

3 Dr Richard Selzer (1928–2016) was an American surgeon and the author of Down from Troy: A Doctor Comes of Age.
A knock at the door at 2 am by a tearful, teenage boy, who requested the morning after pill for his girlfriend, as the condom broke twenty minutes before and ‘her father would kill him’. Listening to my baby screaming for a breast feed while I was resuscitating a choking child, who was rushed to my home by his frantic parents. Having my supermarket shopping prolonged by a patient who asked my advice about his haemorrhoids. Taking my children on a long-awaited outing and stopping at a motor car accident, where instead they were entertained by fire engines, police, ambulance and a helicopter, unsupervised in the back of my car. Stopping at the next accident and praying my children and I wouldn’t know the family this time. Unbandaging my neighbour’s hand at my kitchen table at 11 pm and finding that he amputated his finger, when he fell off the haystack that morning (‘Well who else was going to milk the cows?’). Trying desperately and unsuccessfully to resuscitate a teenage boy after an accident in the Main Street in front of his mother. And having to counsel a community’s grief when I felt I couldn’t contain my own.

Then I remind myself of so many other stories of courage and resilience in the face of chronic illness, child abuse, family breakdown and death. These are mostly the rich images of people from very diverse walks of life, who have taught me what my life career requires of me beyond my work.

Receiving a letter of thanks from the abused child, now a thriving adult. Catching a glimpse of my neighbour on another lonely drive home from work: the 70-year-old farmer riddled with arthritis throwing hay off the back of his driverless truck which was chugging across the paddock with a brick on the accelerator (the day after being discharged from hospital for repair of his amputated finger). Sharing a tearful moment with the mother who lost her son years ago in the Main Street accident, experiencing deep satisfaction by providing continuity of patient care.

And because parenting is more difficult and wonderful than any of this, experiencing the joy of watching my 18-year-old son (who had previously noted that I am an overly anxious, ageing woman with a weird sense of humour and a big arse), saying to his career advisor: ‘I want to be just like my mum’.

Dr Leanne Rowe

**IN SUMMARY**

While deeply satisfying and full of diverse opportunities, a career in medicine can also present many complex challenges. In our daily work, we can witness or vicariously experience a great deal of physical and emotional suffering and trauma. These repeated harrowing experiences can predispose us to negative cognitive biases and unconscious hypervigilant responses.
Just as we are present for the most devastating days of a patient’s life, we often have the unique privilege of being present for their happiest days or for their displays of tremendous courage. We can gain a sense of accomplishment, pride and optimism by practising gratitude and kindness, and taking time to be mindful of moments of joy and beauty in the midst of adversity.
CHAPTER 3

Taking Control of Our Time

My proclivity has always been to talk with my patients, to hear about their experiences, and to understand their hopes and fears. But I soon discovered that talking with patients is not a priority in my profession. In fact, it is often ignored entirely. There are too many other things to learn: ventricular fibrillation and atrioventricular nodal re-entrant rhythms; tailored genetic therapies and recently discovered genetic mutations; acid base disturbances and cholesterol-lowering medications. The onslaught of laboratory results and the mining of patient data leave little space for doctors to consider their patient stories.¹

Dr Angelo E Volandes

We have more time to listen to our patients than we realise. The starting point for this book is about meticulous time management because it is only when we take control of our time that we can focus on what is most important in our lives, including the care of our patients, our families and our own health.

There are over 110 hours available to us each week, in addition to an average of about 56 hours we may spend sleeping. Many doctors work about 40 hours a week, sometimes covering additional overnight shifts, commuting long distances or attending training. Taking into consideration some variability in hours from week to week, this may leave a surprising 60 hours a week, which we can allocate as we choose to replenish and restore ourselves.

Obviously, most of us have responsibilities outside of work, such as family commitments, tasks around the home and administrative burdens. However, we can be proactive in allocating our flexible 60 hours to our priorities, and outsourcing what can be delegated to others. For example, we can prioritise eating healthy food and exercising with family, helping out a friend or spending time on pleasant pastimes like planning a much-needed holiday, reading a

¹ Dr Angelo E Volandes is an American physician, writer, researcher, advocate and the author of The Conversation: A Revolutionary Plan for End-of-Life Care (www.TheConversationBook.org).
great book or listening to music. We can allocate time for much needed slowing down, idleness, solitude, deep relaxation and sleep. We might choose to delegate our financial, legal and business matters to competent, qualified professionals.

Of course, there will be times when the demands on our lives are excessive – we may be working 80 hours a week, doing night shifts or struggling with night calls, whilst sitting for exams and covering a sick colleague. We may be preoccupied with preschool children or a sick wakeful child, relationship problems, elderly parents, a chronic illness or home renovations. Some administrative tasks cannot be delegated. In these times of immense pressure, when there are very few flexible hours available to us in a week, meticulous time management is even more important. It is simply not possible to offer consistent high-quality patient care unless we prioritise adequate time outside work hours to rejuvenate and replenish ourselves.

This is not easy – but it is essential.

It is worth filling out a diary to monitor how we are spending our flexible time outside of work to determine if there are any ways we can make changes. Freeing up our time may involve getting up earlier, saying ‘no’ to energy depleting meetings or unnecessary social events, reducing time spent ruminating or complaining, doing shopping and banking online, outsourcing cleaning and non-essential administrative duties, watching less TV and spending less time on social media, emails and smart phones.

It is also important to consider ways to improve our effectiveness at work to try and reduce excessive work hours. Are we being productive when we are excessively busy? Are there ways to improve administrative systems and practice management by reducing red tape, paperwork, duplication of tasks or interruptions? On the other hand, are there times when it is possible to consciously slow down? Can we take a breath and enjoy being in the moment with patients and colleagues, in order to feel calmer at work and to preserve our energy throughout the whole day?

Some working weeks will feel out of control, no matter how meticulous we are with our time management. A medical career is fraught with excessive challenges. Patients die unexpectedly, people become angry, peer scrutiny can be harsh, the threat of medicolegal action is real, medical workforce shortages create pressures, and disturbed sleep is common.

It is easy to slip into passive negative rumination during time off work by overthinking what went wrong or what could go wrong. Our brains need a break. We can try to create space at work and outside of work to restore ourselves regularly and maintain our optimal physical and mental energy.
If we are finding it difficult to manage crises and consumed with just getting through each day, we can review our priorities. It takes time and sometimes courage to push back and say ‘no’, but it is important to be somewhat ruthless in allocating time to what is most important to us at work and at home.

No matter what challenges we are facing, we have more choice about how we spend our time at and outside work, than we realise.

**IN SUMMARY**

With meticulous time management, we can gain greater control over how we spend our precious time, particularly how we prioritise and enjoy our leisure time. By identifying flexible hours outside of our work, we can proactively plan how to spend time off, and to allocate time to wind down and relax. We can delegate tedious administrative and household tasks where possible. In those weeks burdened with heavy workloads and additional family pressures, it is especially vital to prioritise time out.

If we are struggling to cope, enduring each day to the next, it is important to reconsider which activities are a priority, carefully allocating time for rejuvenation, nurturing relationships, solitude and being ‘ruthless’ in taking well-deserved time off by having the courage to say ‘no’ to unnecessary work and social commitments.
There are a number of practical ways we can strengthen our personal resilience through switching off after work, taking a break from being a driven doctor, communicating effectively, responding to criticism and conflict, and sleeping well.

**SWITCHING OFF AFTER WORK**

As discussed in Chapter 3, our time off work is very precious. It can be difficult to slow the brain after a long intense day. In an overstimulated brain, our negative mental filter can go into overdrive as we rehash the day’s events, often thinking about what we forgot to do or what we must do tomorrow.

Unless we are seeking solutions, it is usually a fruitless exercise to let our minds dwell or brood on the same dysfunctional thoughts over and over again.

Here are some examples of common negative thinking patterns:

- **Black-and-white thinking** supposes that situations or events are either awful or perfect, which is rarely the case. For example, as recent medical graduates we may focus on one medical specialty as a goal, discounting all other options and predisposing ourselves to feeling like a failure if our ‘only’ choice does not eventuate. It can be more helpful to think about options, alternatives and shades of grey. Try to become aware of the more rational feelings and thoughts in between the extremes of black and white.

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1 Commonly attributed to Albert Einstein (1879–1955), regarded as the most influential physicist of the 20th century.
• Common negative over-generalisations are thoughts such as ‘Things always go wrong’, ‘Everyone at work is against me’, and ‘No-one understands how I feel’. Extrapulating is rarely helpful. The evidence for these unhelpful generalisations can be challenged with constructive self-talk like ‘I had a bad day, but tomorrow will be better’, ‘Work has been stressful for everyone recently, but I’ll try not to take things personally’, or ‘Talking about how I feel to like-minded colleagues will help me feel better’.

• Mind reading involves making assumptions about what someone else thinks of us or believes about us. The evidence for such assumptions needs to be questioned, for example ‘How do I know this?’ ‘How can I be sure?’ and ‘Could my colleague have something else on their mind?’

• Making mountains out of molehills is a catastrophic way of thinking. For example ‘It will be awful/terrible/horrible’ and ‘I can’t stand it anymore’. A more helpful inner voice may say, ‘Yes, it will be difficult, but I have got through problems before and I will try to do my best’.

Try this exercise:
Outside of work, try to seek simple pleasures. Identify enjoyable things in your day which bring you joy and do them every day – reading to your child, walking the dog, breathing clean air, feeling the sun on your skin, hugging your partner, laughing with a friend, talking to your parents, singing, listening to music, taking a bath, gardening, swimming, cooking healthy food, riding a bike, learning another language, dancing, smelling fragrant flowers, going to the theatre, taking photos, writing, reading poetry, watching a sunset, visiting an art gallery, tasting fresh fruit, and growing something from seed or fresh herbs on your windowsill. What are the simple things you enjoy? Write them down and try to do more of them every day.

Happiness is a habit – cultivate it.²

Elbert Hubbard

CHALLENGING NEGATIVE THINKING

Sometimes it is difficult to stop intrusive thoughts and rumination about problems at work. We are trained to notice the negative. Whether we are preoccupied with monotonous administrative tasks, overwhelmed with a never

² Elbert Hubbard (1856–1915) was an American writer, publisher, artist and philosopher.
ending to-do list or putting out bushfires at work and at home, we are trained to place ourselves on autopilot to get the job done.

**Try this exercise:**
Think about what you pay attention to when you are not working. Try to switch off your autopilot and consider a recurrent problem that comes to your mind frequently in your free time. Here are some helpful questions to try to understand and reduce unhelpful thoughts:

- What is the evidence for this way of thinking about the problem?
- Is there another explanation for what I am feeling or what is happening?
- What is the worst that could happen in this situation?
- What is the best that could happen out of this?
- What is the most realistic way things could work out?
- What would I advise a colleague if he or she were facing the same situation?

Challenging negative thinking can be more difficult if you have unconscious unrealistic belief systems. Are any of these inner beliefs underpinning your negative thinking patterns?

- I need other people’s approval to make me happy.
- I should always have complete control over my feelings.
- It is weak to feel anxious or sad.
- I should never make mistakes, and I should always be right.
- I must anticipate all risks.
- I must know everything and fix every problem.

Try some more reassuring forms of ‘self-talk’ such as:

- I am human. I have feelings, and it is sometimes helpful to express them.
- I do not need approval, but I would like support.
- I am dealing with many complex challenges, and it is not possible to mitigate all clinical risks.
- All doctors make errors and mistakes, which we can try to prevent and learn from together.
- It is not possible to know everything, but I know where and how to access relevant information.
Practice prefacing your self-talk with words like ‘I would prefer’ or ‘I will try’, rather than ‘I shouldn’t be thinking or feeling like this,’ ‘I am always negative’ or ‘I must not feel like this’.

Respond to your thoughts as you would to a radio station. Try to switch off the ‘unpleasant music and voices’ in your head and proactively focus on pleasurable thoughts that help you relax and feel better.

Many doctors say they do not have time for meditation or mindfulness and they do not relax easily. If this is the case, try to build mindfulness into your day, by shifting the focus of your attention to what you are doing when you are waiting on the telephone, in a queue, taking an elevator or walking from consulting room to waiting room, and at many other times when your mind is usually set to ‘automatic’. Simple things like trying to slow your breathing at appropriate times throughout the day, eating nutritious food slowly when possible, and exercising opportunistically (for example, using stairs not elevators), can all help you keep your stress levels in check during work hours and make it easier for you to unwind after work.

**TAKING A BREAK FROM BEING A DRIVEN DOCTOR**

The reasonable man adapts himself to the world, the unreasonable one persists in trying to adapt the world to herself. Therefore, all progress depends on the unreasonable man.3

George Bernard Shaw

Overwork is often regarded as the sign of a dedicated doctor. Doctors who have driven personalities are often rewarded professionally and financially. They receive few complaints, rarely make mistakes and are highly conscientious. They complete most of their tasks by the due date, constantly pre-empt problems, manage risks and work long hours to go beyond what is expected of them. Many of these personality traits are important to get the job done. But when they become task orientated and slaves to endless ‘to-do lists’ at the expense of their relationships, they stop enjoying their lives.

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3 George Bernard Shaw (1856–1950) was an Irish playwright, awarded the Nobel Prize in Literature in 1925. Acknowledgement: The Society of Authors on behalf of the Estate of Bernard Shaw.
**Try this exercise:**

Are you:

- irritable when late?
  Are you often late because of unexpected emergencies, long consultations or increasing patient demand?
- impatient while waiting?
  Do you get frustrated that you will run even later if you have to wait for others?
- a fast eater?
  Have you been conditioned to eat quickly or risk not eating at all?
- interested in very little outside of home and work?
  Do you find you have very little personal social time because when you are not at work you are making up for lost time with your family responsibilities?
- competitive and ambitious?
  Were you encouraged to compete during student years for rankings and later for postgraduate training positions?
- frequently anticipating what others are going to say, sometimes finishing their sentences?
  Are you sometimes frustrated with how long it takes for others to express their thoughts?
- always in a rush?
  Do you find it a challenge accommodating patients who present with urgent medical problems, but at the same time feel pressured to make adequate time available for review of your current patients?
- trying to do too many things at once, and at the same time thinking about what you will do next?
  Do you find it a challenge constantly pre-empting problems, assessing risks and managing multiple problems, and having to make complex decisions?
- seeking to be recognised by others?
  Do you find you rarely receive recognition because patients, family and friends expect you to maintain your caring role at all times and rarely give you positive feedback because they assume you know you are appreciated?
- feeling guilty when idle?
  Do you experience unease when you have nothing to do?
- never really happy?
Do you have a perfectionist, self-critical personality? Do you have a harsh inner voice? Have you set the bar too high? Do you think in terms of ‘I must’, ‘I should’ or ‘I always’?

Are you being weighed down by other people’s expectations, or do you have unrealistic, harsh expectations of yourself – or both?

If you recognise any of these personality traits, try to slow down and practice being kinder to yourself. Give yourself a break from your harsh inner voice and you may find you are more focused and content.

How do you switch off during your time off? Are you doing this proactively?

COMMUNICATING EFFECTIVELY

Mindful practice in medicine is more than meditation and personal growth. Being mindful is when I know to stop briefly, look at patient in the eye, and ask, ‘have I got it all, or is there more? – And a patient, whose previously well-controlled diabetes is now uncontrolled, then tells me he hasn’t been taking care of himself since his wife died six months ago. It’s when I inject an inflamed shoulder joint – with focused attention, visualising the bones, tendons and muscles – and the needle slides in easily and painlessly. I’m being mindful when I notice that a patient doesn’t look quite right, not her usual self, and then I notice the fatigued expression and the faint rash that are clues to her new diagnosis of lupus. Attending to each patient means that I remember that, although the last patient I saw only has days to live, the next patient – with a stubbed toe – needs the same focused attention.4

Dr Ronald Epstein

From early in medical school, we are taught that good communication skills are critical to quality patient care, preventing patient complaints and avoiding medicolegal action. Communication skills training usually emphasises the value of active listening where we try to understand what a patient is really trying to say by fully listening and then restating what we have heard from the patient in our own words, beginning with something like ‘Let’s see if I understand what you’re saying . . . ’

4 Dr Ronald Epstein is a Professor of Family Medicine, Psychiatry, Oncology and Medicine (Palliative Care) at the University of Rochester School of Medicine and Dentistry in New York. He is a family physician and palliative care physician, writer, researcher and teacher of communication and mindful practice in medicine, as well as author of Attending: Medicine, Mindfulness and Humanity (www.ronaldepstein.com).
Unfortunately, the reality of medicine is such that there is limited time to do this. Instead, it is common to see many doctors avoiding eye contact, interrupting, dismissing and ignoring patients and colleagues. If we take short cuts while listening, we are prone to mistakes, which are likely to be time consuming when other consequences emerge.

What is required is a willingness to value the voices of patients and their carers, particularly those who are frequently unheard – a child with a disability, a woman with poor literacy or an elderly man with morbid obesity. We save time if we take time to listen and communicate effectively because we are more likely to make the right diagnosis and work with our patients to make optimal decisions about management.

**YOU TALK AND I WILL LISTEN**

We give patients as little as 12 seconds to tell their story before we start interrupting them. And then we keep on interrupting them…. You can understand why patients feel they can’t get a word in edgewise. This can lead to all sorts of problems for doctors and patients alike: our hurriedness contributes, no doubt, to some of the dissatisfaction with modern medical care. What observations can be made about medical training that might counter this?

I canvassed the views of 50 colleagues: from family docs and surgeons, psychiatrists and critical care docs, to internists and pediatricians. I was, frankly, surprised by how quickly and enthusiastically most responded. Despite the negative things you may have heard about healthcare, a positive view of medicine is still alive and well. I received many excellent responses.

A family doctor suggested: ‘If there is one thing to learn, to do really well as a physician, it is to listen. In the midst of the intensity of medicine, the crises, the sadness and the everyday, and the wall of computer screens, always listen to your patient. The patient will give you a better history if they see you are listening’.

An internist observed: ‘Think of that patient as the only person you are seeing today, and you can achieve a connection that each patient will appreciate. Every patient is a person, an individual, and giving them each your full attention offers them the respect and connection they deserve’.

Another family physician had this to say: ‘I used to draw inspiration from the heroes I met in literature and on the screen. Now, as a doctor, I have the great privilege of being in the presence of heroes. Regularly, in my office, at the bedside, and in living rooms across my community I am amazed by the courage, compassion, and tenacity shown to me by my patients who allow me to journey with them as we walk together on a path towards healing. They continue to be my greatest inspiration’.
A psychiatrist wrote: ‘Most of us go into medicine because we want to help people – it is an honour and a privilege to be able to help people as their physician – if this remains your primary focus you will be happy in your work while making a positive difference in the lives of your patients. There is nothing more satisfying.’

A geriatrician wrote of the ‘gratitude you feel that you have joined a long line historically of people like yourselves who have dedicated themselves often in many small ways to the betterment of their fellow beings’.

An intensive care unit doctor wrote: ‘As a doctor, you will have the privilege to be present for ALL of the key moments in human life, far more than you would experience in one lifetime. Be humble. Be grateful. Be mindful. Art and science don't have to be in opposition. Let them be informed by AWE.’

An anaesthetist wrote: ‘Be grateful for the opportunity and enjoy every day!’

A paediatric endocrinologist simply said: ‘You’re in for the most exciting time of your life! Buckle up!’

A critical care physician observed: ‘This is the start of a journey. On this journey, you will be part of wonderful and terrible stories. You will have the power to effect positive change. You will also be powerless to prevent dreadful outcomes. You are more than just a witness, or a storyteller on this journey, you are an integral part of it, a player in the stories of the people you care for. Bring your best self. And always remember that although their stories become part of your own story, first and foremost you are there for them.’

An emergency medicine doctor observed: ‘You are human. Do not think of yourself as bad or incompetent for making mistakes. Errors are the fountain of wisdom.’ He emphasized: ‘Every good thing I have done in my entire life has come from a mistake.’

A clinician scientist said: ‘It’s okay to say, ‘I don’t know’ and ‘I’m not sure.’ Your patients and colleagues will respect you more, and the job of being a doctor will be easier. This is where the resilience of the doctor-patient relationship comes in if you are honest and open with patients.’

Professor Emeritus Philip C Hébert

RESPONDING TO INEVITABLE CONFLICT AND CRITICISM

Our medical practice is a deeply dysfunctional, unhappy place, where most doctors don’t say good morning and avoid contact in the staff room. Some of us disagree about patient care. Others about practice management and

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5 Professor Emeritus Philip C Hébert is a Canadian family doctor, bioethicist and author of Doing Right: A Practical Guide to Ethics for Physicians and Medical Trainees, and Good Medicine: The Art of Ethical Care in Canada.
money. But the real problem is that we avoid debates and disagreements, and tension festers.

Anonymous Doctor

We often work intense hours, deal with angry patients and exhausted colleagues, and make critical decisions in emergency situations. Our clinical judgement may be unfairly (or fairly) questioned. In this challenging environment, it may feel easier to disappear into our consulting rooms and avoid conflict and clashes of egos with colleagues, but this is rarely constructive.

Peer review, differences of opinion and debate are healthy in medical practice. This is how we learn. This is how we continue to provide the highest standard of care to our patients. How can we respond to inevitable conflict constructively?

**Try this exercise:**

Next time you are involved in a conflict, try to:

- Leave your ego at the door.
- Regard it as an opportunity to build a stronger relationship with your colleagues, rather than avoiding conflict.
- Remain calm and appropriately assertive. Ask if it is possible to have healthy differences of opinion and express them respectfully.
- Begin the conversation with statements like ‘I hope we can create a trusting relationship where we can give each other constructive feedback’.
- statements like ‘Thank you for the feedback’, ‘I can see we both want what is best in this situation’, or ‘I appreciate that you have high standards’.
- Objectively establish the facts of the situation to ensure there is no misunderstanding. Try to understand if the conflict has arisen as a result of misinformation, poor communication or personal differences.
- Listen to understand, without interrupting. Understand the other person’s intentions. Are they being constructive? What is really behind the conflict? What are they really trying to say?
- Reassure your colleague you understand why the conflict has arisen by saying ‘I can see why you would be concerned/upset over this. I’ll bear that in mind in the future to prevent any misunderstanding’.
- Ask for specific examples so that you can better understand the issue. Try: ‘Thanks for raising these issues so we can talk about some solutions’.
List all the possible solutions to a conflict or problem together and then weigh up the advantages and disadvantages of each solution objectively. Choose the best solution together – if it does not work, try negotiating again.

Agree on finding an outcome that you can both support. This may require mutual compromise.

Be clear on the issues that you cannot compromise on. Be open to changing your opinion as more facts emerge.

Implement the agreed solution, and agree to review it later to determine if it is working.

Ask later: ‘Is everything OK now? How can we work together to prevent any misunderstanding happening again?’ If the conflict becomes heated or personal despite these strategies:

- Acknowledge any strong feelings on either side.
- If you are being interrupted, ask if you may finish your sentences.
- Refer back to the issue at hand if there is any personal attack.
- Take responsibility for your own feelings by using ‘I’ statements like ‘I feel hurt…’ and ‘I feel distressed…’; rather than ‘You make me…’
- Also try: ‘I do not agree with your assessment’, ‘I am not used to being personally attacked’, and ‘I’ll discuss this with you when you are ready to communicate calmly’.
- If the conflict becomes destructive, it may be best to engage professional mediation.

Think about a recent difficult conversation and your reaction. Did you cut it short? Did you acquiesce to a show of authority, an attack on your integrity or yelling? Did the encounter trigger something from your past? Did you back down?

Try experimenting with your next conflict by remaining professional, listening fully and stating your rationale without emotion. Persevere with your point of view even if others behave inappropriately. Try reviewing your response using the points above. What did you find helpful?

Honest differences are often a healthy sign of progress.⁶

Mahatma Gandhi

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⁶ Mahatma Gandhi (1869–1948) was the leader of the Indian independence movement against British rule employing nonviolent civil disobedience.
SLEEPING WELL NATURALLY

General sleep hygiene advice often includes avoiding:

- Daytime or evening naps.
- Lying in bed ruminating or worrying.
- Work or stressful phone calls or emails immediately before bedtime.
- Rethinking about today or tomorrow’s stressful events.
- Drinks containing caffeine or alcohol.
- Exercise near sleep time.

Other common advice to break the sleep/wake/insomnia cycle, includes only going to bed when sleepy, getting up every time we cannot sleep after about 30 minutes and doing something soothing (not watching TV or using a computer), trying to set ourselves a routine time for getting up in the morning, and scheduling relaxation and physical exercise throughout the day.

However, generic sleep hygiene strategies often do not work for doctors. We frequently do not have time to relax, meditate or exercise during the day. We work after hours, night shifts and may be woken from sleep with emergencies. We may have to take phone calls at all hours, and often need to attend to our administrative work late in the day on a brightly lit computer. All of this can wreak havoc with our sleep patterns and cause chronic insomnia. This is significant because lack of sleep results in daytime fatigue and irritability, and may predispose us to depression.

Unfortunately, a number of surveys of doctors suggest that many of us self-medicate with addictive benzodiazepines or consume alcohol to sleep, which is counterproductive and harmful.

The first step is to recognise the special challenges doctors may encounter with sleep, and from early in our careers, condition ourselves to sleep well, and if we wake, to get back to sleep easily. Brief relaxation exercises work well if we do them regularly as we condition our brains to let go. If we do not have time to do them during the day, we can use them at night when we cannot sleep.

**Try these exercises regularly:**

**Muscle Relaxation**

While seated comfortably or lying down flat on your back, become aware of the muscle groups in your body: your hands, arms, shoulders, jaw, face and nose, stomach, and legs and feet.

Tense each of your muscle groups for a few seconds and then let them go as follows.
Hands: Make a fist with each hand and let go and relax.
Arms: Stretch your arms out in front of you, raise them high up over your head and stretch higher. Let your arms drop back to your side and feel them go floppy.
Shoulders: Pull your shoulders up to your ears. Hold in tight and then relax.
Jaw: Clench your teeth together really hard. Then let your jaw hang loose.
Face and nose: Make lots of wrinkles on your forehead, and crinkle up your nose, and then let your face go smooth.
Stomach: Pull your abdominal muscles in. Try to make them touch your spine. Make yourself as skinny as you can, and then release your abdomen.
Legs and feet: Push your feet and toes down on the floor. Let your feet and toes go loose and floppy.
Take time to let each muscle group relax.

Mindfulness
Mindfulness has many definitions. Basically, it is an awareness of the present moment and an acceptance of thoughts, feelings and bodily sensations. To achieve this state of mind, try to watch your thoughts as an observer without reacting to them as ‘good’ or ‘bad’. Try to shift your attention to what you are paying attention to. Sometimes the statement ‘just relax’ can make things worse because your active mind can feel stressed about feeling stressed. Instead, accept your active mind as natural, and try to step aside from your thoughts. Try to get some distance from your thoughts by visualising placing your thoughts in boxes on conveyor belts or imagining your thoughts floating through the sky on clouds. Try not to stop stressful thoughts but let your thoughts flow through your mind and observe them from a distance, without judging them.

Visualisation
Imagining pleasant images is a powerful way to relax. Think of one of your favourite people or one of your favourite places, like the beach, a bush walk, a garden or a park. Imagine the smells, sounds, touch and scenery. Bring yourself back to the state of your mind when you were last at this place. Revisit a state of quietness and peace in this place in your mind. Take a deep breath in and out.

Breathing
Count your normal breathing rate for 60 seconds. Then breathe in on the slow count of three (one…two…three…) and out for the slow count of three, for a
full minute. Try counting your normal breathing rate over 60 seconds again and compare it to what it was before the exercise. The breathing rate often slows down, which in turn helps the heart slow down and makes it easier to relax.

Notice sensations that you do not usually pay attention to. For example, notice that the air you inhale is colder than that air you exhale (unsurprisingly).

In the midst of winter, I found there was, within me, an invincible summer. And that makes me happy. For it says that no matter how hard the world pushes against me, within me, there’s something stronger – something better, pushing right back.\(^7\)

Albert Camus

IN SUMMARY

There are many ways to strengthen personal resilience and effective mechanisms to switch off after work, by identifying particular traits that predispose us to burnout. We can challenge our common negative thinking patterns such as black-and-white thinking, negative over-generalisations and catastrophizing by questioning the evidence for unhelpful thoughts and being kinder to ourselves.

Effective communication skills are essential when facing criticism or responding to inevitable conflicts with colleagues.

Establishing healthy sleep hygiene early in a medical career is important, along with using simple and versatile tools for muscle relaxation, mindfulness, visualisation and breathing. These tools can be utilised in brief breaks during a working day, when trying to fall asleep or when struggling to fall back asleep.

\(^7\) Albert Camus (1913–1960) was a French philosopher, author and journalist, awarded the Nobel Prize in Literature in 1957.
Strong, nurturing relationships with family and friends are the most important sources of our support throughout our careers. But good relationships do not just happen – they require time for communication, respect and love.

Sadly, these close relationships are the ones we may neglect in the face of excessive workloads. This is unfortunate as talking about stress with family and friends can be one of the most effective strategies for dealing with it.

**PARTNERSHIPS**

The essentials of all great partnerships include unconditional love, shared values, mutual respect and the ability to compromise. Good communication, shared decision making, trust, commitment and intimacy all require time, but long working hours and excessive demands may intrude into our family lives.

One of the most effective ways to resolve relationship issues is to recognise the way our personality traits can predispose us to tension or conflict. For example, an extroverted person who enjoys being with people may have to adapt to their introverted partner’s need for solitude. A person who needs the security and certainty of making decisions may have to learn to compromise with a partner who prefers to be flexible and open to new opportunities. People who base their decisions on research evidence alone may have to adapt to the needs of a partner who bases decisions on feelings. A healthy relationship is more important than being right all the time.

Understanding these common sources of relationship problems may assist us to build happy and satisfying relationships.
Here are some common patterns in doctors’ partnerships which can lead to problems.

**The Driven Doctor**
Many doctors tend to have personality characteristics such as obsessional traits, feelings of self-doubt and guilt, excessive fear of failure, hypervigilance in avoiding mistakes and an exaggerated sense of responsibility. These characteristics may be developmental in origin, reinforced during training or a normal adaptation to excessive workloads.

A doctor’s partner may feel dissatisfied with the relationship as the doctor becomes more immersed in work. As the partnership deteriorates, the doctor may immerse him or herself further into work, which is counterproductive.

**The Special Doctor**
All doctors are exposed to extraordinary experiences and sometimes it is easy to assume that no one could possibly understand the special nature or pressures of the work. ‘Special’ doctors may work hard because of a pervasive need for status and to compete with colleagues. Some develop overactive egos and arrogant behaviours.

At work, it is often necessary for doctors to be authoritative, decisive and in control, but these behaviours are rarely appreciated at home.

If doctors do not challenge the medical mindset of ‘specialness’, they risk allowing their identities becoming completely tied up by their work. This can only lead to unhappiness.

**The Career Partnership**
This is a partnership of two people with equally demanding careers, but one career is valued over the other, often in unspoken ways. Sometimes parenting and domestic duties are not shared equally. Superficially, the couple live together peacefully, but there is a lack of balance in the relationship.

Women doctors are particularly vulnerable to this type of relationship. While men are increasingly sharing domestic and parenting roles, women doctors continue to juggle work and family (including extended family) responsibilities and may feel guilty at failing to meet their own and others impossible expectations.

**Sexual Relationships**
One of the most common, but overlooked problems for any partnership are sexual problems related to differences in sexual desire. Sexual problems are commonly dismissed as the least of our problems, but they may herald the onset of major relationship issues.
The most common causes of relationship difficulties associated with sexual problems include the following:

- Inability to communicate about sex and difficulty in understanding each other's needs
- Lack of privacy, wakeful children, after hours calls
- Preoccupation with the excessive demands of work
- Fatigue or stress related to overwork
- Anxiety about sexual performance
- Not making time for sex

The key is to anticipate that excessive work demands usually create discrepancies in sexual desire between partners and to talk about this before it leads to a negative cycle of emotions.

It is important to find out specifically what increases and decreases our partner's sexual desire, and to freely express sexual needs in a loving way without pressing or rejecting our partner. Sometimes rest, relaxation and quality time are all that are required to restore sexual desire. At other times, more effort will be required to reconnect intimately.

If differences in sexual desire and needs are not communicated sensitively, they can develop into a major source of conflict within a relationship. If this negative cycle has already been established in a relationship, a counsellor or a sex therapist may help to restore healthy communication.

Of course, there are many other causes for sexual problems ranging from fatigue to past sexual abuse, medical conditions, drug use and issues related to sexual identity. The gradual onset of sexual dysfunction may also herald a significant medical condition such as diabetes, hyperlipidaemia, hypertension, thyroid disease, hypogonadism, prostatic disease, depression or anxiety. Dyspareunia should not be ignored as it may signal serious illness such as endometriosis, pelvic inflammatory disease, or ovarian or uterine tumours. Many commonly used medications can also be associated with sexual problems. For all these reasons, when sexual problems persist, it is important to consult another doctor for an objective opinion.

**DEALING WITH PARTNER SEPARATION**

Separation and divorce are among some of the most difficult experiences anyone can have. Most people survive separation and go on to live happy and fulfilling lives. Unfortunately, about half of the people who remarry, end up divorcing again. For this reason, it may be a good idea to consider seeking professional support, and to attend partnering and parenting courses following separation.
Separation may not only mean loss of a partner, but loss of time with children and extended family, loss of the family home and neighbourhood, loss of friends and social life, and loss of hopes for the future. It is natural to grieve over these losses. It takes time to rebuild lives and social networks. For this reason, it is common to experience depression and it is important to seek support from family, friends and a general practitioner, maintain a healthy lifestyle, avoid drugs and alcohol, and try to continue normal routines and activities such as exercise and sport.

**PARENTING**

When I was a boy of fourteen, my father was so ignorant I could hardly stand to have the old man around. But when I got to be twenty-one, I was astonished at how much he had learned in seven years.

Mark Twain

The children of doctors are often assumed to have an absent doctor parent and an over-involved, unhappily married, non-medical parent. Doctors are increasingly changing this stereotypical view, and demanding more work life balance to allow them to be effective partners and parents.

Nevertheless, many children of doctors complain about the excessive pressure related to being a member of a medical family. The all too familiar question ‘Are you going to be a doctor like your Mum/Dad?’ may be the reason so many offspring choose an alternative career.

Doctors more than any group in the community see the negative consequences of poor parenting on young people including depression, drug and alcohol abuse, and other major health issues. However, like most of the community, doctors rarely undertake training for the most important job in the world – parenting.

Like all parents in management positions at work, it is easy to adopt an ineffective, overly controlling authoritarian approach to parenting. At the other extreme, parents who juggle excessive work demands sometimes take a permissive approach to parenting to avoid conflict and to keep the peace at home. Sometimes parents swing inconsistently between the two extremes.

What style of parenting protects children and adolescents from harm and promotes resilience? Research tells us the most effective style of parenting is

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warm and respectful, loving, nurturing and flexible, but firm. With this caring approach, parents encourage their children to make good choices, consistent with their personal values.

Warm and respectful parents listen and reassure, but also make it clear when they disagree and for what reasons. They are high on warmth and mutual respect, but firm on consistent boundaries and family rules, while being sufficiently flexible to take account, within reason, of their child’s level of maturity and development.

At the other extreme, pressure cooker parents are low on warmth and high on control, frequently interfering in minor issues that, in the overall scheme of things, do not really matter. Pressure cooker parents tend to believe that ‘molly coddling’ a child will interfere with their growing up into a successful, appropriately independent adult, and they often create a damaging emotional distance. At other times, parents can be overly intrusive, giving advice before listening and either squashing or inflaming conflict. Discipline and punishment are features of pressure cooker parenting, generally of the ‘do as I say, not as I do’ variety.

In response to parenting that is meddlesome, inconsistent and lacking in warmth and care, children often withdraw in quiet resentment, give up seeking their parent’s approval or display behavioural problems. As a result, fear of loss of control drives the pressure cooker parent to interfere more in their child’s life. They may frequently comment on their child’s friends and future ambitions as well as what their child should eat, drink, wear, study and do with their leisure time. These parents tend to believe that if they lose the small battles on the home front, they will lose total control. Unfortunately, they often lose a great deal more than control – it is the child of a pressure cooker parent who will find it very difficult to develop a sense of autonomy or identity, and is at risk of depression.

The anything goes parent, who is generally high on warmth but far too low on control, tends to raise children with poor social skills, insecurity and other similar behavioural traits. Without clear rules and boundaries to test out against, adolescents tend to seek their role models and guidance elsewhere, not always with satisfactory results. The anything goes parent is not only permissive, they usually use material rewards in a futile attempt to keep their children happy.

And, finally, uncaring parents are low on both warmth and control. In this neglectful or chaotic style of parenting, it is easier to give in to the child’s demands to keep them quiet in the moment than to set healthy consistent limits, which may take time to negotiate and understand. In this type of family, the child is adrift without the support of secure attachments to their parents, and is at risk of mental health problems.
LETTING GO OF PARENTAL GUILT

Despite meticulous time management and delegation, there were times when I found cobwebs on the laundry left on the clothes line too long, or a mouldy school lunch/squashed banana forgotten at the bottom of my son’s school bag. I would ensure all the important school dates were in my diary, but I was often tripped up by the ‘curriculum day’ when school was suddenly off without time to organize child care.

On one such occasion, one of my co-authors, a prominent psychiatrist and his wife, also a psychiatrist, happened to be staying at my home and kindly offered to look after my young children. I assumed my sons were angry with me for leaving them when I heard that they had disappeared to our shed for the day. Later, I asked them what was wrong, and then shrugged off my guilt and laughed with relief at their response: ‘We were scared they would diagnose us’.

I learnt most about good parenting from my young patients. Here are a few of the things my young patients have told me about their mothers that have resonated with me as a parent:

My mum hates work and takes it out on us and then says, ‘I’m doing all this for you’. I feel like saying, ‘What exactly are you doing for us?’. My parents get up, go to work, get dinner, clean up, get ready for the next day. I feel I should be grateful, but this doesn’t feel like it’s enough.

I don’t mind my mother working. Her work helps our family financially. What worries me is the way she is rushed, irritable, stressed, preoccupied and distant. She feels guilty and overreacts to things. We get away with murder when she is tired.

When I look back on my school years, the most important thing that helped was that my mum really listened to me. I just wanted her to understand but not to worry, or overreact, or do anything, or give me advice. She would sometimes stop the car and give me her full attention, or stay up late with me just talking on my bed. Most of all she would listen with her kind eyes. She didn’t even have to tell me. I knew when she did this she really loved me.

Dr Leanne Rowe

IN SUMMARY

Healthy relationships based on love and mutual respect can be an immense source of joy and support. However, there are a number of common damaging behavioural patterns among doctors which can create dysfunctional relationships, including ‘the driven doctor’ who is constantly overworked and displays obsessional tendencies, ‘the special doctor’ who draws identity and arrogance
from their status while constantly seeking external validation, and the ‘career partnership’ where there are two equally demanding careers, but a lack of equal sharing of parenting or domestic duties.

Research supports the preferred style of parenting our children that is warm, respectful and:

- **Nurturing**: Loving parental involvement makes a child more responsive to parental influence, creates a secure sense of self and a kind inner voice that enables them to socialise effectively and withstand our harsh world.
- **Firm**: The combination of predictable support and clear limits helps with self-discipline. It allows the child to function as a responsible, competent individual, reduces exposure to risk and protects them from harmful, damaging experiences.
- **Autonomy-granting**: The negotiation of rights and responsibilities at appropriate ages through the journey of adolescence allows for a healthy independence, at the same time fostering social cohesion and strong connections with peers and community.
I called in sick because I had been vomiting and I was told: ‘You don't sound that bad – you need to toughen up princess’. After I gave myself an anti-emetic injection, I went to work, and it was implied that I wasn't pulling my weight. I'm a doctor and I don't have the right to take sick leave when I need it.

Anonymous Doctor

This sad reflection from one of our colleagues illustrates the overt pressure on doctors to keep working through illness. Presenteeism rather than absenteeism is a big issue in medicine. We are often reluctant to take sick leave as it places burdens on colleagues, particularly in workplaces where there are skeleton staff levels or in small self-employed businesses. When we return to work too early, we can place ourselves and our patients at risk. Colleagues may suggest we have to ‘make up’ for an absence from work in a time when we are feeling less than 100%.

For all these reasons, we must have our own family doctor to help us make good decisions about taking sick leave particularly when we are feeling vulnerable. No one will thank us for making a clinical error when we are unwell.

Doctors know how to access the health system, but unfortunately only about 50% of us have our own doctor. What is the reason for this and how can we change this?

Many doctors have fears about breaches of confidentiality, a dislike of waiting in other doctors’ waiting rooms, and experience embarrassment when in the patient role. Some experience difficulty relinquishing control and fear being judged by colleagues as weak or unable to cope.

Doctors may be particularly concerned about presenting to a colleague for a mental health problem and many accept low levels of well-being, chronic stress and fatigue as the norm. Sometimes, it seems as if ‘everyone feels like this’.

On top of this, doctors, like many other patients, often underestimate the impact their mental health problems have on themselves, their patients and their families. We may continue to work and function adequately while depressed, and we may not seek help until a crisis forces us to do so.
Unfortunately, numerous surveys of the medical profession suggest that doctors tend to self-medicate and seek ad hoc treatment from medical friends, rather than accessing the support, management and monitoring they would recommend for a patient with mental health problems. This is clearly unacceptable.

In corporate life, many professionals in senior positions routinely seek coaching, mentoring, leadership training and health assessments to maintain optimal performance. Many healthcare professionals, particularly psychologists, regularly debrief with a trusted mentor to ensure they maintain their well-being, particularly if exposed to trauma and grief. Unfortunately, doctors do not usually avail themselves of this level of support to stay healthy, despite facing significant challenges. We have to change this.

From early in our careers, we must develop a trusting relationship with our own family physician or general practitioner, and seek routine comprehensive preventive healthcare and screening, including mental health screening on an annual basis. Regular health assessments provide an opportunity to develop a professional relationship with another independent doctor. When such a relationship exists, a doctor is likely to feel more comfortable attending early with mental or physical health problems or for regular debriefing. An existing trusted relationship is even more important in a crisis situation or for trauma counselling.

This level of care should be seen as a basic requirement for all doctors and should not have to be mandated by medical regulatory authorities before being accepted as an essential part of a healthy medical career.

Having our own doctor also means we have an effective advocate if we need time off work.

**TREATING OTHER DOCTORS**

… the radiation oncologist who accepted the poisoned chalice of overseeing my post-operative radiotherapy, looked me in the eye and with moving determination declared, ‘we’re going to go after this Chris’. This was the first time that any of my colleagues or treating doctors had spoken so positively and emphatically about wanting to make me better. Like any other patient, I needed my doctors to bring hope and even optimism to the treatment table, to reinforce the fact that fighting was worthwhile.¹

Dr Chris O’Brien

¹ Dr Chris O’Brien (1952–2009) was an Australian head and neck surgeon, Director of the Sydney Cancer Centre and the author of *Never Say Die*, written after he was diagnosed with a malignant brain tumour.
We do not need special skills or training to treat fellow doctors. We are experienced with adjusting our approach appropriately for patients with different levels of health literacy, including high health literacy. Keep in mind that a doctor as a patient may present late with serious and complex medical issues because often they have tried self-investigation and treatment before seeking help or have delayed seeking care.

Here are some tips for dealing with doctors as patients:

- Be kind, listen and reassure your doctor patient about strict confidentiality.
- Take a thorough physical and mental health history, and perform a thorough physical and psychiatric examination if appropriate.
- Maintain empathy with objectivity and be aware of the risk of counter-transference (which is when a doctor/therapist takes on the suffering of their patient often because they overly identify with their experience).
- Provide the option of a long consultation but avoid treating your doctor patients as VIPs. Ask them what their self-diagnostic ideas are, as you would any patient. ‘What do you think is wrong?’ is a reasonable question, but be objective and feel free to disagree with their conclusion.
- Do not assume the doctor as a patient understands all aspects of their own medical or psychiatric condition. Always explain management options fully.

YOU TALK AND I WILL LISTEN

The art of medicine, the art of caregiving, means learning the art of ‘presence’. Presence is looking into someone’s eyes, placing your hand in solidarity on their arm, speaking to them directly and with authentic feeling. To be ready to respond to human suffering – to learn how to care – you have to learn how to listen. And active listening strengthens the bond between physician and patient; it makes it more likely that the bond will hold – will be resilient, bend but not break – in bad times as well as good.2

Professor Emeritus Philip C Hébert

IN SUMMARY

It is critically important for each of us to have our own trusted doctor, given the many barriers we face in looking after our own mental and physical health. We

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2 Professor Emeritus Philip C Hébert is a Canadian family doctor, bioethicist and the author of Doing Right: A Practical Guide to Ethics for Physicians and Medical Trainees and Good Medicine: The Art of Ethical Care in Canada.
are often under pressure to forego our own healthcare needs to fulfil our daily work demands. Unfortunately, all too often, we are also more willing to accept chronic stress, fatigue, depression and low well-being as our normal functional state. Other barriers to seeking help include fear of judgement and confidentiality breaches, as well as embarrassment in accepting the patient role.

We should attend our own general practitioner/family doctor, for regular preventive health checks, mental health screening and debriefing. Additionally, developing a strong therapeutic relationship with our own doctor means we have an advocate and a source of support in times of crisis.

Caring for doctors as patients does not necessarily require special skills. As with all patients, we must uphold confidentiality, listen carefully, provide optimal physical and mental health review, and respond appropriately to our patients’ high level of health literacy.
Prioritising Our Wellness and Physical Health

The doctor who treats himself (or herself) has a fool for a patient.\textsuperscript{1}

Sir William Osler

Here is a six-step approach to staying mentally and physically healthy.\textsuperscript{2}

**STEP 1: HAVE AN ANNUAL PREVENTIVE HEALTH CHECK**

We recommend all healthy doctors, particularly those of us over the age of 40 years, have an annual comprehensive preventive health assessment to ensure we receive appropriate screening for common physical and mental health problems.

As we know, we do not have to feel sick to be sick. Here is a list of recommended routine screening tests backed up by research evidence:

- Mental health screening
- Heart disease and stroke: Waist measurement, body mass index, fasting blood cholesterol, triglyceride and HDL, blood pressure, assessment for obstructive sleep apnoea
- Cancer: Skin check, cervical cancer screening for women, breast cancer screening for women, discussion about prostate cancer screening for men, bowel cancer screening, colonoscopy if there is a significant family history, appropriate genetic testing
- Diabetes: Risk assessment and fasting blood glucose

\textsuperscript{1} Sir William Osler (1849–1919) was a Canadian physician and one of the four founding professors of Johns Hopkins Hospital. He created the first residency programme for specialty training of physicians.

• Kidney disease: Urinary protein
• Osteoporosis: Risk assessment and bone density
• Other: Vision testing, hearing testing, lung function

If we are over our healthy weight, smoke, drink alcohol regularly, do not exercise or have a family history of an illness, we may require more frequent screening than if we are completely healthy.

STEP 2: DOCUMENT YOUR FAMILY HISTORY

Of course, many disorders run in families. The age of diagnosis in a family member can indicate the age after which we require screening for these disorders, including:

• Cancers, particularly of the gastrointestinal tract, breast, colon, lung, ovary or prostate
• Cardiovascular disorders such as hypertension, heart disease, hypercholesterolaemia or stroke
• Type 2 diabetes
• Kidney failure
• Mental health problems such as psychosis, depression or substance abuse

We must remind our own doctor about any significant change in our family history at every consultation.

STEP 3: AIM FOR SUSTAINABLE HEALTHY WEIGHT

The shelves of bookstores are stacked with weight loss books recommending fad diets that do not work and leave us feeling hungry, flatulent or tired. Around 60% of people in Western countries are overweight and at increased risk of preventable serious illnesses such as heart disease, stroke, diabetes and certain cancers.

The secret of healthy weight loss is simple, but not very popular – healthy eating and physical activity. Weight loss is good old-fashioned hard work. Steps to healthy weight loss include:

• Slow down your eating and savour your meals.

Taking time to enjoy your meals, savouring each mouthful, can leave you feeling well nourished and result in consumption of fewer daily calories.

• Choose colourful low-kilojoule foods.
It takes about 37,000 kilojoules to lose 1 kilogram of fat, and it takes a lot of will power to lose weight permanently.

Try to plan your daily food intake to include the following:

- At least two serves of fruit and five serves of vegetables, including green leafy vegetables and colourful varieties
- Wholegrain cereal and bread
- Fish
- Two to three serves of low-fat milk or plain yoghurt, for calcium
- Water or green tea are the healthiest drinks; aim to drink at least 2 litres of water each day

Try to reduce the size of meals and the intake of salt, junk foods, saturated fat (less meat and full cream dairy products) and trans fats (no commercial biscuits, cakes or muffins) to reduce the risk of heart disease.

Many so-called *health foods* are not healthy at all; especially those which are high in fat, sugar and kilojoules. For example, a muffin and a small bottle of orange juice for morning tea may contain about 2,500 kilojoules. A piece of fruit and a glass of water contain about 300 kilojoules. Many unnecessary kilojoules can be cut without making your life a misery.

- Reduce your emotional eating and drinking.

Try not to respond to an emotional appetite with food, alcohol or high-sugar drinks. If bored, irritable, angry or stressed, try to express these emotions in more constructive ways such as talking to a friend or exercising.

- Weigh and measure yourself regularly.

Try to weigh yourself and to measure your waist circumference regularly. Reward yourself with something other than food if you lose weight or centimetres. If you find it difficult to lose weight, do not be discouraged, you may be losing centimetres but adding muscle weight.

**STEP 4: REGULAR PHYSICAL ACTIVITY IS NOT OPTIONAL**

As we all know, regular physical activity has enormous proven benefits:

- keeping weight down
- reducing the risk of Type 2 diabetes
• keeping blood pressure down
• raising HDL and lowering LDL and triglycerides
• reducing stress and mental illness
• preventing osteoporosis
• delaying the onset of dementia
• reducing the risk of certain cancers and improving outcomes after cancer diagnosis, particularly bowel cancer

A minimum of 30 minutes of moderate exercise is recommended at least five times each week. During moderate exercise, the heart rate will be at least 60%–70% of your maximum heart rate (220 minus your age) for at least 30 minutes a day. If you wish to lose weight, you need to exercise more vigorously for longer.

**STEP 5: REDUCE RISKY BEHAVIOURS**

Some very damaging habits like overeating, smoking, drinking excess alcohol and taking recreational drugs are often used as quick fixes for stress.

Nicotine is highly addictive and nicotine withdrawal sometimes requires combination treatment with nicotine replacement therapy and medications like bupropion or varenicline.

The health benefits of alcohol are often overemphasised by the alcohol industry. The use of alcohol as a coping strategy is very harmful.

**Try this exercise:**
These questions may help you consider your resistance to reducing any bad habits:

• How does your lifestyle affect your body, mood and life?
• What concerns you at the moment?
• What did you learn from previous attempts to change your lifestyle?
• How can you do things differently?
• What would have to happen for your motivation to increase?

Be honest about your drug use and alcohol intake at your next consultation with your own doctor.

**STEP 6: RESPOND IMMEDIATELY TO RED ALERT SYMPTOMS**

All doctors know that some symptoms should never be ignored. We know the signs of cardiovascular disease, cerebrovascular disease and cancer. Yet,
many of our colleagues ignore these signs in themselves and fail to seek timely assistance.

If we have central chest pain lasting for more than a few minutes, or temporary or permanent weakness of the face or a limb, we need to call an ambulance immediately. We must see our own doctor as soon as possible for unexplained weight loss or fatigue, prolonged pain, new lesions, or abnormal bleeding or discharge. As we know well, screening and early detection of serious disorders can prevent years of suffering.

**IN SUMMARY**

This six-step approach to maintaining physical and mental health is based on the evidence of what we know works. The benefits of annual comprehensive preventive health checks including routine mental health screening tests are advised, as well as continually updating our family history of disease. The basic principles of losing weight in a healthy and sustainable way include maintaining a healthy body weight, and the importance of regular physical activity. It is essential to address risky behaviours and respond appropriately to red flag symptoms.
We inevitably experience stress when the reality of our medical career collides with our original expectations. A medical career is difficult for all manner of reasons. The sooner we accept the tension between expectations and reality, the sooner we can learn to transcend it.

Nevertheless, many doctors enjoy the mental challenge of positive stress. For example, it is often rewarding and satisfying when we react quickly and competently in emergency situations or manage complex medical dilemmas.

Negative stress is very different and is often defined as an imbalance between perceived demand and the ability to meet that demand. Negative stress is usually about a perceived loss of control.

There is well-established medical research suggesting the link between the prolonged exposure to excessive negative stress and poor physical and mental health. For example, in 2009, Australian-American molecular biologist Professor Elizabeth Blackburn received the Nobel Prize for her work on telomeres, which are repeating segments of non-coding DNA at the end of our
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chromosomes responsible for our cellular health. In her book *The Telomere Effect, Living Younger, Healthier, Longer*, Professor Blackburn describes how ‘stress gets into our cells’, and results in shorter telomeres and premature ageing. She documents research on ways to rejuvenate our telomeres including healthy nutrition, a positive response to emotional challenges, regular exercise, mindfulness, meditation and ‘restorative activities’.

There is also increasing evidence that the brain changes its structure and function at a cellular level in response to mental stimuli, broadly referred to as ‘neuroplasticity’. A number of studies have linked regular meditation practice to differences in cortical density of grey matter. Aerobic exercise has been linked to neurogenesis in certain parts of the brain associated with measurable improvements in spatial memory and cognitive control.

Changes to neural structure and function occur over time. For example, an imaging study of medical students’ grey matter whilst studying for exams, found changes in brain structure as a result of learning within months, demonstrating the flexibility of the brain to adapt to new challenges. Notwithstanding, the need for more research in these areas, there is good evidence that positive thinking and constructive responses to inevitable stressors result in better mental health.

**SOURCES OF STRESS**

Negative stress can be associated with common life events including transition to work from university, marriage, becoming a parent, illness or death of a loved one, separation and divorce, retirement, problems with sexual relationships, change in business or financial status, taking on a mortgage or loan, conflict with extended family, moving house or clinic, or even the holiday season. It is worth taking time to identify common sources of stress.

There are many other causes of immense stress that are unique to doctors, some obvious and some not so obvious. For example, the community has very high expectations of its doctors as care providers and community leaders. Doctors are expected, and we expect ourselves, to be always competent, caring, concerned, responsible, sensitive, trustworthy and honest. The internal pressure to constantly maintain these qualities can be exhausting, particularly while dealing with inevitable trauma, death and grief at work.

Dying and death confront every new doctor and nurse. The first times, some cry. Some shutdown. Some hardly notice. When I saw my first deaths, I was too guarded to cry. But I dreamt about them. I had recurring nightmares in
which I would find my patients’ corpses in my house – in my own bed. ‘How did he get here?’ I’d wonder in panic. I knew I would be in huge trouble, maybe criminal trouble, if I didn’t get the body back to the hospital without getting caught. I’d try to lift it into the back of my car, but it would be too heavy. Or I’d get it in, only to find blood seeping out like black oil until it overflowed the trunk. Or I’d actually get the corpse to the hospital and onto a gurney, and I’d push it down hall after hall, trying and failing to find the room where the person used to be. ‘Hey’ someone would shout and start chasing me. I’d wake up next to my wife in the dark, clammy and tachycardic. I’d felt that I’d killed these people. I’d failed. Death of course is not a failure. Death is normal.2

Professor Atul Gawande

Try this exercise:
Identify your main sources of stress by considering which of the following points resonate with you:

Patient care issues
• Patient anger at their diagnosis or treatment
• Daily contact with people who are suffering
• ‘Therapeutic impotence’ when unable to treat some serious disorders
• Fear of making mistakes and threat of litigation
• New ethical issues in clinical practice related to human genomics, other advances in medical technology and physician-assisted dying
• Dealing with uncertainty in diagnosis and management
• Risk of physical and verbal assault by patients

Attitudes
• Lack of positive feedback or acknowledgement by colleagues
• Lack of understanding from patients and colleagues when a doctor is sick
• Increasing anti-doctor sentiment in the community and the media

2 Professor Atul Gawande is a surgeon, public health researcher and writer, having published four New York Times bestsellers including Complications, Better, The Checklist Manifesto and Being Mortal. He practices general and endocrine surgery at Brigham and Women’s Hospital in the United States. He is Professor in the Department of Health Policy and Management at the Harvard TH Chan School of Public Health and the Samuel O Thier Professor of Surgery at Harvard Medical School.
**Time pressure**
- Coping with excessive numbers of phone calls, repeated interruptions, emergency calls, after hours calls and unrelenting long hours of work
- Time pressure to see more and more patients due to lack of funding, medical workforce shortages and the corporatisation of medicine

**Unrealistic Expectations**
- Patient complaints about long waiting times and waiting lists due to medical and health workforce shortages
- Responding to expectations by friends and relatives to be their carer
- The expectation to work past an age when many other professional people retire

**Lack of workplace support**
- Lack of adequate support from the wider health system for patients with common mental health and substance abuse problems
- Occupational hazards including risk of exposure to serious infections
- Separation from family during medical training
- Professional isolation especially in rural areas
- Lack of access and planning for sick leave, annual leave and long service leave
- Costs of setting up and maintaining a medical practice
- Difficulty in negotiating employment contracts
- Lack of training about the business side of medical practice
- Poor remuneration for some medical specialties, especially in lower socio-economic areas
- Administrative overload and the demands of bureaucratic paperwork
- Inexperienced members of staff and inadequate time to train new people properly
- Conflict with practice partners and other staff in a practice or hospital
- Competition with neighbouring practices
- Problems with the physical environment of the hospital or practice including excessive noise, lack of car parking, poor cooling and heating, fluorescent lighting and poorly designed workspaces
- Government interference in clinical independence

**Lack of work/life balance**
- Perceived loss of personal control due to excessive workload
• Lack of emotional support at home from your partner and the inability to provide emotional support at home for your partner and children
• Distant relationships with children and the inability to share parenting load due to work demands
• Difficulties with finding suitable child care arrangements
• Chronic sleep deprivation
• Unsatisfactory social life

Training and professional competency issues
• Allowing time to keep up to date with advances in quality patient care
• Choosing and competing for a medical specialty and career paths
• Professional activities such as professional development, quality assurance and practice accreditation, all of which take time
• Challenges with use of computer software, electronic communication and data security in clinical practice

SYMPTOMS OF STRESS AND BURNOUT

Burnout is related to chronic stress and is evident by chronic physical health problems, relationship problems, entrenched negative thinking and risky behaviours.

Symptoms of acute stress include:

• dry mouth
• muscle tension
• sweating
• palpitations
• breathlessness

Chronic stress can involve:

• feelings of quiet desperation and being unable to cope
• feelings of helplessness or hopelessness
• worrying excessively and unreasonably about things outside our control or things that have not happened yet
• frustration, irritability and pent up anger
• intolerance of minor problems or transgressions by other people
• excessive mood swings
• withdrawing into daydreams
• apathy and feeling tired all the time
• compassion fatigue or inability to feel sympathy for others
• tearfulness and sadness
• indecisiveness and being prone to mistakes
• inefficiency, doing many things at once and always being rushed
• inflexibility and resistance to change
• lack of interest in leisure pursuits or self-appearance
• change in eating habits including bingeing or skipping meals
• physical symptoms such as headache, backache, neck ache, indigestion, irritable bowel or excessive health concerns
• anxiety and depression

Try this stress bucket exercise:
Think about yourself as a stress bucket. It can help to list all the stresses that fill your bucket and recognise the signs that indicate when your stress bucket is overflowing.

• What are the signs of your full stress bucket (symptoms of stress)?
• What are the causes of your full stress bucket (sources of stress)?
• What are the ways to release your full stress bucket (solutions to stress)?

If you would like to explore this in more detail, on the left side of a page, list all the times and situations when you felt stressed over the past few days, and on the right side, try to answer these questions:
• What did you think, do or try when you felt stressed?
• Did it help?
• What could you have done differently?
• What may help next time?
• What were the circumstances beyond your control?
• What were the circumstances within your control?
• What can you do about them?
• Where can you seek support?
• Imagine your problem has been solved, how would you feel?
• How would you know this had happened?

Here are some suggestions to relieve the pressure in your stress bucket proactively.

**Patient care**

• Remember to seek joy in your relationships with your patients by sharing their achievements, stories of courage and wisdom, and pride in their children and grandchildren; doctors can gain deep insights into life by doing so.
• Discover meaning in your work and understand what a difference you make to your patients’ lives.
• Maintain professional boundaries at work and outside work, for example, avoid discussing medical issues with patients and other people away from the workplace.

**Achieve work life balance**

• Live with or near people you love if at all possible.
• Make your home your sanctuary by building strong relationships with your family and friends through listening to them and taking time to relax with them.
• Speak to a confidante regularly, try not to store your worries, unload them.
• Practice regular meditation, mindfulness, relaxation techniques, music therapy or writing therapy.
• Take time to switch off every day and try slowing down when you can.
• Take solo time out for solitude, especially if you are introverted.
• Have a regular relaxation massage.
• Practice slow breathing when idle, for instance standing in a queue or sitting in a traffic jam.
• Eat slowly and savour each meal.
• Develop interests outside medicine; to make up for a sedentary day job consider bush walking, surfing, skiing, sport, dancing or learning self-defence. Engage in some social, non-competitive activities with your family and friends. Try creative pastimes such as painting, playing music, gardening, and creative writing.
• Socialise with people who support and energise you.
• Remember the birthdays of your family members and friends – pre-buy cards and gifts.
• Turn off the TV and read a book, or have an early night.
• If you must watch TV, watch good-quality documentaries and series or movies, rather than mind numbing reality shows, and avoid the advertising.
• Plan ahead for long weekends, holidays and long service leave.
• Plan career breaks and sabbaticals for self-reflection.
• Seek peer support and mentoring – debrief regularly, especially after experiencing death, trauma, grief or suffering among your patients or your own family or friends.
• Acknowledge your colleagues’ work and value your own.
• Have an annual comprehensive preventive health check with your own doctor.

Deal with unrealistic expectations
• Aim for a sustainable workload and plan breaks in your diary after times of excessive work.
• Book in the occasional appointment with yourself during a busy day and take some time out to think.
• Maintain feelings of choice and control over your work by taking time to make and implement decisions.
• Remain flexible in your career path.
• Commit to realistic goals rather than to too many, and try to have a challenging goal ahead.
• Do one task at a time and accept uncompleted tasks.
• Say ‘no’ without feeling guilty and without apologising when appropriate.
• Recognise your own achievements and give yourself rewards.

Leverage time
• Prepare for the next day the evening before, then have an early night and get up earlier than usual the next morning to do some exercise.
- Basic time management skills include planning ahead, prioritising urgent and non-urgent matters, scheduling time off including lunch and morning and afternoon tea breaks, and avoiding unnecessary interruptions and distractions.
- Eliminate time wasting by being proactive about how you spend your time, being selective about who you meet, when you answer the phone and when you respond to emails; it can help to identify activities that waste time like double handling of mail and emails, reading junk mail and attending non-essential meetings.
- If you are a slow typist, get a typing tutor program for your computer or attend a typing course, pay someone else to do your typing for you, or use voice recognition software or a writing plate for your computer.
- Any committee or practice meeting should have a purpose and clear expected outcomes.
  - The meeting agenda should be distributed well before the meeting, and should list the people to attend, state the expected time of commencement and duration, and include well prepared background papers.
  - Any meeting should result in agreed outcomes with documented minutes and resolutions.
  - At the end of every meeting all participants should feel as if their views and opinions are valued; if this is not the case on a repeated basis, you may wish to reconsider your involvement.
  - Consider shopping and ordering office supplies, medical equipment and personal items in bulk or online to save time – waiting in shopping queues is not a good use of anyone's time, so try to shop at times when you know the queues will be short.

Delegate effectively
- The most effective way of leveraging time is by delegation; paying other people can save you money and make you money. You may wish to seek expert advice on hiring staff, employ a senior practice manager or employ a practice nurse who can competently triage telephone calls, run chronic disease management programs, and provide services such as wound care and immunisations.
- Engage competent child care or try to pool your child care arrangements with other doctors who understand your work pressures.
Consider delegating home and office cleaning and gardening. However, if you enjoy gardening or home maintenance, do it yourself.

A short course in business management is not enough to prepare a doctor for the challenges of running a medical practice, and trained experienced staff can save you a lot of time, worry and money. It is usually better to delegate the appropriate aspects of your business to your competent and qualified practice manager, accountant, bank manager and lawyer.

Write to the president of your medical organisation about patient care and professional issues that are worrying you. You pay subscriptions to medical organisations to advocate on your behalf for positive changes in patient care and professional issues, so don’t be afraid to engage with the leadership of your medical organisations.

Break unhelpful habits

- Overanalysis is not helpful; if you have had a bad day try to use positive psychology techniques, constructive self-talk and mental diversion after work and avoid rumination.
- Take time out and regain your sense of humour. Stop taking yourself so seriously – have some fun
- Stop trying to please everyone.
- Vent steam with exercise.
- Recognise your own self-worth, most other people assume you know you do a great job.
- Accept your human limitations, the natural course of events and your personal vulnerability.
- Stop whinging! Worrying without gaining insight does not change a thing, it just wastes your precious time.
- Try to focus on positives, see the temporary nature of many of your problems and accept the influence of factors outside your control.
- Life is too short for gossip.
- Slow down and simplify your life.
- Do not worry about the ‘if only’ or ‘what ifs’ in life – deal with problems as they arise rather than worrying about what might happen in the future or what mistakes you may have made in the past.

Attend to your training needs

- Attend quality continuing professional development activities.
- Access online education and training at times that suit you best.
FIVE WAYS I KNOW WHEN I HAVE HAD A GOOD DAY IN MY PRACTICE

I’ve asked the right questions and at least one person has cried and at least one person has laughed in my consulting room.
I’ve had at least one person tell me the real reason why they have come to see me.
I’ve learned something new about human existence.
I’ve increased my medical knowledge.
I’ve cared about what happened to each patient and each colleague I have seen today.

Dr Michael Kidd

GROUPS OF DOCTORS MORE AT RISK OF STRESS

There are certain times in every doctor’s career when stress is more likely to be a problem. And there are unique experiences of stress for different groups of doctors.

New Doctors
The time of transition from medical student to intern can be a time of great excitement but also of serious stress for many new doctors. New doctors report many stressors including meeting the demands and expectations of senior colleagues, learning to work with other health professionals and hospital staff, feeling undervalued, and the isolation of working long hours, night shifts and after hours.

Some new doctors find it difficult to balance the demands of work and family and friends, and also experience the significant pressures of having to prepare for specialist training assessments. Junior doctors often feel overwhelmed when confronted with large numbers of patients and what may be perceived as unrealistic patient expectations. The sudden realisation that the ‘buck stops here’ can be daunting. For all these reasons, it can help to seek mentorship or professional support from more senior colleagues.

In medicine, there is a language of fear – a fear of failure, ‘screwing up’, making mistakes, even killing someone. If we complain, medical students are told to ‘suck it up’ or questioned about our suitability for medicine. We are also frequently told to enjoy med school because it gets much worse after graduation. Our medical training prepares us well for managing complex clinical cases, but there seems to be a reluctance to train us to respond to common personal challenges. We need tangible solutions.

Anonymous Medical Student
Of course, medicine is challenging and we need to empower doctors to manage the challenges competently, rather than fear them.

**Try this exercise:**
Tips for the transition from medical student to doctor:

- Reassure yourself you are still learning and it is normal to feel out of your comfort zone with new rotations.
- Always be professional with patients, other doctors and staff including other health practitioners – even when you feel overworked and tired, develop a reputation for being consistently kind, caring and professional.
- Try to establish healthy patterns of sleep prior to commencing your long hours as a doctor, through using mindfulness, meditation, relaxation techniques and breathing exercises.
- Strengthen and maintain your physical fitness. Get out in the fresh air as often as you can.
- Find a trusted family doctor or general practitioner, who you feel comfortable to debrief with, especially if you experience stress or burn out during your career.
- Keep in touch with people you love – your family and your friends.
- If you find any aspect of being a doctor difficult, ask for help from a trusted colleague. You will often find that other new doctors are concerned about the same things but don't talk about them.

**Women Doctors**
Women doctors commonly experience constraints on their career ambitions and have concerns about effects of work on family life. Many women continue to fulfil traditional roles of daughter, wife and mother as well as meet their professional responsibilities.

Career options may be limited by the need to take time out of training for childbirth and child rearing. Family commitments are sometimes undervalued by colleagues. Unfortunately, women are more likely to experience gender bias, discrimination, sexual harassment and violence in the workplace. These topics are covered in detail in Chapters 14–16.

**Rural Doctors**
Rural doctors tend to find it more difficult to obtain locum and peer support. In rural areas, there is more after-hours emergency work and less access to training and specialist support. Rural doctors are more likely to feel isolated and at times out of their depth than those practising close to specialist centres.
Families often bear the brunt of these stresses and children may be sent away for education. Professional boundaries are more difficult to maintain for doctors working and living in rural areas.

Rural doctors also commonly experience great barriers deterring them from seeking professional help for routine health matters and in a crisis. For example, many rural doctors carry the burden of being regularly exposed to traumatic death and suicide of patients well known to them, and yet debriefing and recovery time is often inadequate. The last thing that many rural doctors want to do is to wait in the waiting room of another local doctor during their precious time off. Amongst concerns about confidentiality and independence, they are likely to be recognised by their own patients. Greater access to telehealth will help overcome some of these barriers for rural doctors.

**Indigenous Doctors and Doctors from Other Vulnerable Groups**

As medical schools become more socially accountable and encouraging diversity among doctors, there are more efforts worldwide to recruit medical students from Indigenous communities and from other groups of people who have been underrepresented in the medical profession. These doctors may be the first people in their family to enrol in higher education and may have few visible role models who they can relate to among their peers and among more senior members of the medical profession. Cultural safety competence may be missing from clinical settings and medical education programmes and among teachers and supervisors.

Doctors from these groups may often face additional pressures, in trying to meet commitments to their extended family and wider community, as well as conflicts with traditional health beliefs and practices.

Challenges may also exist for doctors from other minority groups in a community including doctors of colour, doctors with disabilities and doctors who are lesbian, gay, bisexual or transgender.

**Doctors Emigrating to a New Country**

Doctors moving country face multiple complex stressors. These include adapting to a new culture, a need to engage in further training and study in order to have their qualifications recognised, lack of available support from extended family and community, professional isolation if required to practice in remote locations, and the stress of being separated from their partner and children if the doctor has emigrated first. They may also face difficulties with cultural change, language and lack of awareness of local systems and norms.
Some doctors may be emigrating to a new country due to exposure to human rights abuses in their country of origin, and they and their family members may be traumatised.

We must provide mentoring and support for these doctors. As is the case for all doctors, international medical graduates must have their own trusted family doctor or general practitioner for comprehensive preventive health assessment, including mental health screening, early intervention and routine debriefing, intervention for mental illness and postvention in times of crisis and trauma.

**Senior Doctors**

Senior doctors can be a great source of wisdom and advice to younger colleagues. Many doctors gain great support through having an older, more experienced colleague as a mentor.

Worldwide workforce shortages are placing greater demand on us to remain in clinical practice, and many doctors continue to work beyond the age when their peers in other professions retire. Other doctors feel under pressure to continue to work full time in order to meet financial commitments and the desire to provide for their family members.

Some doctors continue to work even if they are experiencing the effects of chronic disease, chronic pain or mental health concerns. Clearly, we need our own trusted treating doctors who can objectively assess whether we are fit to continue working in these circumstances.

Our retirement should be a personal choice and age discrimination has no place in medicine.

However, because it is common for us to have driven natures, many of us fail to seek or heed the advice that we might give to our own patients about slowing down, engaging in other worthwhile pursuits outside work, and enjoying the many joys of the later years of life.

**THE STRESS WE CREATE FOR OURSELVES**

To regard states of distress in general as an objection, as something that must be abolished, is the supreme idiocy, in a general sense a real disaster in its consequences...almost as stupid as the will to abolish bad weather.³

Friedrich Nietzsche

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³ Friedrich Nietzsche (1844–1900) was a German philosopher, essayist and cultural critic.
Our reaction to symptoms of stress may be to withdraw from other people. It is common to feel as though we have nothing left to give after a challenging day’s work. While time for solitude is often helpful, especially for those of us who are introverted, prolonged isolation will fail to rejuvenate us. Distancing ourselves from other people, especially our main supports, can begin a spiral of increasing problems including depression and excessive alcohol and drug use.

Sometimes we may ruminate about our sense of martyrdom. Putting in 100% effort, 100% of the time, is exhausting, and the self-expectation to be everything to everyone all of the time can lead to an exaggerated sense of responsibility. Many high achievers never feel perfect enough. It is easy to become emotionally detached when there is no outlet for painful emotions. It is worth thinking about how we may create unnecessary distress by failing to meet our own impossible expectations and failing to seek personal support.

Emotional intelligence is about self-control, self-mastery and the ability to get on with oneself and others. It is about feeling, understanding and using emotions positively.

If we are going to be effective clinicians, we need to develop a high level of emotional intelligence, recognise the warning signs of stress, and make changes in our lives to restore a sense of balance. Most of the time we know the right things to do, but there is a gap between knowing and doing. Sometimes, the greatest challenge is just putting into place what we already know we should be doing in terms of reducing stressors.

Dealing with excessive demands is a normal part of being a doctor. For this reason, it is important to be honest with ourselves, to actively seek support, to identify our strengths and weaknesses and to proactively look after our minds and bodies.

**A PLAN FOR MANAGING IMMENSE STRESS**

For many years, I could not find the time to meditate or exercise. When I took up the new craze of colouring in for relaxation, I gained a new insight into my nature as I experienced the ridiculous self-inflicted pressure to finish the page as soon as possible and then the self-critical voice in my head about my poor choice of colours.

My driven perfectionist nature makes me a good doctor, but to enjoy what I do, I try to consciously let go of my obsessive traits and accept the uncertain nature of medicine. I have learnt to replace my harsh inner voice with a kinder one, and to actively put aside time for relaxation every day to counteract the inevitable chaos. When the pressure of my work is excessive, I use three simple strategies to restore my balance:
Reprioritise. I write down everything that is currently worrying me from major world events such as the threat of a North Korean war, to minor irritations like being overcharged on my credit card. I reassure myself that feeling stressed is a natural response to my long list of concerns. I cross out items I can’t influence and pursue solutions for issues I can change. Similar to responding to only important emails and ruthlessly deleting my junk box folder, I redirect my focus to things that matter. My limited time is precious. I say a polite ‘no’ to things that are not in line with my priorities or values, and I withstand the inevitable push back when people don’t like it – without feeling guilty.

Recharge. I know it is more effective when I recharge fully rather than run my battery on 10% and risk running out of power. But I am not a machine. I am human and I accept my humanity, including when things inevitably go awry. Before my battery runs flat, I re-establish good habits – healthy nutrition, exercise, mindfulness, sunshine and time with my family. I catch up on sleep and I actively seek love, kindness, beauty and laughter. When I care for myself, I am able to provide better care to my family, patients and colleagues.

Rethink. I use positive psychology strategies to rethink the grind, misery and set backs of my work. I am grateful for my good health, family, music, and ability to keep learning from people of diverse backgrounds. I am grateful for the deep insights into life and courage amidst patient grief, depression, chronic illness and pain. I remind myself of my purpose to advocate for quality and equity of patient care.

Dr Leanne Rowe

IN SUMMARY

In order to deal with immense stress we need to unpack the symptoms and sources of stress, and seek solutions for dealing with the inevitable stress that we face across many facets of our lives. While some stress is positive, negative stress can be destructive to our lives and medical careers. Sources of stress include our own attitudes, time pressures, unrealistic expectations, lack of workplace support, juggling work and family responsibilities, patient care issues and professional competency issues.

The ‘stress bucket’ can help us recognise these sources and implement solutions such as leveraging time, delegating effectively, breaking unhelpful habits and meeting our training needs. A simple plan for managing stress includes documenting and reprioritising stressors, recharging fully with healthy and joyful pastimes, and redefining stress with a more positive narrative.
The most beautiful people we have known are those who have known defeat, known suffering, known struggle, known loss and have found their way out of the depths. These persons have an appreciation, a sensitivity, and an understanding of life that fills them with compassion, gentleness, and a deep loving concern.¹

Dr Elisabeth Kübler-Ross

LOSS

Paradoxically, one of the most uplifting, important experiences in medicine is to witness patients and their families endure enormous loss with courage and dignity. Loss is not only felt with death, disability and loss of independence. Other life changes such as relationship breakdowns, job changes particularly due to unemployment or retirement, role changes when children are born or leave home, or moving away from family and friends, can leave a profound sense of loss too. Grief and anger can be normal reactions in these circumstances, but when these feelings become entrenched or have a long-term impact on well-being, they may lead to depression.

Even doctors – or perhaps especially doctors – need to be touched by something personally to understand the suffering of others. We’ve been taught about the enormous power over life and death that is invested in us; we can be deluded into thinking we are almighty. Almost instinctively we view death, incurable disease and disability as challenging our power. We forget that this is all part of life. I guess that we have to defend ourselves against the human suffering that confronts us every day, otherwise we’d quickly go under. Medical jargon helps keep

¹ Dr Elisabeth Kübler-Ross (1926–2004) was a Swiss-American psychiatrist, pioneer in near-death studies and the author of the groundbreaking book On Death and Dying, where she first discussed her theory of the five stages of grief.
us remote, yet seeing colleagues suffer is hard. If we think too much, we realise that we – and our loved ones – are just as vulnerable as the rest of humanity.  

Dr Jane Wilson-Howarth

As doctors, we are not immune from experiencing loss. This is yet another reason why it is important to have our own trusted family doctor or general practitioner and to maintain strong relationships with our families and friends throughout our lives. While dealing with a major loss or personal crisis can be devastating, many doctors have used the lessons learned through such an event to become even more effective clinicians and healers.

GRIEF

Doctors, like the rest of the population, can experience intense emotional reactions after bereavement, including crying, irritability, worry, anger, guilt, insomnia, bad dreams, loss of interest in usual activities, depression and anxiety. Grief is likely to be more severe if there is a history of mental illness, a lack of social support or an unexpected or violent death of a loved one, especially a spouse or a child.

Everyone reacts differently to grief. While some people are unable to concentrate on normal activities, others will wish to continue working. Each person’s reaction is normal and should not be judged as pathological just because it differs from the reactions of other people.

At a time of bereavement, it is OK to allow ourselves to cry and to talk about our feelings. It is OK to expose ourselves to sad memories. It sometimes helps to try and do this in a graded way, at the same time as focusing on positive and happy memories.

It is important to seek supportive relationships with family members and close friends, because prolonged grief may lead to depression requiring ongoing treatment with formal psychotherapy and antidepressant medication. We must avoid the temptation of self-prescribing benzodiazepines or other psychoactive drugs, and should consult with our own doctor if we feel we need assistance.

It is only when we make time for deep reflection that we will work through grief and emerge stronger.

The confrontation with death lays bare the spiritual core of the human condition. The force of impending death acts like a hot wind to strip away all pretences and expose each person’s elemental essence. What we call spiritual is our

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2 Dr Jane Wilson-Howarth is a British physician, lecturer and the author of *A Glimpse of Eternal Snows: A Journey of Love and Loss in the Himalayas.*
innate response to the awe-inspiring and terrifying history of human life and the universe. A heightened awareness of the central mystery of life and the potential to evoke terror and awe affects anyone who ventures close to a person’s dying. Confronted with the mystery of life – and death – we reflexively try to make some meaning of our experience in the world, strengthen our relationships with others, and feel part of something larger and more enduring than ourselves.3

Dr Ira Byock

SERIOUS ILLNESS

Many of us remember thinking we might have the symptoms of one of the many serious illnesses we learned about during our early years as medical students. Over the years, we tend to develop a healthy level of denial of personal illness, which may be one of the reasons we tend not to seek help from other doctors.

But when doctors are actually diagnosed with a serious or life-threatening illness, many of us experience those old feelings of heightened anxiety because we know too much about options, possibilities and risks. We are likely to gain access to our investigation results before our own doctor. Patient brochures only give us limited information and we tend to spend our time on searches of the international medical literature studying treatment options when it would probably be better to spend time seeking the support of friends and family.

Our medical friends tend to ask us about our ‘stage’ and prognosis and other details of our disorder, rather than offering support or an opportunity to express our feelings. Our colleagues fully understand the reality of our answers and may then find it difficult to continue the conversation.

Our non-medical friends may tell us just to think positively as they know many people with similar illnesses who have survived. This superficial theory reflects a lack of understanding and unwillingness of others to confront serious illness. Unfortunately, doctors who are patients can recount many stories of their own patients who have not survived their illness.

Our interactions with the health system can be very different when we are the patient. Our late friend and colleague, leading evidence-based medicine advocate Professor Chris Silagy (1960–2001), described his experience with lymphoma like this:

3 Dr Ira Byock is an American physician, author, professor of community health and family medicine at Dartmouth College, and the author of The Best Care Possible.
Being a doctor does not guarantee easy access to good advice and appropriate medical treatment. I have learned to respect the skill and compassion of the oncology nurses. On many occasions, they have made the difference to how I feel. I have also learned that a similar caring and compassionate approach is essential and desperately needed among medical staff. I have been fortunate to have some outstanding clinicians involved in my care. But I have also had my share of arrogant, insensitive and clinically atrocious doctors (right through from interns to senior consultants). This experience has impressed on me the need for doctors to really listen to their patients. As my lymphoma has gone through remissions and relapses, I have usually been the first person to detect the new small nodes or lesions. At times, I have had to almost plead with the medical staff to take notice of my symptoms. Ironically, at one point I was so determined to prove that I was right, I designed a small study on myself to confirm the findings and then published them in The Lancet!

Being a doctor patient can also be an advantage. We know how to access evidence-based health information, navigate the health system assertively and seek the best specialist care promptly. We gain a new understanding of the fear and powerlessness experienced by our patients. We gain a new understanding of the value of good communication and simple questions like ‘How are you feeling?’ and ‘How can I support you?’

Facing a personal crisis is a life challenge for anyone, but personal pain can be a wonderful teacher. For doctors, it is associated with unique challenges that require special care from close family, friends and other colleagues. It is essential to find a doctor we trust, and then to trust their judgement. It is never easy to allow others to see us when we are vulnerable and to ask for support. When we do, we open ourselves to experiencing the profound love and kindness of others. We may then ask ourselves why we waited for a personal crisis to happen before we did so.

And now, weak, short of breath, my once-firm muscles melted away by cancer, I find my thoughts, increasingly, not on the supernatural or spiritual, but on what is meant by living a good and worthwhile life – achieving a sense of peace within oneself. I find my thoughts drifting to the Sabbath, the day of rest, the seventh day of the week, and perhaps the seventh day of one’s life as well, when one can feel that one’s work is done, and one may, in good conscience, rest.⁴

Dr Oliver Sacks

⁴ Dr Oliver Sacks (1933–2015) was a British neurologist, naturalist, historian of science and author of several books including *Awakenings* and *The Man Who Mistook His Wife for a Hat*. Acknowledgement: Various articles by Oliver Sacks. Copyright © 2015, Oliver Sacks, used by permission of The Wylie Agency (UK) Limited.
IN SUMMARY

Doctors are exposed to different facets of human suffering in their professional and personal lives. We are just as susceptible to personal crises as our patients, and we may often feel vulnerable like our patients. We may have intense emotional experiences when dealing with serious personal illnesses, and it is important to have our own trusted doctor and supportive relationships with friends and family. It is not just okay, but essential, to let ourselves grieve for our patients’ losses and for our own personal losses, and to accept care from our loved ones and our treating doctors in times of grief.
WILFUL FORGETFULNESS

A doctor’s best debriefing tool after a hard day is wilful forgetfulness. I recently invited two friends, a neurosurgeon and an anaesthetist, to dinner. My husband is a general practitioner and I am an oncologist – due to our schedules, it took us weeks to find a convenient date. Our friends arrived many hours late. The surgeon had been operating on a brand-new mum whose headaches revealed a brain tumour. He inserted a life-saving shunt that night, but her prognosis was grim. The anaesthetist had been monitoring another precarious situation where the patient’s life still hung in balance. Earlier that day, my husband’s elderly patient had suffered a near cardiac arrest while chatting to him. The waiting room was evacuated and sirens rang out. That same evening, I had received a tearful call from a terminally ill patient. He was in excruciating pain, the hospice was full, there was a long wait in emergency and he was frightened of dying. Could I help?

These were the accounts of our day as we greeted each other. Then the oven beeped, reminding us of a dinner many times reheated. In the course of just one day, we had been witness to serious and tragic life events; yet, as if observing a silent code of conduct, we never once mentioned those misfortunes as we ate. One such event once in a life might have ruined most people’s appetite for food and company, but not ours. We were different.

That night, I didn’t sleep. My thoughts turned to the young mother who would not see her baby grow up. And I fretted over my sick patient. I suspect we all had a disturbed night, our equanimity fractured by the fate of our patients. But I also knew that the next morning we would return to work, our facade repaired. For in that small space between sleep and wake, we would have consoled ourselves that bad things happen and our job as doctors is to not let ourselves feel too bad about them lest we fail our future patients.

A doctor’s best debriefing tool after a hard day therefore turns out to be wilful forgetfulness. If you can minimise or better still, normalise catastrophe, you can keep going. Except, as a recent Australian survey of more than 14,000
doctors and medical students shows, this attitude comes at a great cost. One in 10 doctors entertained suicidal thoughts in the past year, compared to one in 45 in the community. More than a quarter of doctors are highly likely to suffer from mental illness. Oncologists like me, who routinely deal with death, face an especially high risk, as do young women and international doctors. This laudable study has caused a collective gasp in the community, but for most doctors, it has simply put sobering numbers to a problem we are all too familiar with. Far too many of us have lost a dear friend and able colleague to drugs, alcohol, crippling mental illness or suicide. Many more feel like helpless bystanders as we watch good doctors slowly self-destruct.

Every doctor knows that the very problems we counsel our patients for are those that beset us in far greater measure. So, you might ask why intelligent, driven, capable doctors would ignore the warning signs that they know by rote. Again, the survey identifies what every doctor either knows or suspects: the stigma attached to mental illness is magnified within the medical profession. Doctors regard their mentally ill peers with uncertainty and fear. They consider them less capable and are less willing to hire them or work with them. It therefore makes sense to keep problems under wraps in an unsupportive environment.

For me, watching the journey of some of my mentally ill friends has been in turns frightening, unsettling and sad. It’s a tightrope to envelop a colleague in understanding while protecting their patients from harm as a result of inattention. As a sympathetic observer, it is tempting to become impatient with at-risk doctors who don’t or won’t seek help, even though they have access to it. But it is also difficult to convince doctors to appreciate the extent of their problem, because we have been shaped to believe in our infallibility. Diseases afflict our patients, they don’t touch us. Our patients are defined by their illness, while we are defined by our ability to cure their malady. Medical education shies away from discussing our vulnerabilities. Students and young doctors are rarely reminded that despite their hallowed place in society, they are prone to the same vicissitudes of life as everyone else. It is no wonder that when faced by personal catastrophe, a doctor’s first response is to deny the problem exists.

Doctors have a long tradition of being considered different from the rest of society. But when it comes to mental illness, our serious differences are jeopardizing our own health and that of our patients. The culture of medicine demands a change. To do any less would be to short change doctors and patients.¹

Dr Ranjana Srivastava

¹ Dr Ranjana Srivastava is an Australian oncologist, a Fulbright scholar and the award-winning author of After Cancer: A Guide to Living Well. Article first published in The Guardian, reprinted with permission.
Although mental illnesses can be treated successfully, there are a number of reasons why doctors are continuing to report high rates of depression, anxiety, post-traumatic stress disorder and suicidal ideation.

In addition to the common risk factors in the general population such as chronic exposure to stressful events, physical health conditions, substance abuse, uncaring relationships, isolation and loneliness, and family history of mental illness, we are surrounded by misery, grief and trauma at work. Doctors may be more at risk of mental illness because of common personality traits including the tendency to worry a lot, overthink, have low self-esteem, and be perfectionist, sensitive to personal criticism, self-critical and overly negative or risk averse.

Doctors tend to work long hours and suffer from chronic sleep deprivation, and the culture of the medical profession is such that the signs of burnout are often worn as ‘badges of honour’. For these reasons, it can be difficult to recognise or assess our own mental health issues or those of a work colleague because low-grade depressive or anxiety symptoms in doctors are sometimes perceived as ‘normal’. In addition, medical workplaces can be harsh environments where there is little understanding for doctors with mental illness, which creates a negative stigma.

Unfortunately, doctors do not tend to take sick leave to consult their own doctor, nor do they like to spend their precious time off waiting in other doctors’ waiting rooms. Rather than seeking formal support and management, doctors sometimes self-medicate (although all doctors know they should never self-prescribe drug treatment for their own mental illness) or seek ad hoc treatment from a medical friend, which is clearly inadequate.

For all these reasons, many doctors may mask their depressed or anxious mood, and usually continue to provide a high standard of care to patients at great expense to themselves.

It is imperative that doctors seek formal counselling and optimal management from an experienced, independent treating doctor or psychologist. The treating professional must appreciate that for all the wrong reasons, doctor patients often present late with atypical or partially self-treated symptoms of mental illness, but are able to continue function normally at work. Atypical symptoms are sometimes described as feelings of general unease, quiet desperation and numbness, rather than sadness. Other symptoms include loss of interest in anything outside work, withdrawal from people, excessive guilt, taking too much personal responsibility for things going wrong, being easily offended or defensive, uncharacteristic anger, frustration or excessive cynicism.
When they present to another doctor, many doctor patients will present with a tough emotional shield. In this situation, it takes time for the treating doctor to develop trust by listening fully and to get beneath the shield to build an effective therapeutic relationship.

It is important for professionals treating doctors to offer the same high standard of care they would offer their other patients, which includes taking a comprehensive mental health history, checking for psychotic symptoms, substance misuse, cognitive decline and suicide risk.

Here is a reminder of the features of a comprehensive mental health history:

- What is the nature of the presenting problem?
- What are the specific symptoms?
- What events led to this presentation?
- Are there any symptoms or signs of underlying physical illness, which may have predisposed this person to mental illness such as an endocrine disorder, infection, neurological disorder, cardiovascular disease, collagen disorder, malignancy or metabolic disorder?
- Is there relevant past history? What past and current medications has this person been taking, including drugs that may be associated with depressive symptoms such as analgesics, anti-inflammatory agents, antihypertensive, antineoplastic, neurological agents, steroids or hormones?
- What is the developmental history as a child and adolescent and young adult?
- What is the education and work history?
- What is the family history?
- What is the quality of relationships with partners, children and significant others?
- What is the suicide risk?

Optimal mental health assessment involves asking these questions in a sensitive manner in a confidential environment. Optimal management of mental illness requires diagnosis, formal treatment with structured psychological therapies and/or appropriate doses of medication, regular review and relapse prevention strategies.

In the next section, is a summary of the main symptoms and management of common mental illnesses such as depression, anxiety disorder and post-traumatic stress disorder. Doctors with mental illness often suffer from a mixed pattern of partially treated symptoms of all three conditions, which can make management more challenging.
DEPRESSION

Major depression is characterised by a cluster of symptoms, which vary from person to person. Symptoms include feeling sad or irritable, hypersomnia or insomnia, loss of interest in usual activities, feeling worthless or guilty, changes in appetite or weight, loss of sexual interest, physical aches and pains, impaired thinking or concentration and thoughts of death. Five or more of these symptoms are usually present for two or more weeks for a formal diagnosis of major depression to be made.

Dysthymia is a chronic mood disturbance present on most days over a span of at least two years. The symptoms are not as severe as those for major depression, but it can be just as damaging as symptoms may last longer.

Seasonal affective disorder (SAD) is a mood disorder that has a seasonal pattern related to the variation in light exposure in different seasons, over a few years. It is usually found in countries with shorter days and longer periods of darkness, such as in the cold climate areas of the Northern Hemisphere. However, doctors who are not exposed to much sunlight, such as radiologists or those working night shifts, may also be at risk of SAD. Light therapy can be an effective treatment for this form of depression.

Antenatal and postnatal depression in women during pregnancy and in the year following childbirth often result from a combination of factors, and affect not only the mother, but her relationship with her baby and partner, as well as the child’s development.

Formal early optimal treatment is preferable for all types of depression as it results in a better prognosis. Effective formal psychological therapies include:

- **Cognitive behaviour therapy (CBT)** is a psychological treatment that recognises thinking patterns (cognition) and behaviour patterns that affect the way we feel. By thinking more rationally about common difficulties, it helps to shift negative or unhelpful thought patterns and reactions to a more positive and solution-orientated approach.
- **Interpersonal therapy (IPT)** is a psychological therapy that focuses on skills to strengthen personal relationships and overcome relationship and other problems.
- **Behaviour therapy/Behavioural activation** is a major part of cognitive behaviour therapy, but it focuses on actively planning activities that are pleasant and enjoyable, to help overcome social withdrawal and inactivity.
Mindfulness-based cognitive therapy (MBCT) is different to the treatments above as it helps change our process of thinking, not only the content of our thoughts. It helps us to let go of unhelpful thoughts and emotions, as well as realizing that we do not have to respond to every thought or emotion. It is about learning to develop a new relationship to our thoughts and emotions. Mindfulness encourages us to notice when automatic thoughts are occurring and to alter our reaction. It encourages our attention to our attention, without making any judgements about whether thoughts are positive or negative.

In offering formal psychological therapies, it is important to recognise that doctors may find it difficult to reduce critical self-talk, overthinking, over-checking or negative cognitive bias. These common thought habits are part of the risk averse nature of everyday medical practice. Juggling excessive demands through multi-skilling is a common way to successfully attend to hundreds of patients and thousands of important decisions each week. In response to being challenged to change their thinking patterns, it is common for doctors to become frustrated that they cannot stop ‘faulty’ thinking patterns or intrusive worrying. Mental overload is part of our DNA.

Individual psychological therapies may also be counterproductive when doctors are working in toxic cultures, where bullying, harassment or discrimination are being tolerated. For example, helping doctors with anger management skills may not be helpful when anger as a response to injustice, inequity and poor quality of patient care is justified. Some challenging experiences in medicine cannot be solved with ‘rational thinking’. Sometimes it is better to sit with sadness, fear, pain and uncertainty for a while. At other times, it is more effective to challenge a negative workplace culture than to focus on strengthening individual skills.

It can take time for psychological therapies to work because brain habits and conditioning do not change easily. It can help to rest, accept overthinking without judging it as good or bad, and practice muscular relaxation regularly. Seeking out supportive family and friends, planning simple pleasant experiences, and creating worthwhile goals outside of medicine can also help.

If formal psychological therapies do not help, it may help to seek a second opinion. More often, antidepressant treatment may be required after a thorough assessment by an experienced treating family physician/general practitioner and/or psychiatrist.

Selective Serotonin Reuptake Inhibitors (SSRIs) are the preferred drugs in most people for the treatment of depression, including postnatal depression,
because of the lower side effect profile and safety in overdose, compared with older classes of antidepressants. SSRIs are usually taken in the morning with food as they often disturb sleep at night. There can be a delay of one to two weeks before any benefit is experienced and the full effect may not be apparent for four to eight weeks.

Well-known side effects of SSRIs may include increased appetite, weight gain, nausea, constipation, postural dizziness, drowsiness, dry mouth, sexual dysfunction and increased sensitivity to sun exposure, but these symptoms are usually minor. To increase compliance, these side effects may be managed appropriately by simple techniques such as increasing exercise, adjusting diet, increasing fluid intake and dividing doses. Serotonin syndrome and suicidality are rare side effects of SSRIs.

Common warning signs of a depression relapse include changes in sleep pattern, decreased concentration, withdrawal and isolation, lack of energy, irritability, loss of interest in usual activities and lowered mood.

To prevent the high likelihood of a relapse or recurrence of depression, a number of psychological strategies are used including structured problem-solving, sleep hygiene techniques, relaxation training and assertiveness and communication training. Long-term maintenance antidepressant medication may be recommended to prevent relapse in people at risk, including those with chronic exposure to stress.

The explanation for the increased prevalence of suicide in doctors compared with the general population is multi-factorial. As already discussed, doctors face barriers in accessing mental health care and work in stressful and often unsupportive environments with easy access to lethal drugs. Recurrent thoughts about death, suicide or self-harm are a medical emergency in anyone. Anyone in this situation must seek urgent psychiatric support and advice.

**ANXIETY DISORDERS**

Anxiety is often a normal reaction. Intermittent high levels of anxiety may be an appropriate response to dealing with excessive demands. Temporary levels of anxiety can improve performance and be protective.

Anxiety disorders are different. They are characterised by prolonged distress and tension out of proportion with life stressors, which impairs functioning.

Anxiety disorders are usually caused by a combination of factors, which may include personality factors, difficult life experiences, family history, substance abuse and physical health problems such as thyroid disorders. Stressful events may predispose to the development of anxiety disorders, including frequent job
changes, change in geography, relationship problems, exposure to trauma or verbal, sexual, physical or emotional abuse, and/or death or loss of a loved one.

Types of anxiety disorder include:

- persistent excessive or unrealistic worries which interfere with life, work or activities (generalised anxiety disorder)
- uncontrolled compulsions or obsessions, including overchecking, fear of germs, overcleaning, overcounting and repeating routine activities and actions (obsessive compulsive disorder)
- intense excessive worry related to social situations (social anxiety disorder)
- panic attacks (panic disorder)
- an intensely irrational fear of everyday objects and situations (phobia)

Symptoms of anxiety disorders may include palpitations, difficulty breathing, gastrointestinal disorders, muscle tension, sweating, sensations of choking, and feeling faint or tremors.

Formal psychological therapies, relaxation therapy and online mental health resources used in depression are also very effective in managing anxiety disorders.

In addition, cognitive bias modification is a simple technique to break the habits of anxious thinking and reduce subconscious attention to negative stimuli, risks and threats. We can always find something to worry about and this can cause a feeling of general unease or mild irritability. For example, we may be watching for anything that may go wrong, unconsciously constantly scanning the world for risks and threats, and assuming the worst-case scenario without evidence. This can take a lot of energy. It is possible to retrain the mind to consciously reduce excessive hypervigilance, but this can take time.

By becoming aware of our negative biases, we can try to consciously shift our attention to trying to scan the environment for positive images and sensations. We can also use healthy cognitive disassociation as a technique to help separate ourselves from negative or unpleasant thoughts. For example, sometimes it helps to try visual distancing where we can try to imagine viewing an event or our thoughts from a distance. In addition, it can help to try self-reassurance and kindness with self-talk like ‘This is painful and part of being human’.

SSRIs are also very effective in the treatment of anxiety disorders, but as previously discussed, psychotropic medication must never be self-prescribed.

Benzodiazepines are not recommended in anxiety disorders as they can reduce alertness, compromise coordination and be addictive. They may
occasionally be useful intermittently for a very short period of time (up to two or three weeks) as part of a comprehensive treatment plan, but never as the first or only treatment.

**POST-TRAUMATIC STRESS DISORDER**

I feel I should have sought crisis debriefing after my first patient death on the operating table. I spent months feeling that it was my fault (which it wasn’t) and being terrified that every patient was going to lose blood and die. Compounding the problem was my junior status, my rural location and lack of consultant support. When the death occurred, the consultant left the hospital immediately after telling me to close the abdomen and ‘sort it out’ with the family. I suspect mentoring, a supportive network and appropriate crisis debriefing would all have been helpful to me.

Anonymous General Surgical Registrar

Acute stress disorder is defined as a short-term reaction to trauma that impairs a person’s ability to function. It usually lasts between two days and four weeks. After experiencing an episode of trauma, it is a normal reaction to have cycling of strong emotions, usually for about 10 days. The cycling often involves intrusive memories of the event and avoidance behaviour, sometimes with associated feelings of numbness and denial.

Post-traumatic stress disorder is a type of anxiety disorder and is characterised by feelings of intense fear, helplessness or horror. Common features include the following:

- Repeatedly reliving the traumatic event through unwanted and recurring memories, often with nightmares
- Being overly wound up with insomnia, irritability, lack of concentration and constantly on the lookout for signs of danger
- Avoiding activities, places, people, thoughts or feelings associated with the traumatic event to avoid painful memories
- Feeling emotionally numb or cut off and detached

Acute stress reactions and post-traumatic stress disorders can occur in response to witnessing traumatic death or suicide, being involved in major motor vehicle accidents, medical emergencies, natural disasters, homicide, family violence, physical or sexual assault, stalking, threats, home invasion or property damage. Doctors, of course, are vulnerable to these disorders by being repetitively exposed to traumatic incidents. Doctors may also be at risk of vicarious
traumatisation after providing counselling and support to patients who have experienced catastrophic events.

When we help our patients work through traumatic experiences, we encourage them to carefully confront the memories of trauma, allow them to re-experience the thoughts, talk about the event, and cry with our support. We encourage our patients to seek support from family and friends as this can help our patients find meaning in the trauma and facilitate recovery. We reassure them that this is followed by a period of adjustment and time out when a sense of equilibrium and resilience is restored. We need to be open to doing this for ourselves after witnessing a traumatic event by seeking professional support.

However, there are many reasons why doctors do not seek help. We regard traumatic events as a normal part of our job. We often do not have the ability to confide in family and friends about our personal reactions to a traumatic event, as patient confidentiality is involved. We may not take the time to attend debriefing or counselling, and instead of resting and taking time out after a traumatic event, we often have to respond to our patient, their family and sometimes the whole community fallout following an incident. In order to deal with an emergency at hand, we learn to put our feelings on hold and delay our own reaction to a traumatic incident. It can be difficult for us to take time away from our busy practices to attend to our personal distress and grief.

Doctors, working in rural and remote areas may experience even greater stress when responding to significant incidents or catastrophes. This is because they are often working in isolation, and sometimes with inadequate or poorly maintained equipment and facilities. Rural doctors often know the victims of traumatic events personally or socially, and may suffer greater self-recrimination and an excessive burden of responsibility. They may be exposed to possible sanctions from community members of rural towns when resuscitation attempts of community members have not been successful.

As doctors, we often underestimate the seriousness of acute stress disorder or post-traumatic stress disorder. It is essential to seek professional help and incident debriefing with a family doctor or general practitioner, grief counsellor, psychologist or psychiatrist in a timely manner.

Healing is part of life and continues through death and into life again. It occurs throughout a person's life journey as well as across generations. It can be experienced in many forms such as mending a wound or recovery from an illness. Mostly however it is about renewal. Leaving behind those things that have wounded us and caused us pain. Moving forward in our journey with hope for the future, with renewed energy, strength and enthusiasm for life. Healing gives us back to ourselves. Not to hide or fight anymore. But to sit
still, calm our minds, listen to the universe and allow our spirits to dance on the wind. It lets us enjoy the sunshine and be bathed by the golden glow of the moon as we drift into our dreamtime. Healing ultimately gives us back to our country. To stand again on our rightful place, eternal and generational. Healing is not just about recovering what has been lost or repairing what has been broken. It is about embracing our life force to create a new and vibrant fabric that keeps us grounded and connected, wraps us in warmth and love and gives us the joy of seeing what we have created. Healing keeps us strong and gentle at the same time. It gives us balance and harmony, a place of triumph and sanctuary for evermore.²

Professor Helen Milroy

IN SUMMARY

The impact of mental health disorders amongst doctors is often underestimated. For those in medicine, daily exposure to distress, grief, trauma and uncertainty is normal, as are burnout and sleep disturbances. These experiences can leave us highly susceptible to mental illness in a workforce where seeking help is stigmatised and acknowledging human fallibility is discouraged. If experiencing mental health problems, doctors must seek out and consult a trusted family doctor or general practitioner, psychologist and/or psychiatrist early to prevent the many negative consequences of mental illness on our patients, our families and ourselves.

While the individual self-care strategies described in Section 1 of this book can be helpful, they have limited value and may be counterproductive if the medical workforce culture is dysfunctional or toxic. Section 2 focuses on practical ways for doctors to work together to create a healthier and happier medical culture.

² Professor Helen Milroy is a child and adolescent psychiatrist and was a Commissioner on Australia’s Royal Commission into Institutional Responses to Child Sexual Abuse.
SECTION 2

Every Doctor Can Work with Colleagues to Create a Healthier and Happier Medical Culture

THE PHYSICIAN’S OATH (DECLARATION OF GENEVA)

AS A MEMBER OF THE MEDICAL PROFESSION:
    I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;
    THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;
    I WILL RESPECT the autonomy and dignity of my patient;
    I WILL MAINTAIN the utmost respect for human life;
    I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing, or any other factor to intervene between my duty and my patient;
    I WILL RESPECT the secrets that are confided in me, even after the patient has died;
    I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice;
    I WILL FOSTER the honour and noble traditions of the medical profession;
I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due;  
I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare;  
I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard;  
I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;  
I MAKE THESE PROMISES solemnly, freely, and upon my honour.¹

It is a serious matter to ‘solemnly pledge’ to ‘dedicate my life to the service of humanity’, and it is impossible to fulfil the physician’s oath without a life-long commitment to self-care and care of colleagues. The pledge to a common purpose is also an acknowledgement of the role and responsibility of every doctor to work together to create a healthier and happier medical culture.

Workplace ‘culture’ has many complex definitions, which usually encompass traditions and customs, shared histories, joint training, a common language, and set of conscious or unconscious values, beliefs, behaviours and assumptions. Culture is often referred to as the climate of a workplace or simply ‘the way we do things around here’.

A ‘special’ medical culture often exists within a health service or hospital culture. Subcultures also exist within different medical and surgical specialties. While it is difficult to objectively measure a culture, people will usually readily identify common features of the culture of their own group or organisation.

Our medical culture has been described as cold, uncaring, unforgiving, ego driven, crisis orientated, caustic, toxic, dysfunctional, dehumanising, money orientated, fragmented, paternalistic, arrogant, aloof, hierarchical, competitive, belittling, fearful, mistake averse, combative, resistant to change and power orientated.

At first glance, this assessment will at first glance be regarded by doctors as overly critical and harsh. However, when we consider that our high rates of mental illness and suicide, bullying, harassment and discrimination, patient complaints, clinical error rates and medicolegal issues, and patient-initiated violence are either increasing or have not changed significantly, can we really defend our medical culture and subcultures if we tolerate the status quo? Can

we continue to accept that in many medical workplaces, our status within our profession is based on the earning capacity of our specialty, rather than our humanity?

While there are many examples of positive medical workplace subcultures, the case for change in many medical workplaces is strong when we contemplate having to meet the challenges and advances of 21st-century medicine. However, there is resistance to change – overcoming the fear of loss of status, reputation, identity and power requires collaborative medical leadership and professionalism.

No one would disagree that principles such as mutual respect, trust, compassion, altruism, integrity, justice and accountability should be upheld by every doctor. There are a number of practical ways we can collaborate with each other to do this by

- Creating healthier clinical teams.
- Managing challenging behaviours together.
- Learning from complaints and clinical errors to change systems of care.
- Calling out conscious and unconscious biases.
- Eliminating sexual harassment, discrimination and bullying.
- Preventing and managing patient-initiated violence.
- Supporting colleagues to respond to serious mental illness.
- Looking after our physical environment.

We wish to emphasise the importance of ‘supporting colleagues to respond to serious mental illness’. Doctors must be proactive in ensuring their colleagues receive the right professional help from independent medical and health practitioners because doctors, like other patients with serious illness, do not always have full insight into their own problems when they are vulnerable. One of the most obvious indicators of a caring workplace is when colleagues stand by a doctor through difficult times. Medical workplaces must be as empathetic to their doctors, and all other staff, as they are to their patients.

Whatever the challenge, we can meet it more effectively if we work together and support each other. When we care for each other, we care for our patients and ourselves, because we create a positive culture, in which we can all thrive.
CHAPTER 11

Creating Healthier Clinical Teams

The brutality of the medical culture needs to be addressed – the lack of support mechanisms and the sniping, the attitude that anybody with a mental illness is too weak, they’re not fit to be a doctor. The caring profession needs to care for itself.¹

Dr Mukesh Haikerwal

HOW DOCTORS TREAT EACH OTHER

I met a young doctor who used to work with me recently. I had just completed my night rounds in the hospital and I was leaving for home. And then I saw him. He was unkempt, exhausted and appeared famished. Worst of all, he looked like a man who has totally given up on being a doctor. He appeared hesitant when I asked him what was wrong, but I could not just leave him there.

After much persuasion and insistence on my part he agreed to join me for a late supper. While he ravaged through his first proper meal of the day, he finally opened up. He has started working for the past week in a new speciality. Though the hours are longer, it was not an issue. He was well aware of the sacrifices he was expected to make.

However, the degradation, humiliation and constant harassment have finally taken their toll. He was literally chased out of the ward just minutes before he met me because he could not remember the details of a patient he clerked. He was not allowed to refer to his notes and had to recite the lab results by heart like a trained poodle. The words were abusive, hurtful and condescending. And worst of all, it was said right in front of the patient.

He finished his meal and stood up to leave. And as he left he said this ‘Please don’t worry about me. I will be fine’. I was not convinced. The shame of being publicly humiliated is not a stain that washes easily.

¹ Dr Mukesh Haikerwal (born 1960) is an Australian general practitioner, past chairman of the World Medical Association and past president of the Australian Medical Association.
The doctor-patient relationship often takes centre stage, but the epitome of good clinical practice depends on how the doctors treat each other. The medical profession is filled with fragile and vulnerable egos that often have trouble working with each other in a genuine collaboration of trust and mutual respect.

We complain, argue, fight and obsess for the sake of our patients, but do we dare reflect for even an iota of moment our actions and attitude towards our fellow caregivers?2

Dr Dharmaraj Karthikesan

Those of us who have worked in healthy clinical teams will recognise the essential ingredients of strong collaborative clinical leadership and culture. Functional clinical teams recognise that this involves open, honest, constructive debate and feedback, based on objective analysis and clinical experience. They value healthy communication and diversity of thinking, recognise equal opportunity, treat people fairly and help them reach their full potential, investing in ongoing training and education.

Healthy clinical team members work in the best interests of the team rather than for the status of a few individual doctors. Effective clinical meetings have planned agendas and result in clear outcomes as meeting discussions encourage participation of the whole multidisciplinary team. Clinical decisions are based on evidence and reasoning. High standards are expected but personal blame is not attributed to mistakes or errors, which are appropriately attributed to issues related to systems of care and regarded as opportunities for learning and continually improving.

Unfortunately, many of us have also worked in dysfunctional clinical teams, which are renowned for the arrogance and egos of a few doctors, and the quiet despair of their junior people who are competing to stay on the team. Dysfunctional clinical teams have a tendency to ‘drown in their work’ because they do not effectively tap into the knowledge and skills of all team members. There is a lack of trust between team members, who struggle to solve complex clinical problems as they do not engage in debate or listen to diverse clinical opinions. Team members, who express vulnerabilities are regarded as weak, and blamed individually for poor patient outcomes.

Superficially, there may be a veil of politeness, but team members behave in passive/aggressive ways, blame others, hold grudges and avoid or become defensive in difficult conversations or conflict. Consequently, team members

2 Dr Dharmaraj Karthikesan is a Malaysian interventional cardiologist and blogger at https://dharmarajkarthikesan.com/.
usually dislike or fear clinical meetings, which do not have clear outcomes. Junior members of the team may be humiliated for their knowledge and skill gaps in clinical meetings. Sometimes, there is a toxic culture where unconscious and conscious biases, bullying, discrimination and harassment are not called out.

There are many shades of grey between these two extremes of teams. What sort of team do you work in?

**Try this exercise:**
Here are some healthy questions for healthier clinical teams. In the last week:

- What did you do to help or support a colleague, particularly if they are unwell?
- What did you do to acknowledge the good work of a colleague?
- What did you learn from a mistake?
- Did you ask for advice from a trusted colleague?
- How did you improve your care of patients in response to their suggestions or complaints?
- Did you take time to welcome a new colleague, congratulate a colleague’s achievement, celebrate a colleague’s significant work anniversary, or say a special goodbye to a retiring colleague?

**A WONDERFUL, DIVERSE AND HIGHLY SKILLED TEAM**

As a newly graduated doctor I worked in a community clinic providing care to people with HIV. This was in the early 1990s before effective treatments transformed HIV from being an inevitably terminal condition to a chronic manageable condition for many people. Working in general practice with people affected by HIV, I discovered something new about human existence every single day. I couldn’t provide everything that my patients needed, but I could do so much more by working as a member of a wonderful, diverse and highly skilled team of healthcare professionals and volunteer carers. I experienced and valued the camaraderie between general practitioners that supports us in our important work. Being able to assist someone who trusts you and to care for them while they are supported to die with dignity is a very special privilege. I learned it is okay to cry with people who call you their doctor. I also discovered that wisdom came with experience. My patients of course knew more about their experience of their own condition than I did, and they became my greatest teachers.

Dr Michael Kidd
IN SUMMARY

In creating healthier clinical teams, we challenge the stifling hierarchies and unforgiving cultures perpetuated by some medical workplaces. Despite the medical profession's commitment to care for others, caring for colleagues can often be lacking. This may manifest through unrealistic work expectations, teaching by humiliation, and a culture of accepting ‘burnout’ as normal.

Dysfunctional clinical teams may be dominated by egotistical individuals, where there is a lack of collaboration, trust and listening between members. As a result, these teams are often overworked and demotivated, creating a toxic work environment and poorer outcomes for patients. Healthy clinical teams centre around strong collaborative leadership, honest communication and have an overarching goal to provide excellence in patient care, while caring for colleagues.
As doctors we are as diverse as our patients. Those patients we find difficult can push our individual buttons in different ways. I have often discovered that one doctor’s ‘heartsink’ patient can be another doctor’s joy.

Dr Michael Kidd

Patient anger is often justifiable. It may relate to intense fear, grief or a past negative experience in another health service or with another doctor. It may be in response to a diagnosis, rudeness from members of staff, a prolonged waiting time, an adverse event, or a perceived lack of support from family, friends and doctors.

As doctors, we often bear the brunt of patient anger, and we need to learn how to react without taking this personally. When a patient is angry or a patient arouses anger in us, it is important to listen carefully, objectively assess the situation and consider the underlying cause. A calm question like ‘I sense you are angry. Can you tell me what is happening?’ will often diffuse the situation and help our patients articulate very significant fears. Statements such as ‘That must be very difficult for you’, ‘I am sorry you are feeling like this’, and ‘What can I do to support you?’ can help our patients resolve their anger.

Sometimes patients with specific personality types are more likely to display anger and frustration because they feel misunderstood and they are unable to assertively communicate their needs. Here are a few examples of common personality types:

- A patient who is preoccupied with details may have a tendency to be rigid and only undertake treatment with excessive cautiousness
- A patient who is hypersensitive to disapproval may have difficulty presenting for healthcare because of their fear of negative evaluation or rejection
- A patient who has a strong need for reassurance may have a tendency to seek frequent consultations
- A patient who displays a lack of emotional responsiveness may be reluctant to talk about their problems

Sometimes, it may take longer to develop a trusting relationship with people who display some of these traits. Nevertheless, taking time to understand the person as well as their illness is essential in establishing a meaningful long-term therapeutic relationship. Sometimes, people who initially challenge us through their behaviour can teach us a great deal about what it means to be human. For all these reasons, it is helpful for doctors to support each other when managing patients with challenging behaviours.

It is particularly important for doctors to support each other if patients display vexatiousness or psychopathic tendencies. Querulant (morbid) complainants are relentlessly driven by a ‘pursuit of justice’ or ‘perceived injustice’, and their complaints cascade over years, devastating the lives of their victims and their own lives. Vexatious litigants often repeatedly institute a diverse range of legal proceedings without reasonable grounds.

Unreasonable complainant behaviours are demanding, persistent, uncooperative or aggressive through unreasonable anger, intimidation, threats or violence. Their communications are often relentless, out of proportion, voluminous but vague, and they often misconstrue communication from others. They seek reparation and retribution, but are rarely satisfied with offers of resolution.

Doctors who are targeted by unreasonable complainants require the support of skilled mental health professionals to help them set firm boundaries and limits, and to debrief after encounters and attacks.

Querulousness should, in our opinion, once more take its place among the legitimate concerns of mental health professionals. Querulousness is a behaviour into which mental health professionals can provide insights conducive to its better management in courts and complaint organizations. Those caught up in a querulous pursuit of their notion of justice are amenable to treatment that can at least ameliorate their distress and reduce the disruption they create for others.1

Dr Paul E Mullen and Dr Grant Lester

It is helpful to identify patients with psychopathic traits, and they may benefit from psychiatric intervention. A number of studies have confirmed the value

1 Dr Paul E Mullen and Dr Grant Lester are Australian forensic psychiatrists.
of the Hare Psychopathy Checklist–Revised (PCL-R) for evaluating a person’s degree of psychopathic traits. The Hare PCL-R contains two parts, a semi-structured interview and a complex review and evaluation of the subject’s file records and history by a qualified professional. Because psychopaths lie frequently, the information they provide must be confirmed by a review of the documents in the subject’s case history.

Some of the traits assessed by the Hare PCL-R score are as follows:

- Glib and superficial charm
- Grandiose (exaggeratedly high) estimation of self
- Pathological lying
- Cunning and manipulativeness
- Lack of remorse or guilt
- Shallow affect (superficial emotional responsiveness)
- Callousness and lack of empathy
- Parasitic lifestyle
- Poor behavioural controls
- Sexual promiscuity
- Early behaviour problems as a child and juvenile delinquency
- Lack of realistic long-term goals
- Impulsivity
- Irresponsibility
- Failure to accept responsibility for own actions
- Many short-term relationships
- Criminal versatility

When patients with challenging personalities and behaviour complain about another colleague’s management, there is usually no benefit to be gained in reinforcing a patient’s anger or vexatiousness about their previous doctors or perceptions of their prior healthcare experiences. In these situations, we need to work with our colleagues on ways to manage challenging situations cooperatively and constructively to protect the very highest standards of patient care.

IN SUMMARY

Some patients carry vulnerability and anger with them due to past medical experiences, may have difficulties establishing a trusting relationship with their treating doctor, and may possess challenging personality traits and behaviours that may predispose them to querulousness. Despite our best efforts, we may
face a vexatious litigant, an unrelenting complainant or a patient with psychopathic traits.

We need to support each other in responding to patients who are angry, querulous, vexatious or psychopathic. Patient complaints can be debilitating and exhausting. As well as identifying, managing and reviewing our patients with challenging behaviours, it is important to seek the support of our colleagues, work cooperatively with our peers, and have access to a treating family doctor/general practitioner or a skilled mental health professional with whom to debrief.
CHAPTER 13

Learning from Complaints and Clinical Errors to Change Systems of Care

The volume and complexity of what we know has exceeded our individual ability to deliver its benefits correctly, safely or reliably. The ninth edition of the WHO International Classification of Diseases has grown to distinguish more than 30,000 different diseases. Clinicians have at their disposal some 6000 drugs and 4000 medical and surgical procedures – it’s a lot to get right.1

Professor Atul Gawande

As doctors, we must be mindful of the special needs of certain groups of patients. For example, older people with cognitive issues may require extra time to ensure they can make informed choices, people with a disability may require special attention to ensure access and communication, and people from culturally and linguistically diverse backgrounds may require increased sensitivity to cultural beliefs about treatment. Often, a doctor may be the only person someone feels they can completely trust and confide in, and we need to be aware we are often an important person in our patients’ lives.

While we understand this in theory, it can be difficult to uphold a caring approach to all patients in reality, particularly in a crowded public healthcare setting or when patients challenge us. It is easy to forget what it means to be kind in the process of juggling all the complex demands of patient care. When we fail to live up to the high expectations and complex needs of our diverse patients, we will inevitably receive complaints.

We also need to be mindful of the stresses faced by our staff, which may result in negative interactions with our patients. This is a common cause of patient dissatisfaction and may be another source of complaints. It is worth

1 Professor Atul Gawande is a surgeon, public health researcher and writer having published four New York Times bestsellers including Complications, Better, The Checklist Manifesto and Being Mortal.
taking time to observe what is really happening in our waiting rooms and on our front desk telephones. Staff training on customer service is especially important in a medical context where patients may feel sensitive and frightened.

Clearly, it is important to deal with complaints or adverse events effectively in order to restore trust in the doctor–patient relationship and prevent any risk of recurrence. Legal action is more likely if a situation has been handled insensitively, or if there has been a delay in communication or poor communication after an incident.

Unfortunately, doctors who have experienced medicolegal action are more likely to practice defensively and more likely to order unnecessary investigations, refer to other specialists for minor issues, and consider leaving their practice or retiring early.

For all these reasons, we must confront the realities of the risks associated with practising medicine and manage inevitable patient complaints and clinical errors effectively and constructively.

To become a good and empathic doctor, you need to be interested much more in the person you are encountering than in the complaint or disease. Furthermore, you need to continue to be curious, critical of yourself, and reflective.²

Professor Job FM Metsemakers

PATIENT COMPLAINTS

Everything can be improved.³

Professor Max Kamien

Clinical care is complex, and it is inevitable that patients and their families complain when things do not improve as they expect. Nevertheless, perhaps because we pride ourselves in maintaining very high standards, one of the most stressful situations in medicine can be receiving a formal patient complaint.

Open, honest, timely and caring communication is encouraged in this situation. Patients need to be reassured that their complaint is being taken seriously and responded to by the doctor concerned.

² Professor Job FM Metsemakers is a Dutch family doctor and Chair of General Practice/Family Medicine at Maastricht University in the Netherlands.
³ A ‘Maxism’ by Professor Max Kamien, general practitioner and Emeritus Professor of General Practice, University of Western Australia.
Tips for responding to a patient complaint:

- Try to re-establish patient trust by having a prompt face-to-face meeting. Listen fully. Use a concerned, sincere tone, take your time during the meeting, and offer to work with the patient to address the situation together.
- Establish the facts behind the complaint and the factors that led to the complaint, to deal with the patient’s concerns and identify any changes that can be implemented to prevent this happening to another person.
- Establish what the patient expects to happen after the complaint.
- Validate a patient’s anger by saying ‘It must be very frustrating for you.’
- Provide relevant clinical information and document the process of dealing with the complaint. Ask if there is anything else the patient needs to know about or if the patient requires any other support.
- Discuss appropriate ways of dealing with the payment of accounts. For example, it may be appropriate to waive payment. Do not send accounts for incorrect treatment.
- Provide options for ongoing medical care and consider referral if required.

A CLINICAL INCIDENT

... young physicians still learn largely by observing more senior members of their field. (‘See one, do one, teach one’ remains a guiding maxim at medical schools.) This approach produces confident and able physicians. Yet the ideal it implies, of the doctor as a dispassionate and rational actor, is misguided. As Tversky and Kahneman and other cognitive psychologists have shown, when people are confronted with uncertainty – the situation of every doctor attempting to diagnose a patient – they are susceptible to unconscious emotions and personal biases, and are more likely to make cognitive errors.4

Dr Jerome Groopman

Many doctors are concerned about the consequences of a clinical incident for good reasons. The human body is not a machine, and adverse events are inevitable.

To mitigate against the risk of medicolegal action, we are encouraged to contact our medical defence organisations immediately after a clinical incident, particularly when there has been a clinical error and before open disclosure or

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4 Dr Jerome Groopman, the Dina and Raphael Recanati Chair of Medicine at Harvard Medical School, chief of experimental medicine at Beth Israel Deaconess Medical Center in Boston, and staff writer for The New Yorker magazine.
an apology is offered. Medical defence organisations will usually advise against making any admission of liability or error of judgement, particularly before all the facts of the case are known. Our medical defence organisations usually have teams of experienced doctors, who are expert in giving us advice on legal matters.

It’s easy to make perfect decisions with perfect information. Medicine asks you to make perfect decisions with imperfect information.5

Professor Siddhartha Mukherjee

Expressions of sympathy do not constitute an admission of fault. We can say to our patients, ‘I am upset about this outcome’ without admitting negligence. We may express regret for what has happened by saying ‘I am very sorry this has happened.’ Many patients wish to be reassured that an error will not be repeated and may seek compensation if they believe this is the only way to raise awareness about a medical mistake. Others may take legal action to punish the doctor or to raise money.

Whether a clinical incident involves a near miss, an adverse event or a sentinel event, we must also recognise the way the system in which we work might predispose us to making mistakes, by requiring us, for example, to work long hours or without adequate supervision and training. After any clinical incident, it is important for a hospital or practice team to undertake root cause analysis to determine the cause and contributing factors, in order to identify and manage systems issues, and avoid repeat incidents.

Sometimes this involves identifying clinical training needs, performing clinical audits and examining the systems that have contributed to a failure such as processes for reviewing investigations, infection control procedures, and the management of confidentiality and privacy. While being involved in these investigations and peer reviews can be difficult, they are a routine process to maintain the highest standards of safety and quality in healthcare.

Doctors have become more aware of the importance of proactive clinical risk identification and the management of quality and safety in everyday practice. While it can be a time-consuming process to be involved in clinical governance, most doctors understand the importance of regular formal meetings with colleagues to continuously improve the quality and safety of patient care, and to prevent future clinical incidents.

5 Professor Siddhartha Mukherjee is an Indian-American physician, oncologist and the author of The Emperor of All Maladies: A Biography of Cancer.
I’m Sorry
As I reviewed the small mountain of reports on my desk, one gave me pause. I had just returned to my small-town family practice after an extended leave of absence. Pat had lung cancer.

Pat was a 78-year-old beloved patient for whom I had cared for more than a decade. She was a dairy farmer, mother of six, interior designer, and one of the best pie bakers in the county. Reports from the hospital and oncologist confirmed widespread metastases. Pat had declined aggressive treatment. She was receiving palliative care from hospice under the supervision of an oncologist. I called Pat to express my concern. Her response was lukewarm. I offered help if she desired.

A few days later I spoke with the oncologist. He provided details and added, ‘You might want to check the records. The primary lesion was detected years ago, but there was no follow-up. Someone dropped the ball.’

What had happened? I reviewed Pat’s electronic record, including reports from a hospital stay more than 3 years ago for pulmonary emboli following knee surgery. The computerized tomography (CT) report described extensive bilateral infiltrates and a possible small nodule in the base of the left lung. Follow-up was recommended, but no follow-up was obtained. A chest X-ray report from a visit more than a year ago with one of my partners revealed a left lower-lobe pneumonia and suggested follow-up to ensure resolution; no follow-up was obtained.

Pat presented infrequently for care and usually only if something was wrong. There was no indication in any of the notes that the abnormality was noted. Pat had not been informed of the findings. Who was responsible for identifying, discussing, and following these issues – the hospital team, my partners, or the radiologists? None of these was to blame. As Pat’s family physician, it was my responsibility to follow up abnormal tests. I had made a serious mistake.

I was afraid, ashamed, and confused. Had Pat rejected me because of this mistake? Was she angry? Would she sue me? What was wrong with me? Was I a bad doctor? Could I be trusted? Had I made other serious mistakes? What was wrong with our healthcare system? Was the mistake due to pressure to see more patients more quickly? Did the conversion from a paper chart to an electronic medical record contribute to the error? Would early detection and treatment have changed the outcome? What should I do?

Forgive Me
Discussion with a trusted colleague helped me sort out my thoughts. Yes, I had missed a finding. No, we will never know if early detection would have
EVERY DOCTOR

changed the outcome. Yes, I should share this information with the patient and apologize. I took a deep breath, called the patient, and asked permission to visit her at home. She agreed. It was a quiet, bright, sunny day.

Pat was lying in bed in a darkened room with mildly laboured breathing. I kneeled at the bedside and took Pat's hand. She wept when she saw me. She said she had no pain but was very tired. She was worried about her husband of nearly 60 years, who had also been ill, and distraught about conflicts with many family members who were not on speaking terms. I listened.

Finally, I shared what I had come to disclose. I had made a mistake. I did not note the possible nodule on the CT scan. I was sorry that Pat had cancer. I was sorry that I had not fulfilled my responsibility to provide her with as much information as possible so that she might have taken action sooner. I did not know if this would have made a difference in the outcome.

Pat's immediate response was, 'It's not your fault that I have cancer. If you had found this earlier, I might have had 4 terrible years, instead I had 4 good ones. You did nothing wrong.'

I emphasized that yes, I was indeed responsible for not noting the nodule on the report, for not discussing it with her, for not providing options for further evaluation and management. She repeated that no, I was not to blame. I was forgiven.

A tremendous load was lifted from my shoulders. Since Pat had forgiven me, perhaps I could forgive myself and continue as her doctor through the end of her life.

I Love You

I took another deep breath and continued. 'Pat, I have known you and your family for many years. I care about you. May I continue to be your doctor?' I wondered if Pat could trust me with my imperfections. Pat immediately responded, 'Of course. You're my doctor. You know me. I want you to care for me. The oncologist is fine, but he doesn't know me.'

One week later we conducted a family meeting in Pat's home with her husband, children, and the hospice team. Another deep breath: 'We are here because we love Pat. None of us is perfect. There are no perfect families. Yet because of Pat's love, forgiveness, and courage, we have this precious gift of time together.'

We discussed Ira Byock's four things that matter most at the end of life (saying 'Please forgive me', 'I forgive you', 'Thank you' and 'I love you'). Pat expressed her love and hopes: for the family to be at peace, to celebrate the good times, and to support one another in the difficult times to come. Pat died less than 2 days later.
Thank You
In her quiet and simple way, Pat taught us profound lessons about accepting the unexpected, forgiving, celebrating, hoping, and living and dying with courage and dignity.

I’m sorry. Forgive me. I love you. Thank you.  

Professor Cynthia Haq

IN SUMMARY

Despite our best efforts and intentions, we can make errors that can leave our patients unhappy and adversely affected. Facing complaints is difficult and stressful, and subsequent medicolegal action can have serious consequences on our confidence, mental health and performance. In handling complaints, it is important to engage in open and earnest communication, and liaise with a medical defence organisation.

It is critical to make time for a sincere face-to-face conversation with aggrieved patients and to offer open disclosure. Such interactions allow us to clarify the relevant facts about why an adverse event has occurred, by earnestly listening to our patient to understand their expectations, validating the patient’s frustration, expressing regret and sympathy, and discussing mutual goals to help re-establish a trusting professional relationship. It is also important to recognise that many clinical incidents are the manifestation of systemic failures in the health system, which need to be identified through root cause analyses, and rectified with supervision, training and systems changes, rather than blaming individuals.

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6 Professor Cynthia Haq is an American family physician and Chair of Family Medicine at the University of California Irvine. This extract was first published in Family Medicine 2006;38(9):667–668.
Cultural awareness is the recognition and acknowledgement that we are all cultural beings, and that this may affect our interactions with patients, their families and our colleagues. Cultural sensitivity is the conscious attempt to understand the possible influences of culture and cultural differences on interactions between patients, their families and ourselves. Cultural competency is the ability to identify and challenge one’s own cultural assumptions, values and beliefs, the development of empathy for people viewing the world through a different cultural lens, and the application of specific communication and interaction skills that can be learned and integrated into clinical encounters. There is a growing body of evidence to support the need for cultural competence among health professionals to positively influence clinical consultations and health outcomes.¹

Professor David Bennett

There have been numerous studies on the significant negative impacts of doctor bias on the quality of patient care in relation to gender, age, sexuality, culture, disability and even obesity. Conscious or explicit bias occurs when there is a deliberate attempt to discriminate a person or a group of people based on certain characteristics. Unconscious or implicit bias involves a lack of awareness of inadvertent prejudice, and although it may be unintended, it can be very harmful. Unconscious and conscious bias and cultural safety training is essential to help all doctors become more aware of the dangers of stereotyping certain groups of patients.

Conscious and unconscious bias between doctors is less talked about, but remains problematic. Doctors increasingly understand how to effectively deal with overt, unlawful bullying, sexual harassment and discrimination at work,

¹ Professor David Bennett is Senior Staff Specialist in Adolescent Medicine, Sydney Children’s Hospital Network, Australia, with a major focus on the development of integrated, creative health services for young people and their families.
but sometimes find it difficult to respond to repetitive subtle gender, racial and other bias or exclusion between colleagues.

For example, cultural stereotypes often characterise women doctors as kind, helpful, supportive, nice, modest, collaborative, self-deprecating, gentle, soft spoken, compassionate, understanding, complaint and nurturing. In their role as doctors, women may receive push back from both male and female colleagues and other staff when they display behaviours usually attributed to male stereotypes. Women who are authoritative, strong and efficient violate their gender stereotype and may unfairly be accused of being controlling, bossy or dominating. At the other extreme, they may be told they are too weak or emotional if they show sensitivity. They walk a tightrope of labels, as they are perceived to be either too assertive or too passive, too aggressive or too soft.

More commonly, women doctors are unconsciously held (and hold themselves) to higher standards than men, and expected to prove themselves over and over again, which is exhausting and frequently leads to burnout. They may be asked about their plans to have a family in job interviews and unfairly labelled as less committed to their work after they have children. Women are often invited to join committees to provide a gender balance, but find their opinions are not welcome, particularly if they do not agree with the status quo. The ‘stolen idea phenomenon’ may be recognised where a woman states an opinion that is later attributed to a man. Women doctors are more likely to experience income inequity and less opportunity to be promoted to medical leadership roles than men although they have equal competencies.

The slow grind of ‘everyday sexism’ can be difficult for women doctors to tolerate. Very often, the biases may seem too trivial to call out, and if women complain, they risk being labelled as overreactive or difficult. The repetitive nature of unconscious gender bias may be harmful as the stereotyping of women interferes with their full participation in the workplace and the advancement of women at all career stages in medicine.

Unfortunately, gender bias training may not be effective, particularly if it focuses on how women need to change in order to overcome these negative stereotypes, attitudes and barriers. It has to be called out by others. What we have to ask ourselves in our everyday work is: ‘would this comment, attitude, behaviour be appropriate if it were directed towards a man?’

Medical women also experience high levels of anxiety, depression, bullying and violence, compared with the general population and male doctors. These issues are at the tip of the iceberg of gender bias, sexual harassment and discrimination and have been prominently documented in the medical literature for decades, without significant progress, despite the resulting suboptimal
participation of women at work in times of workforce shortage. That our medical organisations and workplaces (often led by men) often do not regard gender issues as priorities, is an issue of gender bias and discrimination in itself.

Practical tips for responding to unconscious bias:

- Value all voices.
- Challenge outdated role stereotypes and labelling.
- Focus on capability and competence not superficial appearance.
- Call out disrespectful language and jokes.
- Be aware that seemingly harmless comments may trigger painful feelings in people who have been subjected to chronic low-grade bias.

**THINGS WE DON’T SAY OR DO IN MEDICINE ANYMORE**

‘... in a multiple hour hernia repair surgery, I was told that since I am the only female in the room that it is my job to hold the patient's testicles throughout the entirety of the procedure.'

This was written by an anonymous female physician who said she was squeezed by the cheeks, kissed and endured other forms of unsolicited touching, and inappropriate sexual advances by consultants as a medical student. She called for other doctors to speak out about sexual harassment in her article, but there was a poor online response from only four male doctors. Among their public comments were the inappropriate ‘joke’ – ‘Sorry but what ‘cheeks’ are we talking about?’ and ‘My opportunities have been gazumped by confident flirtatious female colleagues'. Another doctor wrote: ‘There is a large contingent of female grads coming out of Med Schools now, that enter the workforce with girded loins and judging everything through an irritating gender lens – sometimes even infantilised by ‘trigger alerts'. The thread continued on the topic of women doctors not pulling their weight and taking time off work to care for their children with the comment ‘Clearly the biological imperative of who bears the children is never going to go away, so we just have to deal with it.' The final response to the story was about ‘standing up for yourself’ with this conclusion ‘..., when it comes to being harassed, one has to learn to stand firm, which is something no-one else can do, or be, for another'.

Let's be clear, sexual harassment, bullying and discrimination are unlawful and should never be tolerated by anyone. Despite this, we continue to hear stories of unacceptable behaviors by doctors, which may be why subtle repetitive forms of everyday bias are commonly overlooked in medical workplaces. Perhaps perceived as too small or stupid to waste precious time on, doctors may let them pass.
At other times, there is no question when unacceptable comments overstep the mark, such as in the anecdotal comments above from the four male doctors, which ignore what the medical and other literature tells us about the prevalence of sexism in medical workplaces.

Repetitive everyday sexism is sometimes difficult to call out. Sometimes there is ‘eye rolling’ when women speak, or we may hear ‘she talks too much’ when the reality is that women are often less likely to dominate workplace discussions as much as men because fewer women hold leadership roles or chair meetings. Many women can also report being repeatedly ignored, dismissed or misconstrued, such as what happened to the anonymous female physician writing on an important topic.

We can no longer ignore the medical literature on the resulting high rates of stress, depression and suicidal ideation amongst women doctors, and the disproportionate lack of women in medical leadership roles, although females represent over 50% of the medical cohort in many countries.

It’s time for the medical profession to consider Duke University’s campaign on ‘Things You Don’t Say’, encouraging staff and students to identify inappropriate comments in everyday language which stereotype and discriminate against both women and men based on gender, age, sexuality, culture, religion, disability and even obesity.

What are the things you don’t say or do in medicine? Will you call out major and minor harmful comments and behaviours regardless of a doctor’s status or gender? Will you stand firm and can you do that for another?

Dr Leanne Rowe

IN SUMMARY

Medicine is certainly not exempt from harmful stereotyping and conscious and unconscious biases. While incidents of explicit harassment and bullying are increasingly identified and addressed as they are unlawful, subtle repetitive everyday bias often goes unchallenged, and can result in harm to the health and career outcomes of those affected.

For example, women doctors may be discriminated against and disadvantaged in workplaces where they are expected to affirm stereotypical labels, in leadership roles where they see less opportunity to progress, in committees where they may be given tokenistic roles and find their opinions unwelcome or dismissed, and in the overarching medical culture that deters women from expressing strong opinions.

Displays of conscious or unconscious bias by doctors in relation to gender, age, sexuality, culture, disability and obesity have no place in medicine. They must be called out.
A doctor must work eighteen hours a day and seven days a week. If you cannot console yourself to this, get out of the profession.¹

Dr Martin Henry Fischer

Healthy workplaces provide caring, inclusive cultures, that do not tolerate sexual harassment, discrimination or bullying. Sexual harassment, discrimination and bullying are unlawful. Consequently, many forms of abuse are low grade, chronic, and difficult to document, rather than overt. It can be difficult to make sense of what is happening over time or to prove recurrent negative behaviours, particularly if witnesses cannot verify incidents.

All organisations, including hospitals, clinics and health services, have a legal responsibility to ensure that their workplace is safe and free of discrimination, sexual harassment and bullying. Vicarious liability means that an employer may be found to be liable for the discrimination, sexual harassment or bullying of others by its employees. All doctors must be aware of safe workplace policies and undergo occupational health and safety training.

Here are some steps to take if you believe you have experienced discrimination, sexual harassment or bullying:

- Know the definitions of discrimination, sexual harassment or bullying, and document your experiences over time. This may be in the form of emails or personal records of telephone calls or meetings.

¹ Dr Martin Henry Fischer (1879–1962) was a German-born American physician and author. He is most famous for his teachings on the art and practice of medicine, including this infamous quotation, which in the past was often recited on the first day of medical school.
• Write a formal letter detailing the facts of repeated incidents to the most senior person in the workplace, which is usually the chief executive officer, people and culture manager, or the practice principal.
• It is the responsibility of the person who receives the formal complaint to meet individually with the person making the complaint, separately from the alleged perpetrator to establish the facts.
• If the evidence is clear, a formal apology must be offered by the perpetrator, and it may not be appropriate for this to occur face to face. Sometimes the complaint results in the termination of the employment of the perpetrator and it may be appropriate for the complainant to remain anonymous.
• The organisation or practice must ensure that the person who has made the complaint and other staff are not subjected to recurrences of discrimination, sexual harassment or bullying. This can be done by revising policies and procedures and providing mandatory training to staff.

WHAT IS DISCRIMINATION?
Discrimination includes direct discrimination and indirect discrimination. Direct discrimination occurs if a person is treated less favourably than others because of a personal characteristic such as race, age, gender, disability, sexuality or obesity.

Indirect discrimination occurs if a requirement, benefit, condition or practice is imposed that treats everyone in the same way and appears neutral, but which significantly reduces the ability of people with a particular personal characteristic to comply with or benefit from it.

Discrimination in any form is unlawful and against the Declaration of Geneva. It has no place in medicine, or anywhere else in the community.

Racism is often defined as the belief in the superiority of one race over another, which often results in discrimination and prejudice towards people based on their race or ethnicity. However, this definition has limitations, which are discussed in the following story on implicit systemic racism in medicine.

DISCRIMINATION AND RACISM

As a medical student, every eight weeks I rotate through a new specialty in a new hospital or health service. This means every eight weeks I flick over to a new chapter in my textbook, learn a new set of medical lingo, meet a new team of doctors, and a new cohort of patients. As a person of colour however, this translates to something far more challenging yet predictable. It means responding to ‘where are you from?’ followed by ‘but where are you really from?’ when
the answer fails to adequately explain my brown skin. It often means responding to ‘your name is too hard to remember; do you have a nickname?’ with something conveniently anglicised for my supervisors to remember. It means constantly dispelling the notion that anything other than a white culture is homogenous; no I don’t love cricket and no my mum does not exclusively cook curries. It means feeling confused when my white colleagues can simply introduce themselves as medical students and be judged in a professional capacity while I am frequently in the background still justifying the colour of my skin.

To many, these conversations may sound perfectly benign and even well intentioned. They don’t make your skin crawl and your stomach churn like blatant racial attacks. I could write about the patient who insisted I leave her room during morning rounds because she only speaks to white doctors. Or the patient who demanded my Muslim colleague remove her hijab before beginning a consult. Or the patient who asked me if I could even speak English while I wrote in his chart. While these experiences are traumatising, overt racism is paradoxically easy to distance oneself from. We let ourselves simply implicate the ignorance of individuals, rather than challenge the overlooked systemic nature of implicit racism.

I have always thought that racism stems from ignorant assumptions. In my experience, overt racism seldom occurs amongst educated health professionals. But implicit systemic racism persists, impenetrable to the protections of a higher education or the health system.

My most hurtful experiences as a person of colour have come from medical colleagues far more learned than me. From the residents, registrars and consultants who reject the notion that they can be racist, because they assume that racism is about subscribing to the idea of biological white superiority, which they do not. And from my white colleagues who feel the need to assure me that racism plays no part in medical workplaces or medical schools.

Morally rejecting the idea that white people confer biological superiority to non-white people is not enough. There is a general lack of acknowledgement that white privilege is omnipresent in medicine; that naïveté alone acts to discriminate against people of colour. In fact, if we do not understand racism as a social construct underpinning our everyday behaviours, we continually underdiagnose what it means to be racist. We continue to be complicit, through our daily actions or inactions, in the reproduction of systemic racial inequity.

Daily actions like staying silent when our colleagues face racial slurs from patients, or defining our colleagues by their skin colour before their medical skills and accolades. Daily actions like forming generalisations about racial groups and leaving it up to members of those racial groups to prove otherwise or defend themselves.

I recently sought guidance from an Indian-born physician on how to succeed through these daily challenges that grind away at my professional
and emotional sense of worth. I thought that given his success in medicine, he could offer some advice. My heart sank when his response was to simply ignore it.

I refuse to ignore the racism masked within the foundations on which our medical workplaces operate. We all deserve a work environment in which we can feel truly accepted and thrive - a work environment where we stand out for our professional abilities rather than our perceived otherness.

But people of colour cannot succeed alone in quiet defiance. Our voices require the amplifying volume of the majority. Everyone must acknowledge and challenge everyday implicit racism and break the silence of white complacency in our workplaces whether they be medical schools, hospitals, general practices or other community health services. And when I feel safe to attach my name to my views without fearing career repercussions or racial vilification – I know we will have achieved this.

Anonymous Final Year Medical Student

**DISCRIMINATION AND SEXUALITY**

I found my first year at University was a real challenge. I was used to being one of the clever kids at high school but at University I was swamped by really clever people. I had moved out of home, was working part-time and trying to keep up. It was a tough year. I started to feel really anxious. It all seemed too hard. I started to spend the day hiding under the blankets rather than heading to uni for lectures or prac classes.

Fortunately, I had made some great new friends at University who rang me to find out where I was. They tried to tell me that what I was experiencing was normal. They were all feeling anxious about exams and their progress as well. They were all finding it hard, even the people I thought were brilliant and knew all the answers. I went to see a doctor at the university health service, a great young woman, who immediately diagnosed that I was depressed and together we started some treatment which helped me turn the corner. I had a couple of sessions with a counselor but we didn’t hit it off mainly because, as a young person, I thought if he wasn’t going to ask the right questions, I wasn’t going to own up to what was really worrying me.

One of the main reasons that I was having trouble coping was because I was coming to realize that I was gay. It was something which had been obvious to many of my family members and friends since I was a toddler but it was a part of me that I had always denied. I eventually decided during my first year at uni that it was time to come out as a gay man although several of my friends advised me to keep quiet about this, because, believe it or not, having sex with another man in Australia in the 1970s was against the law and if I was charged and convicted, it could mean the end of becoming a medical practitioner.
I have to tell you that my years as an openly gay guy didn’t last long. A couple of years later there were newspaper reports about gay men in the United States starting to die from a new disease called Gay-Related Immune Disease, or GRID. A huge wave of fear gripped the world. In Australia we had the Grim Reaper campaign which whipped up fear. A group of babies were found to have contracted HIV through blood transfusions taken from a donation from an HIV positive gay man. One Member of the Australian Parliament stood up in Parliament and recommended that all homosexually active men in Australia be quarantined on an island. It was not a time to be openly gay if I wished to graduate as a doctor in a very scared and homophobic society.

It’s amazing where our careers as doctors can take us. In my first year at university as a young gay medical student I had no idea that I would become a general practitioner working mainly with people with HIV, that I would spend time working with child victims of the Chernobyl nuclear disaster in the former Soviet Union, that I would have the opportunity to teach in countries like Uganda, Sri Lanka, Malaysia and Saudi Arabia, that I would give a talk in the grounds of the temple where the founder of western medicine Hippocrates had his own clinic and taught his own students, that I would become a consultant to the World Health Organization and have the opportunity to influence health programs and health policy around the world, that I would spend time working in South Africa setting up clinics to test and treat people with HIV living in some of the poorest rural communities in the world, that I would become an advisor to a succession of Australian Health Ministers, that I would find love and be able to marry my beautiful same sex partner and live together as openly gay men, that 20,000 doctors would vote for me to become the President of their Royal Medical College, twice, and that doctors from over 100 countries would vote for me to become the President of their Global Organization.

If things get tough, and you feel more like hiding under your blankets than going to lectures or prac classes, please don’t give up. If you are feeling sad or anxious or exhausted or just can’t cope, please go and speak to one of the doctors or counselors at your university health service. It is normal to have good times and bad times as a medical student. If you find that you drinking too much for your own good, or engaging in other risky behaviors that put your health at risk, seek some support from your friends or from a trusted doctor or counselor or from a member of staff. You may feel alone at times but you are never alone. You are part of a wonderful community of people who care about you and your wellbeing.

Remember each of us is able to make a positive difference to our world every single day, through the way we live our lives, through the care that we show to other people, through the passion that we have for doing what is right. Don’t lose your passion. You are going to make a difference.

Dr Michael Kidd
WHAT IS SEXUAL HARASSMENT?

Sexual harassment is any unwanted or unwelcome sexual behaviour, which makes a person feel offended, humiliated or intimidated. Examples of sexual harassment may include:

- offensive verbal comments and offensive jokes with sexual connotations
- propositions or lewd gestures
- making promises or threats in return for sexual favours
- displays of sexually graphic material including posters, cartoons or messages left on notice boards, desks, computer screens or common areas
- repeated invitations to go out after prior refusal
- sex-based insults, taunts, the spreading of rumours, teasing or name calling
- unwelcome physical contact such as massaging a person without invitation or deliberately brushing up against them
- sexually explicit conversations
- offensive phone calls, voicemails, letters, emails or text messages or computer screen savers

Sexual assault is defined as a sexual act in which a person is coerced or physically forced to engage in a sexual act against their will or non-consensual sexual touching of a person.

WHAT IS BULLYING?

To sin by silence when they should protest, makes cowards out of good men.\(^2\)

Abraham Lincoln

Workplace bullying is repeated, unreasonable behaviour directed towards an employee or volunteer, that creates a risk to their health and safety. The following types of behaviour, where repeated or occurring as part of a pattern of behaviour, could be considered bullying:

- verbal abuse
- constant criticism
- excluding or isolating an individual

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\(^2\) Abraham Lincoln (1809–1865) was an American statesman and lawyer who served as the 16th President of the United States from March 1861 until his assassination in April 1865.
• psychological harassment (for example isolating someone by preventing others from befriending them)
• intimidation
• derogatory comments
• assigning meaningless tasks unrelated to the job
• giving employees impossible assignments
• deliberately changing work rosters to inconvenience particular individuals
• suppression of ideas
• deliberately withholding information that is vital for effective work performance
• spreading rumours about an individual or group

A person who displays bullying often has controlling needs and focuses on select targets. On the surface, a perpetrator may be charming and intelligent. People who are being bullied are often not believed at first and may be labelled as weak or negative by co-workers. Others sometimes recognise the perpetrator’s behaviour, but prefer to stay neutral to avoid the risk of being targeted themselves. Individual lives and organisations can be seriously damaged by inaction.

In recent years, workplaces have become more aware of the need to assertively performance manage staff who repeatedly display unwanted behaviours. Bullies are sometimes oblivious to their actions and are mortified when their behaviours are brought to their attention.

It is also important to note what bullying is not. It is not when someone expresses a different opinion, has a conflict or debate, or is undergoing constructive and honest feedback in a performance review. It is not when someone is rude, uncivil or takes a bad mood out on someone on occasion, especially when desperately tired or worried.

In these situations, sometimes it helps to say, ‘I’m not sure if you realise this but sometimes you…’ Confronting someone like this does not always work, but not confronting them never works.

**IN SUMMARY**

Sexual harassment, discrimination and bullying are unlawful and unacceptable behaviours. No doctor should have to face such harmful and debilitating conduct from his/her co-workers or workplace structures. Organisations must assertively
prevent, and sensitively manage, cases of sexual harassment, discrimination and bullying to prevent future recurrence.

If a complaint is made, the following principles apply:

- offer support to anyone who is being discriminated against, sexually harassed or bullied and advise them how to seek assistance
- report incidents to the most senior person in the organisation or practice
- deal promptly with any issue or complaint raised by documenting the evidence
- as far as possible maintain the confidentiality of the people involved in a complaint of discrimination, sexual harassment, bullying

If you witness discrimination, bullying or sexual harassment, will you call it out?
As doctors, we are quick to recognise that patient anger is often justified and not directed at us personally. It is our role to mediate anger and to understand its underlying cause, which is often related to a medical or psychiatric condition that requires optimal treatment. Anger usually quickly dissipates when it is managed calmly and kindly.

Occasionally, patient anger escalates to a personal threat against a doctor and we must recognise the point at which strong emotion tips into unacceptable behaviour. For example, a threat of violence is never acceptable behaviour and requires firm boundaries.

Patient-initiated violence is increasingly common in medical practice and is a reflection of increasing community violence. While zero tolerance is a superficially attractive proposition, most doctors find it ineffective in practice as it usually only deflects violent behaviour onto other colleagues or to the wider community. Patients who display violent behaviours usually have an underlying disorder which requires assertive clinical management. Unfortunately, medical workplace violence is often tolerated because of duty of care issues, and tends to be underreported to the police.

In assessing the severity of violence, we must examine the intention behind the threat. The definition of assault is any act that intentionally or recklessly causes another person to fear physical and other forms of unlawful violence. Verbal threats of violence are often dismissed as common but can sometimes be more damaging than unintended physical assault. For example, consider this scenario:

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1 Plato (427–347 BCE) was a Greek philosopher, and the founder of the Academy in Athens, the first institution of higher learning in the Western world.
a threat by a patient to abduct a doctor’s children from school is likely to be more harmful than an accidental punch in the face from a patient in extreme pain.

The effects of patient-initiated violence are serious for doctors and other staff and include anxiety, depression, post-traumatic stress-related illness, diminished productivity due to poor concentration, social withdrawal and reduced participation in the medical workforce.

Patient-initiated violence is an occupational health and safety issue. It is an issue that needs to be proactively managed by identifying the extent and nature of the risk, the factors that contribute to the risk, and the changes necessary to eliminate or control the risk.

Doctors and other staff must feel confident expressing anxieties regarding unacceptable patient behaviours. The hospital, medical practice or clinic must not accept threatening behaviour as a ‘normal’ way of working or ‘just part of the job’. Staff must be reassured that their concerns will be acted on.

The prevention and management of patient-initiated violence is largely dependent on the identification and clinical management of patients at risk. This can include people with:

- Borderline personality disorder
- Alcohol and drug problems
- Untreated psychosis

The association between violence and mental illness is a sensitive issue. It must be emphasised that many people with these health problems are more likely to be the victims rather than the perpetrators of violence. People with mental illness often experience very damaging stigma and discrimination in the community and no one wants to make this situation worse. Nevertheless, there are times when people with untreated disorders lose control of their ability to regulate their emotions and doctors have a responsibility to manage threatening behaviours assertively and to ensure that their patients are not at risk of harm to themselves or to others.

Unfortunately, people with mental illness and drug and alcohol problems are overrepresented in the criminal justice system. This is a human rights issue directly related to poor access to comprehensive mental healthcare in the community. We must all do better.

**Borderline Personality Disorder**

Borderline personality disorder is a psychiatric illness including some or all of the following pervasive symptoms:
• Frantic efforts to avoid real or imagined abandonment
• Unstable and intense personal relationships
• Impulsivity in at least two self-destructive ways including excessive spending, gambling, sex, abuse of alcohol and other drugs, dangerous driving and road rage, or binge eating
• Recurrent threats of self-harm, self-mutilation or suicidal behaviour
• Mood changes
• Chronic feelings of emptiness
• Difficulty controlling anger, temper and violent behaviour
• Transient stress-related paranoia or dissociative symptoms

This disorder is a disorder of regulation of emotions and affects about 2% of people especially young women. The disorder is thought to be often related to neglect and physical and emotional abuse as children or negative stressful events in adolescence.

People with borderline personality disorder are sensitive to rejection and usually react with anger at mild disturbances. They are often seen by doctors as a result of being harmed through their destructive behaviours.

Group and individual psychotherapy and pharmacological treatments can be effective. Doctors can help the person with borderline personality disorder by scheduling regular appointment times with the same healthcare professional, and encouraging the patient to follow a daily routine. Setting limits on destructive behaviours can be helpful.

People with borderline personality disorder are more likely to be the victims rather than the perpetrators of violence, often at their own hand. Their impulsive behaviours can bring them into dangerous situations or relationships. People with borderline personality disorder sometimes target their doctor with destructive and violent behaviours and this requires assertive clinical management, which may include the involvement of police if appropriate.

Alcohol and Drug Problems
Doctors who have been in practice for a number of years will have seen many people who have come through drug or alcohol addiction and go on to lead happy and productive lives. It is important to remain non-judgemental and optimistic about prognosis for our patients with substance use disorders.

It can be difficult to determine the difference between someone who is genuinely seeking help and someone who may be misrepresenting the truth to obtain drugs of addiction. A comprehensive history and examination can help shed light on the person’s motivation. Patients who are genuinely seeking assistance
EVERY DOCTOR

will usually co-operate fully with this approach. Patients who are only seeking a prescription will often leave after the first few questions, although some can be very persistent.

If we ever feel threatened by a patient, especially someone who appears to be affected by alcohol or drugs and is seeking a prescription, we should consider giving the patient what they want and asking them to leave immediately. If we do this, we must then report our actions to the police and our medical defence organisation.

Untreated Psychosis

It is a shameful fact that people with psychosis are also overrepresented in the criminal justice system. About 10% of people who commit murder or major crime are acutely psychotic at the time of the incident. Tragically, many of these people have fallen through the gaps in our mental health systems and end up receiving mandatory treatment in the criminal justice system.

Acute psychosis, especially first-onset schizophrenia, should be treated as a medical emergency. Schizophrenia has a better lifetime prognosis if treated with antipsychotic medication early, usually within one week of the development of acute symptoms. If a psychiatrist is not immediately available, any doctor may initiate treatment with antipsychotic medication for acute psychosis. Failure to do so may result in lifelong disability or death by suicide or occasionally by police.

It is important for people with psychosis to establish a strong relationship with their treating doctor and other supporting healthcare providers. Education and support of the patient and their family and friends are essential for a good outcome. Patients who are at risk to themselves and/or others may require emergency involuntary admission to hospital.

REVIEWING AN INCIDENT OF MEDICAL WORKPLACE VIOLENCE

Any incident of patient-initiated violence should be reviewed. Whether it occurred in a hospital, in a private medical practice or on a home visit, doctors must meet with members of their team to discuss the following questions:

- What happened?
- What factors may have triggered the violence?
- Could the incident have been prevented?
- How should we manage this patient now?
DEALING WITH PATIENT-INITIATED VIOLENCE

- What safeguards or barriers can be put in place to minimise the risk of recurrence?
- Have the police been informed and what advice was received?
- Should we flag the patient’s file to warn other practitioners about the future risk of violent behaviour?

These questions not only assist medical staff members manage the current situation, but help prevent future episodes. Often staff members can identify ways to create a safer physical environment. In the case of major violence, it may be necessary to terminate the doctor–patient relationship in consultation with our medical defence organisation.

STALKING

Stalking is more common than we think. It is a pattern of repeated, unwanted attention, harassment and contact where the offender threatens physical harm or causes mental distress. Stalking should be recognised early so that it may be dealt with promptly and effectively. Every medical workplace should have a policy in place which informs all staff how to protect themselves from stalking.

Here are some strategies for dealing with stalking:

- Document every contact with the stalker, including telephone calls, emails, letters and deliverables.
- Record all cases of being followed by car, or on foot, or being watched.
- Contact the police every time the stalker makes contact. The police should also maintain documentation.
- Have a phone with a caller-identification screen. Log all calls from the stalker, recording time, date and nature of the call, for example ‘heavy breathing’.
- Advise the practice team, friends, family and neighbours of the situation. Ask people to watch for any unusual activity near your home, workplace or car.
- Never enter into a conversation with a stalker.
- Vary your routines. For example, go home by different routes at different times and arrive at work at different times.
- Keep your car locked when you are driving.
- If you travel by public transport, plan your trip to avoid excessive waiting times at bus or train stops. When stepping off a bus or train, ensure you are not being followed.
• Request that the police assess the security of your home and practice.
• Keep the outside of your practice and home well-lit and free of places where a stalker may hide.
• Install appropriate locks, deadlocks, window security, floodlights, security screens and door alarms in your practice and home.

When a complaint about criminal conduct is made to the police, their assistance should be sought about taking out an intervention order and seeking further legal advice.

**Cyberstalking** has been defined as the use of the Internet or other electronic means to stalk or harass an individual, a group or an organisation. It may include false accusations using monitoring, identity theft or threats.

**TERMINATING PATIENT–DOCTOR RELATIONSHIPS**

There are going to be times when it is necessary to terminate the care of a patient. This may be related to violent or inappropriate behaviour by the patient or other occasions when the doctor is unable to continue to provide the best possible care.

As with all aspects of clinical care, a thoughtful and considered approach, including clear communication, will help minimise any potential harm to the patient.

It is often wise to seek medicolegal advice from a medical defence organisation when terminating a doctor–patient relationship. A doctor has a duty of care to inform the patient of their decision in a sensitively written letter that explains that it is no longer possible for the doctor to treat the patient.

If the patient requires ongoing medical care, the doctor should offer them a referral to another treating doctor. The patient’s new doctor should be provided with enough information from the patient’s medical file to enable ongoing care, including details about violent behaviour.

**IN SUMMARY**

Prevention of patient-initiated violence is dependent on recognising potentially high-risk situations, and different forms of assault. Patients known to have untreated borderline personality disorder, drug and alcohol problems or psychosis can experience great difficulty regulating their emotions and navigating healthcare settings, which may predispose them to violent behaviour.
If an incident of violence does occur, we must be aware of how to immediately manage this collaboratively, sometimes terminating patient relationships if appropriate, notwithstanding our duty of care under such circumstances. The utmost importance of prevention and first feeling safe in the workplace by working together with colleagues is the paramount theme.\(^2\)

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PLEASE STAY

The only career advice my father ever gave me was not to follow in his footsteps and become a doctor. I had no plans to – I already knew I wanted to be a journalist – and never asked him more about it.

Within a year he had died by suicide, in the grip of depression. I was 16 when I found him in our yard, his stethoscope nearby. It seems that, a practitioner to the last, he had listened as his own signs of life began to fade.

It’s been 25 years since our family was blindsided by my father’s suicide. Always the taciturn type, he had told my mother of his depression without revealing its depths. She assured him of our love, that we would all get through it together.

He took his life less than a week later, at 48. It still pains me that he died alone. Had he been able to speak openly about his darkest thoughts, and given all of us who loved him every chance to help, he might be here now – a part of our lives, and still living his.

But I know myself how suffocating stigma can be. It was years before I discussed Dad’s suicide outside our family, for fear that he – that we – would be judged. My grief was complicated by feelings of guilt, shame, anger and abandonment, and I grappled with them largely on my own.

Eventually I came to understand that Dad had not made a choice to leave us. It wasn’t death he wanted, but relief. With more time and treatment, he could have found it. There were far better paths than the one he took; lost in his despair, he just couldn’t see them.

There are so many things I wish I had said to him. If I had my time again, I’d keep it simple:

You will get better.
Don’t give up hope.
We love you.
We need you.
Please stay.¹

Ms Kim Arlington

It should not be surprising that doctors suffer from the same mental and physical illnesses as the general population. Like the rest of the community, doctors fear the stigma of admitting to symptoms of mental illness and often receive late or suboptimal treatment, which can result in a poor prognosis or increased likelihood of future relapse. Many doctors do not recognise mental illness in themselves, despite their knowledge of the symptoms and signs. Doctors commonly say ‘I’m just run down’ or ‘It couldn’t happen to me’. In addition, many members of doctors’ families, friends and work colleagues fail to recognise or support a doctor with a mental illness because they stereotype the doctor as ‘the strong one’.

One of the most common signs of mental illness can be failure to cope with work or study because of the problems associated with poor concentration and decision making. Doctors have a tendency not to take sick leave and are good at wearing emotional disguises, often continuing to provide a high standard of patient care at the expense of their own health.

Unfortunately, when doctors do admit to finding it difficult to cope with work demands, they are often viewed critically by other colleagues for ‘letting the team down’ or ‘not pulling their weight’.

It is time to recognise the special barriers, stigma and challenges doctors with mental illness face. It is often necessary for doctors to gently approach a colleague struggling with mental illness at work and assist them seek professional help, preferably early.

Many psychiatrists routinely seek supervision and debriefing to work through any vicarious effects of consulting clients with mental health problems. However, doctors working in other specialties are also affected by patient suffering, but tend to be less aware of the need to debrief regularly and seek professional help for mental health issues.

In many countries, doctors are mandated to report seriously impaired colleagues to the medical practitioners’ board or regulator, which sometimes deters doctors from seeking help. However, the threshold for mandatory reporting is usually high – doctors have to be at risk of substantial harm to patients. It should not be left this late before there is an intervention.

¹ Extract from an article published in *The Age*, permission provided by Ms Kim Arlington and family and Fairfax.
Prevention is the key word here. Every doctor should be proactive in supporting colleagues in their clinical teams and developing practice policies on self-care. This involves an acceptance by the team that it is ‘normal’ for every doctor to have annual comprehensive preventive health assessments, including mental health screening, regular debriefing, early intervention for excessive stress, best practice management of mental illness and postvention with an independent family doctor/general practitioner after trauma or a crisis.

**Prevention** Every doctor needs an annual comprehensive preventive health assessment for routine screening including mental health screening.

**Early intervention** Every doctor could consider attending their own doctor at least every six months for routine debriefing for common negative experiences.

**Intervention** Every doctor must have their own trusted doctor if they have a mental illness, including major depression, adjustment disorders, eating disorders, obsessive compulsive disorders, anxiety disorders or psychosis.

**Postvention** Every doctor should have a trusted doctor in case of crisis or for acute debriefing after exposure to trauma, especially following the suicide of a patient or colleague.

Where possible, doctors should not treat other doctors in their close clinical teams or doctors who are members of their families, because they cannot provide proper objectivity and review.

**RESPONDING TO DOCTOR SUICIDE**

I’m facing a grilling by the Medical Board to defend myself against a vexatious patient complaint. I wear an emotional shield at work because I don’t want anyone else to unfairly question my competence. I get an occasional SMS asking me if I’m OK, but doctor friends don’t want to spend their precious time off listening to my problems. I’m burying myself in my work and withdrawing from my family, who don’t seem to understand the gravity of what is happening to me.

Anonymous Doctor

For our distressed patients, we have been trained to respond: ‘Many people who are under extreme pressure feel like harming themselves. Have you ever felt this way?’ However, many of us would feel uncomfortable saying this to a colleague...
in distress, because we understand the special barriers deterring doctors from disclosing suicidal thinking. But not doing so can be fatal.

Community suicide prevention and intervention strategies usually address general risk factors including mental illness, alcohol and substance abuse, chronic illness and pain, previous non-fatal suicidal behaviour, genetic and biological factors, negative life experiences and relationships, fractured family structures, family of origin history of violence or suicide, work stress and social isolation. It is essential that we also identify these risk factors in our doctor patients, as they are as prevalent in doctors as in the rest of the population.

Doctors have additional risks for suicide, including high rates of self-medication, access to lethal means, and our exposure to traumatic death and suicide in patients, often without routine debriefing or postvention, which also need to be identified.

Our clinical interventions for suicide should be tailored to the special needs of our diverse profession. For example, one dimension that requires more research is the significantly higher rate of death by suicide of female doctors compared with the general population (about two and a half times higher). The 2013 Australian National Mental Health Survey of 14,000 Doctors and medical students by beyondblue: the national depression initiative in Australia, shone some light on gender differences. In this survey, female doctors were more likely to have had suicidal thoughts in the previous 12 months (an extraordinary 20.5% of female doctors versus 17.1% of male doctors) and prior to the previous 12 months than their male counterparts (34.3% of female doctors versus 27.3% of male doctors).

Similarly, female medical students were more likely to have a current diagnosis of depression (9.8% of women versus 5.2% of men), a current diagnosis of anxiety (8.8% of women versus 5.2% of men), and have attempted suicide (4.6% of women versus 3.4% of men). Female students reported higher levels of burnout across the three domains of emotional exhaustion, cynicism and low professional efficacy than their male counterparts.

These gender differences may relate to additional risk factors in women doctors including an increased prevalence of stress, depression, anxiety, eating disorders, posttraumatic stress responses, postnatal depression, intimate partner violence, domestic violence and patient violence, childhood sexual abuse, and exposure to workplace bullying, harassment, discrimination, all requiring special care.

Amidst this complexity, the most neglected issue is our negative culture, where disclosure of doctor distress often results in ‘career suicide’, the unfortunate term whispered in medical workplaces. Most of us recognise our harsh culture is intolerant of doctors with reputations for ‘not coping’, ‘being emotional’, ‘overly
sensitive’, and ‘not up to it’. The beyondblue study documented some of these common negative attitudes with about 40% of doctors judging colleagues with a history of mental health problems as less competent than their peers.

Fears around confidentiality of clinical consultations and mandatory reporting to medical boards are also misplaced. Mandatory reporting is usually only relevant if doctors are placing the public at risk of ‘substantial harm’ because of a health issue, which is rarely the case. The confidentiality of doctors’ health information, like that of other patients, is protected by strict privacy laws in many nations, and we know how to make an effective complaint in the unlikely scenario of a breach.

Our medical organisations and professional colleges and academies must do more to understand the special needs of different groups within our diverse profession, and encourage doctors of all specialities to have their own trusted family doctor or general practitioner to make it easier for them to reach out to a colleague for routine mental healthcare and in a crisis.

Each of us must do more than send the occasional SMS or ask the clichéd ‘Are you OK’? If we suspect a colleague is quietly suffering, we should look behind the ‘emotional shield’ and make time to listen carefully as a trusted friend, and facilitate the right professional intervention. When we suspect our colleagues and friends are at risk, it may help to ask ‘I need to know you are being looked after and you are safe. ‘What can I do to support you through this difficult time?’

In the following sections, we discuss the symptoms and signs of bipolar disorder, schizophrenia, substance use disorders and cognitive decline in our medical colleagues. As there is usually an inherent lack of insight, and heightened risk of suicide in doctors with these conditions, there is a need to be proactive in assisting a colleague to get the right professional help – early. Major depression, anxiety disorder and post-traumatic disorder have been discussed in Chapter 10.

Where there is no hope, it is incumbent on us to invent it.2

Albert Camus

**BIPOLAR DISORDER**

Bipolar disorder is a form of psychotic illness. People with bipolar disorder may experience extreme highs and lows of mood and may behave in an irrational or risky manner. The cycles of highs and lows vary from individual to individual.

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2 Albert Camus (1913–1960) was a French philosopher, author, and journalist, awarded the Nobel Prize in Literature in 1957.
Doctors with untreated bipolar disorder may present with difficulty making decisions and concentrating, or may become uncharacteristically reckless. Grandiose ideas, inflated self-esteem, increased energy, enhanced libido, impaired judgement and impulsive behaviour along with impaired insight may put a doctor at risk of ruining their reputation and place their patients at serious risk of harm.

As with other serious mental illness, the sufferer requires a lot of support from their colleagues at work and their family and friends. Most of all, it is essential that a doctor with a sudden onset or relapse of bipolar disorder is actively assisted to seek help from their treating doctor early.

Mood-stabilising medication such as lithium is used to treat depressive and manic symptoms. An antidepressant may be added to treat depressive symptoms, but must be ceased if there are manic symptoms. Manic symptoms may also require a benzodiazepine or an antipsychotic.

To reduce the likelihood of recurrence, a prophylactic mood stabiliser is used. Doctors as patients must be educated about the risk factors and the early signs of relapse of a bipolar disorder. It must be emphasized that anyone with bipolar disorder must attend routine reviews by an experienced independent family doctor/general practitioner or psychiatrist, and comply strictly with their medication.

**SCHIZOPHRENIA**

Schizophrenia is another form of psychotic illness which also interferes with a person's ability to think, feel and behave, and usually has the following features:

- delusions
- hallucinations
- disorganised speech (e.g. incoherence)
- grossly disorganised or catatonic behaviour
- negative symptoms (i.e. affective flattening)

The focus is on early intervention but the sufferer often lacks insight and requires the support of others to seek treatment. Early recognition by colleagues at work is usually essential because facilitation of early treatment of schizophrenia by an experienced independent psychiatrist is associated with a good prognosis. As with all mental illnesses, most people who receive optimal treatment lead happy and fulfilling lives. However, late treatment is often associated with poor prognosis and lifelong disability.
Again, the importance of assisting colleagues get the right independent psychiatric assessment and management early cannot be overestimated.

**SUBSTANCE USE DISORDERS**

A substance use disorder is generally characterised by a strong desire to take alcohol or drugs or prescribed medication, with harmful physical and psychological consequences, which may include reduced work performance, negative impact on relationships, depression or physical illness including liver damage.

Dependence is a physical and psychological syndrome resulting from the repetitive use of a psychoactive substance. A person who is dependent, has a strong desire to take the substance and difficulty controlling the use of the substance. Symptoms of withdrawal from the substance include anxiety, depression and sleep disturbance. The use of the substance relieves the withdrawal symptoms. Over time, higher doses are required to achieve the same effect and a tolerance to the drug is evident. Unfortunately, the substance use often continues despite evidence of harmful consequences.

The use of substances must be assessed within the context of the individual’s life and their readiness for change. A comprehensive psychiatric history is important to identify possible comorbidity including depression, anxiety, psychosis, post-traumatic stress disorder, eating disorders and bipolar disorder. The severity of dependence, the physical health consequences, and any risk-taking behaviour associated with substance use, must be explored by the treating doctor. The treatment and management plan must be adjusted according to the history and the motivation of the individual. While self-management and monitoring are to be encouraged, it is essential that a doctor with a substance use disorder is monitored and reviewed regularly by an independent, experienced treating doctor.

Doctors who work under the influence of any alcohol or other substances are a significant risk to their patients and should be reported immediately to the relevant regulatory authority.

**COGNITIVE DECLINE**

Cognitive decline is another cause of mental impairment and is associated with very serious implications for public safety. It can be very difficult to approach this subject with a colleague.

Knowing when to retire is an important decision and a critical challenge for some. Many doctors choose to retire before their health affects their clinical
practice. For example, some surgeons choose to retire by the age of 65 years, despite their skill and experience. Other doctors, who have suffered with mental illness, choose to have well-planned career breaks and attend their own doctor regularly for objective reviews of their situation.

We must encourage each other to plan for career breaks and eventual retirement from practice. We must ensure we take heed of our colleagues’ concerns if they gently broach the subject. It is our responsibility when we notice a colleague in difficulty to say, ‘I can see you are having some problems. How can I support you?’

Senior doctors should not be discriminated against for their commitment and dedication to their patients. Many doctors continue to work effectively and contribute enormously to the health and well-being of the people of their local communities in the later years of their lives.

On the other hand, medical practitioners are required to report an impaired colleague at substantial risk of harming patients to the relevant medical board or similar organisation. This action usually results in formal peer review and appropriate intervention, which may include temporary or permanent deregistration. However, if colleagues intervene early in cases of mental dysfunction, the dignity of the doctor may be protected and intervention by a medical board may become unnecessary.

All doctors have a responsibility to respond early and appropriately under these circumstances in the interests of patient safety, but this can be a harrowing outcome for a doctor after a long and dedicated career.

**IN SUMMARY**

Doctors must proactively care for themselves and colleagues throughout experiences of stress and mental illness by encouraging everyone in the medical workplace to have their own trusted family physician/general practitioner, who can provide regular health screening, early intervention, debriefing, postvention and acute care in times of a crisis.

Unfortunately, there are cultural barriers in medicine that deter many doctors from seeking help early, and as a result doctors may present late or with partially self-treated mental illnesses including bipolar disorder, schizophrenia, substance use disorders and cognitive decline. Early recognition and intervention are the key factors in effectively managing these potentially debilitating conditions.

As doctors, we need to care for each other in meaningful ways and know the right questions to ask a colleague who is in distress or who may be impaired. We must all do better with responding to our colleagues when they need our assistance.
Climate change is one of the greatest challenges of our time. Climate change will affect, in profoundly adverse ways, some of the most fundamental determinants of health: food, air, water. In the face of this challenge, we need champions throughout the world who will work to put protecting human health at the centre of the climate change agenda.¹

Dr Margaret Fung Fu-chun Chan

Our health and the health of our patients can be protected and compromised by our physical environment. Medical workplaces have a reputation for being physically unfriendly. For example, daily exposure to cramped cubicles, under-functioning or over-functioning air conditioning, fluorescent lights, grey walls and floors, and a mix of unpleasant smells and excessive noise can be dehumanising. And unless, we manage our own architect-designed private medical practice, it can be difficult to do anything about this.

Whether we work in a hospital or a medical clinic, each of us can bring to work reminders of what it is to be human. It is possible to personalise our space and reclaim offices and staff rooms with simple things like photos of family, artwork from our paediatric patients, plants, aromatherapy oils, music and bowls of fresh fruit.

THE MEDICAL CONSULTING ROOM

At a personal level, one of the most basic of all physical needs is to have a comfortable chair and to be aware of your posture while working in your consulting room or at your computer.

- Ensure you are comfortable when you are sitting.
- Your computer must be straight ahead with no neck bending.

¹ Dr Margaret Fung Fu-chun Chan is a Chinese-Canadian physician, who served as Director-General of the World Health Organisation from 2006 to 2017.
• Your chair should support your lower back.
• Keep your wrists straight without resting them on the desk.
• The height of your chair should be such that you have relaxed shoulders with your elbows hanging by your sides.
• Clean your computer monitor regularly.
• Ensure you have optimal lighting.
• Take regular breaks.
• Regularly stretch your arms and fingers, rotate your shoulders, shrug your shoulders, shake your arms, stand up and stretch your arms and legs.
• Take a brisk walk when possible.
• Take meal breaks away from your work area.

At the same time, it is important to consider making our hospitals and medical practices more environmentally friendly. There is growing awareness of the need for hospitals and other medical workplaces to reduce the use of non-renewable energy and non-recycled water, to recycle materials when possible, and to ensure waste disposal is environmentally sound.

The use of fresh air, natural lighting and solar panels are being considered in the design of new medical buildings. Medical workplaces are recycling plastics, cardboard and other recyclable materials. There are also examples where hospitals are working with local councils to supply bicycle paths, storage racks for bikes, access to showers for staff and incentives for staff to use carpooling or take public transport to work.

**A GREEN PRACTICE**

Here are some ideas to make your medical workplace more environmentally friendly.

Ten tips for a green medical clinic (developed by the Australian Conservation Foundation and Doctors for the Environment Australia): 

1. Install low-energy lighting.
   • Replace old style incandescent globes with compact fluoro globes or use fluorescent tubes. Avoid halogen downlights.

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• Replacing one incandescent globe with a compact fluoro can save 0.5 tonne of greenhouse gas and save money in energy costs in its lifetime (about eight years).

2. Turn off computers and appliances to save energy.
• Turn off computers and screens when not in use.
• Turn off standby power at the end of each day, i.e., switch off all appliances at the wall or power board (e.g., photocopiers, printers, chargers).

3. Buy ‘green power’ for your clinic.
• Ask your energy supplier to switch you to accredited green power, or change to another energy supplier with accredited green power.
• Buying 100% green power means all your electricity will come from wind, solar other renewable sources.

4. Energy-efficient refrigerators.
• Aim to have the most energy-efficient and smallest refrigerator(s) you can. When buying a refrigerator choose the one that uses the least energy per year.
• Maintain your existing refrigerator(s) to be as efficient as possible:
  • Ensure the seals are completely intact and gripping – replace any damaged ones.
  • Position your refrigerator so it has air space around it to expel the heat it generates (especially behind and above) and keep it away from the sun.

5. Reduce car journeys.
• Arrange pick up with pathology companies in advance to avoid them making unnecessary trips – try to restrict pickups and deliveries to the minimum number per day.
• Encourage staff to take public transport or ride to work – provide bicycle storage and changing facilities.
• Reducing petrol usage from car trips saves greenhouse gases – with every litre of petrol saved, 2.5 kilogram of greenhouse pollution is saved.

6. Aim for a paper-free office.
• Communicate with doctors and patients by email where possible.
• Request test results and other information be sent to you by email.
• Manage files and patient records on computer to avoid the need for printed documents.
• When using paper for printing, try to reduce paper usage by printing on both sides of the page and only print the pages you need.
7. Recycle paper and plastics.
   • Arrange for a regular paper and plastic container recycling collection.
   • Have a paper shredder to shred patient documents before recycling.
   • Make the recycling bins available to both patients and staff, and clearly label the recycling and landfill bins.

8. Buy recycled paper, stationery and toilet tissue.
   • Try to buy 50%–100% recycled office paper.
   • Look for other stationery made from recycled materials (e.g., toner, pens, pencils).
   • Buy recycled toilet paper, kitchen towels and tissues.
   • Arrange for your toner cartridges to be collected for refill or recycling.

9. Save water in the bathroom and kitchen.
   • Fit aerators to all taps to reduce tap water usage by up to 50%.
   • Fix all dripping taps or leaking toilets immediately.
   • Convert an old single-flush toilet to a dual-flush toilet or install a cistern regulator that allows the user to determine the flush length.

10. Reduce junk mail.
    • Put a ‘No junk mail’ sticker on your letterbox.
    • Ask to be taken off the direct mail lists of pharmaceutical companies and other businesses who regularly post you materials you do not want.

A healthy physical environment is fundamental to good health. While we may have direct control over our immediate physical environment, we can also have a global impact through working with our colleagues and national and international organisations to influence international and national policies and practices which protect the environment.

**IN SUMMARY**

We as a society are now becoming more aware that both our natural and workplace environments fundamentally impact our physical and mental well-being, which is particularly important for anyone working long hours. Simple techniques, such as optimising an office setting, personalising one’s own space, investing in an ergonomic chair, maintaining good posture and taking small breaks to stretch can all make a difference.

We need to care for the environment in order to safeguard the health of our own generation and of future generations.
Every Doctor Can Lead and Influence Positive Changes in Their Workplaces Every Day

We cannot solve our problems with the same thinking we used when we created them.

Commonly attributed to Albert Einstein

There are many intense challenges facing the medical profession, which require effective advocacy through leadership. We work in complex, changing environments where we are witnessing serious health inequities, ethical dilemmas and social injustice at the same time as an exponential growth in transformational advances in medical, surgical and eHealth technologies.

In the next decade, further subspecialisation of medicine and disruption of our unsustainable health systems are inevitable. There are a myriad of diverse issues confronting the medical profession, which require greater leadership focus, such as changing education and training requirements; quality and safety of patient care; clinical independence; high rates of mental health issues in doctors; and bullying, harassment and discrimination between doctors.

All these issues impact our daily lives as doctors and cause us a great deal of personal distress. In this wider context, programmes focussing on the individual
resilience of doctors have limited benefit. To effect real change, all doctors must step outside their individual consulting rooms, and lead and influence positive changes in their workplaces – together.

Despite these compelling reasons for doctors to embrace leadership roles, there is an increasing trend for doctors to be disengaged from the management of corporate, government and non-government-funded hospitals, aged care and other health services, which are often managed by non-clinicians and governed by non-clinician shareholders. Many doctors are disillusioned with bureaucratic structures, frameworks and policy documents, which may impose time-wasting red tape on clinicians and paradoxically reduce patient access and satisfaction with health and medical services. In this complex landscape, it is critical that more doctors understand how to influence the leadership of their workplaces, not only to protect the quality of patient care, but to promote a caring medical culture, in which the health of all doctors and other staff can flourish.

In addition, boards and management teams of hospitals and other health services sometimes fail to understand the clinical needs of the patient populations they serve, and invest unwisely or fail to support ‘unprofitable’ but essential parts of their health businesses. Without meaningful input from doctors and other clinicians, scarce resources can be wasted and waiting lists can blow out, leading to enormous pressures on clinicians to ‘process’ large volumes of patients in unrealistic time frames while delivering suboptimal care. The pressure on doctors to do more and more with less and less, is a major systems issue that impacts negatively on patient outcomes. It also impacts the health of clinicians and limits their ability to take on leadership roles in addition to clinical roles.

For all these reasons, doctors are often reluctant to engage in medical and other leadership positions. However, for all these reasons, it is important for doctors to do so.

In medicine, training for medical leadership and coaching is comparatively underdeveloped, which is surprising given the challenges of a medical career. The leaders of our medical organisations are frequently under fire externally and internally, and tend to hold their positions for relatively short periods, which makes it difficult to achieve lasting or significant change. There may be many different medical organisations representing the interests of different groups of doctors, who are sometimes ‘at war’ with each other. Leading in this environment is often an unpopular choice. Women doctors and doctors from marginalised groups are often underrepresented in medical leadership roles, despite their strong presence in the medical workforce and high performance,
which suggests that systemic discrimination and bias continues in the medical profession.

Aside from these serious challenges, how can we find the time to take on leadership roles and responsibilities?

What is required is a different medical leadership philosophy and definition, where every doctor recognises their own role as a collaborative leader in their everyday work, whether they are a clinician, educator, researcher, chief executive officer or board member. Leadership is a mindset rather than a position or title. It is not about one person but about what people can do together for the greater good. In medicine, everyone matters, not just a few at the top of the pecking order or hierarchy. Collaborative medical leadership is about embracing shared aspirations and enabling others with the skills and capabilities to effect change – our colleagues, registrars and students. It is also about making our medical organisations work together for us, rather than trying to do it on our own.

This section includes some leadership basics and challenges for doctors to recognise their leadership roles in their everyday work. Rather than write a comprehensive tome on medical leadership, this section focuses on four main chapters including the following:

- Medical leadership research
- Practical aspects of medical leadership
- Contributing to global, national and local medical membership organisations
- The why and how of healthy everyday medical leadership

All of us are leaders in our everyday care of patients and the final chapter concludes with some of the principles we can embrace to demonstrate healthy leadership.

How it is we have so much information, but know so little?1

Noam Chomsky

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1 Noam Chomsky (born 1928) is an American linguist, philosopher, cognitive scientist, historian, social critic, political activist and author of over 100 books.
Leadership coaching is a big commercial industry with a huge array of glossy books and training courses espousing impressive cliches and expensive marketing strategies. These resources usually describe a multitude of non-evidence-based theories on what constitutes an effective leader, often identified as an authoritative, charismatic individual, someone at the top of an organisation with many loyal followers. Great leaders are often described as having authenticity and purpose, with a vision, which is embraced by the whole organisation. They are transformative, creative, innovative and adaptive individuals. They are also difficult to find in reality. Not surprising, there is an anti-leadership movement questioning common assumptions about traditional leadership models.

Complex leadership research also abounds in business and management literature and in formal accreditated university courses. However, there is very little contemporary research on effective medical leadership in complex health systems that can be applied to meet the future challenges of 21st-century medicine.

What is required is for doctors to explore some of the evidence based on the topic of leadership and to try to apply it to their diverse medical workplaces. Here are two brief summaries of some research that cut through some of the complexity of the topic and may be applied to medical leadership.

**SEVEN TRANSFORMATIONS OF LEADERSHIP**

A summary of 25 years of research on thousands of general managers and professionals, entitled ‘Seven Transformations of Leadership’, was published in the

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1 William Bruce Cameron, American sociologist and author of *Informal Sociology, A Casual Introduction to Sociological Thinking*. 

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Harvard Business Review by David Rooke and William Torbett in 2005. The authors recognised that what differentiates leaders is how they react when they are challenged, and whether leaders can learn to react in effective ways. Seven different levels of leadership emerged from their research which may be applied to leadership styles in the medical profession:

- **The Opportunist** is out for him or herself and self-orientated and ego-driven. These individuals are often highly competitive, dominating and authoritarian in crises or emergencies, which are often viewed as positive traits in doctors.
- **The Diplomat** stays neutral, shuts down debate and avoids conflict, usually needing to be liked and wanting to belong. They obey group and bureaucratic norms and do not rock the boat in clinical teams, but are supportive of other team members. They avoid providing negative feedback to colleagues and other staff or making hard decisions. Doctors exhibiting this style are sometimes loved in the short term, but not respected in the long term.
- **The Expert** rules by logic and data, rather than wisdom and clinical experience. These doctors use hard data to convince others they are right. They are good individual contributors, but they lack emotional intelligence and display a lack of respect for those with less expertise. They have extensive but narrow specialist expertise in one or two areas, and find it difficult to work across multiple specialities. Many doctors with highly developed technical skills fit into this category.
- **The Achiever** strives to achieve strategic goals of a health organisation or service, by promoting teamwork, juggling managerial duties and achieving internal goals. They are well suited to bureaucratic managerial work, ticking checklists or to being technical experts, but they lack innovative and creative thinking.
- **The Individualist** is different from the opportunist because they are innovative and creative, but similar in that they pursue solitary goals albeit in unconventional ways. They ignore rules and irritate colleagues and bosses by ignoring key organisational processes, hierarchies and people. However, they get important and interesting things done by challenging the status quo. Many doctors in this category would achieve

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richer outcomes if they were to collaborate with like-minded people and make their medical organisations work with them for a greater impact.

- The **Strategist** drives highly collaborative organisational and personal change. They challenge existing assumptions and generate transformations in healthcare over the short and long terms through their extensive experience and networks. The Strategist consistently follows ethical principles and practices beyond self-interest or the interests of an individual organisation. There have been many examples of this form of leadership in the medical profession, which are often not fully recognised by other doctors, who tend to gravitate to the styles described above. These rare individuals work with others to change health systems at a local, national or international level.

- The **Alchemist** generates social transformations outside the medical model in historically significant ways. They lead society-wide change. The Alchemist has an extraordinary capacity to deal simultaneously with many situations at multiple levels across many domains. They can deal with immediate priorities yet never lose sight of long-term goals. Unfortunately, it is unusual to see this form of medical leadership working outside the health system.

The authors found that the three types of leaders associated with below-average performance (Opportunists, Diplomats and Experts) accounted for 55% of their sample. Achievers, Individualists, Strategists and Alchemists showed the consistent capacity to innovate and to successfully transform their organisations. The research also found that leadership styles can evolve with training, experience and mentoring, that is from Experts into Achievers, from Achievers into Individualists, and from Individualists into Strategists and so on.

Although their research did not specifically explore medical leadership, there are a number of principles and traits that intuitively apply to doctors as described above. Many doctors are ‘experts’ and ‘achievers’, but can strive to be effective ‘strategists’. This requires opening oneself to collaboration and continual peer-to-peer review and feedback to gain greater self-awareness, better interpersonal skills and highly effective communication skills. Many doctors have the potential to become ‘Alchemists’, but few lead high-level health system reform, perhaps because of our relatively narrow focus on medicine rather than societal change.

**TOP LEADERSHIP BEHAVIOURS**

McKinsey research has consistently shown that good leadership is a critical part of organisational health, which resonates with the medical profession.
In a McKinsey research report, ‘Decoding Leadership: What Really Matters’ by Claudio Feser, Fernanda Mayol and Ramesh Srinivasan, the authors performed a search of the academic literature and a survey of nearly 190,000 people in over 80 diverse organisations in Asia, Europe, Latin America and North America. The authors concluded that a small subset of leadership skills closely correlate with leadership success. They correlated 20 leadership skills with leadership performance and found that high-quality leadership teams most commonly displayed four of 20 possible types of behaviour. Highly performing leaders:

- Support others by building trust and helping colleagues overcome challenges.
- Operate with strong results orientation by following through efficiently and prioritising high-value work.
- Seek different perspectives by encouraging everyone to contribute and collaborate to improve performance.
- Solve problems effectively through research, consideration of the evidence, reasoning and debate with colleagues.

Although the research did not specifically involve a study of medical leadership, the four behaviours listed above are intuitively important, but often lack in the leadership of our health systems and services. Too often, our medical culture is uncollaborative and unsupportive, meaningful patient outcomes are not measured, diverse opinions are squashed or ignored, and problems fester.

Other leadership behaviours considered in the study included the following capabilities which can also be applied to medical leadership:

- Champion desired change
- Clarify objectives, rewards and consequences
- Communicate prolifically and enthusiastically
- Develop others
- Develop and share a collective mission
- Differentiate among followers
- Facilitate group facilitation
- Foster mutual respect

• Give praise
• Keep group organised and on task
• Make quality decisions
• Motivate and bring out the best in others
• Offer a critical perspective
• Recover positively from failures
• Remain composed and confident in uncertainty
• Role model organisational values

Which capabilities resonate with you?

A NEW DEFINITION OF COLLABORATIVE MEDICAL LEADERSHIP

There are many definitions of leadership, mostly based on outdated general research published in non-medical literature which is not relevant to the changing future of medicine in the 21st century. In this void, it is important for current and future medical leaders to define a new definition based on strong collaboration and shared aspirations.

Collaborative medical leadership can be defined as a form of shared ‘ground up’ rather than ‘top down’ leadership that is flexible and open to adapting to complex, changing health systems and services. Contrary to the traditional definition of leadership where the leader is at the top of a group of loyal followers, collaborative medical leadership takes a more egalitarian view where everyone is recognised as a potential leader in their everyday work.

Doctors have the influence and power to challenge and change health systems of care, by using our collective knowledge and networks to drive continual improvements in patient care. Sometimes this happens under traditional management structures and hierarchies. Very often, it happens with a small group of motivated doctors who take it upon themselves to bring colleagues together and make time to create large-scale change through alternative ways of thinking about complex challenges. There are many examples where individual doctors or groups of doctors have identified gaps in patient care and have driven change by advocating to fundamentally change the way care is delivered. They often make life easier for other doctors.

Collaborative medical leaders mobilise clinicians to tackle tough clinical systems issues with a unity of purpose. They not only meet or exceed the expectations of their job descriptions, but also challenge expectations and co-create in an environment that is often resistant to change.
IN SUMMARY

There are many reasons why doctors may be reluctant to engage in leadership, such as increased pressure from employers to prioritise productivity over high-quality patient care. While these attitudes can deter doctors from seeking leadership roles, they likewise reinforce the need for good medical leaders to challenge and change such attitudes.

Collaborative medical leadership is a form of shared ‘ground up’ rather than ‘top down’ leadership, and is flexible and adaptive to complex changing health systems. In collaborative medical leadership, every doctor can develop leadership skills, and transcend the individualist structure of medical workplaces, by cooperating effectively with colleagues to influence positive change in the profession and healthcare at the clinic, service and institution level.
CHAPTER 20

Practical Aspects of Medical Leadership

Medical leadership does not come from a position, it is embodied in action that brings positive change in people's lives. Creating positive change flows from interactions that are genuine, with oneself, with others, and with the world. One of my favorite leadership quotations is from Lao Tzu: ‘A leader is best when people barely know he exists, when his work is done, his aim fulfilled, they will say: we did it ourselves.’

Dr David White

Write down the name of a medical leader who inspires you and one characteristic of that leader that you admire. Chances are they are someone who has inspired you as a compassionate doctor, perhaps a colleague in your practice, one of your teachers, a leader of one of your medical organisations or a medical writer.

Many medical leaders will often admit that they discovered their leadership role by accident, through pursuing a cause they felt strongly about. Most will say that if they had their time again, they would have sought formal support from mentors and leadership training on effective chairing and participation in meetings, as well as skills in public speaking, writing and media. In this chapter, we discuss a few of the practical aspects of medical leadership, which we can all learn.

LEADERSHIP TRAINING

No one is born a leader – you learn leadership through experiencing life. Learn to be among different people and settings. Network – take different opportunities, see how groups work, get your face known. Watch out for the

1 Dr David White is a Canadian family physician, past President of the College of Family Physicians of Canada, and Vice-Chair for Family Doctor Leadership in the Department of Family and Community Medicine at the University of Toronto.
power mad and for the effects of jealousy. Work hard, be humble, and don’t panic.²

Professor Amanda Howe

Medical leadership training should be available to all doctors. We believe that one of the most important roles of our medical organisations is to foster and train the next generation of medical leaders. Young doctors are the future of our profession and need to be welcomed by member organisations, and given leadership opportunities.

There are many different approaches to leadership training and experience including the following:

- First-hand experience by being thrown in the ‘deep end’ and learning from mistakes, which unfortunately is the common method in medicine
- Reading about other leaders
- Mentoring with an accomplished leader
- Supporting other leaders and those who seek to lead
- Participating in effective university or medical college leadership training programmes

Having studied and researched this problem for the last seven years, it has become clear to me that there are four common issues built into the design of many leadership development programs: 1. Wrong focus: Too much time is spent delivering information and content and not enough on the hard work of developing the leaders themselves. Most leaders already know what they should be doing; what they lack is the personal development to do it. 2. Lack of connectivity: While the content of programs may be very interesting, it is too often disconnected from the leader’s work. When the leader returns to the ‘real’ world and is overwhelmed by tasks, it is too hard to convert what was learned in a program into actions that address real problems. 3. Leader in isolation: Most programs fail to engage the leader’s key stakeholders back at work in the change process. As a result, leaders not only miss out on the support, advice, and accountability of colleagues, but are also more likely to experience resistance from stakeholders who are surprised and disrupted by changes leaders make in their behaviour. 4. Too short: The programs are designed as events rather than

² Professor Amanda Howe is a British general practitioner and medical academic based at the University of East Anglia, who served as President of the World Organisation of Family Doctors (2016–2018).
as processes over time. Programs give leaders a short-term boost but not the ongoing follow-up to solidify new thinking and behaviours into new habits.3

Nick Petrie

This quote from Nick Petrie sums up the limitations of current leadership programmes with useful suggestions for change. Clearly, there is no one-size-fits-all approach to leadership training.

Practical leadership tips for aspiring medical leaders:

- Give a leadership position a go to see if you enjoy it.
- Preparation is the key to being an effective leader.
- Develop a clear understanding of roles and responsibilities of the role, and what is expected in what time frame.
- Have a clear vision for what you wish to achieve, and articulate it frequently to others.
- Develop a detailed plan of action – with documented strategies and tactics.
- Understand the time and energy commitment required.
- Be visible to people, make visits, give presentations, connect with your people.
- Communicate clearly and always be professional, constructive and courteous.
- Deflect praise to others, and routinely thank those who make a contribution.
- Shoulder any inevitable criticism yourself.
- Stand up for principle, even in the face of defeat.
- Do not countenance gossip.
- Criticise issues and attitudes, rather than individuals.
- Meet potential adversaries afterwards and in private.
- Stand up to bullies.
- Identify and manage risks.
- Listen and do not stop learning, and do not become arrogant.
- Focus on the big picture and keep in mind how you wish to be remembered when you have finished in this role.
- Nurture your supports and value your mentors.
- Allow time for yourself to recharge.

3 Nick Petrie is a New Zealander, based at the Center for Creative Leadership in the United States. He is the author of Vertical Leadership Development: Four Reasons Many Leadership Programs Don’t Work.
CHAIRING AND PARTICIPATING IN MEDICAL MEETINGS

Everyone appreciates a well-chaired meeting with a clearly prioritised agenda and meaningful outcomes where everyone is encouraged to participate, and where it is recognised that the collective voice of consensus after a full debate is more effective than the voice of self-interested individuals.

Practical tips for effective chairing of medical meetings:

- Appreciate a chairman, who is the facilitator of the meeting discussion not the dominator.
- Understand the terms of reference for the group meeting and the overarching strategic priorities, which determine the content of the meeting agendas.
- Standing items on each meeting agenda should reflect the strategic priorities and big picture items for discussion. It helps to develop a calendar of agenda items to ensure that all items are covered within a year.
- Develop realistic performance measures for each strategic priority and monitor progress on achieving outcomes within realistic time frames to help stay focussed on outcomes and solutions.
- Meeting agendas should have invited input from all committee members and agenda papers should be circulated in a timely manner to allow everyone time to read them.
- Start each meeting on time and finish on time, but arrive early and stay late to engage informally with the members of the committee.
- Ensure that every voice is heard but keep the discussion focused on the agenda.
- Encourage constructive debate and mediate differences of opinion.
- Foster consensus based on reasoning and evidence, not ego or the loudest voice.
- Ensure there are clear outcomes of every discussion documented in the meeting minutes with timelines, actions and accountabilities noted. A competent secretariat is essential.
- Ahead of each meeting, follow up the actions determined at the previous meeting to ensure they are completed.
- Review the board or committee strategy and charter at least annually to ensure they remain relevant and appropriate.
- Maintain confidentiality of formal meeting discussions but communicate your main messages effectively to your members or stakeholders where appropriate after each meeting.
• Review the performance of your board or committee at the end of each meeting while everyone is present, and also do this in a more detailed way on an annual basis.

Participating in meetings with medical colleagues can sometimes be daunting and you may feel intimidated, but your point of view is important and can help to shape the future directions of your organisation.

Practical tips for participating in medical meetings and influencing meeting outcomes:

• Read the papers for the meeting and always be prepared with at least three points you plan to make.
• Turn up early and sit in a prominent chair or position.
• Introduce yourself and engage with the other participants as they arrive.
• Before speaking, it can be helpful to note down the points you wish to make so you get your thoughts in order.
• Remember some participants may have be hard of hearing so speak loudly and clearly.
• During the meeting, state your points of view with conviction and back them up with evidence.
• Be succinct and articulate the outcomes you are seeking.
• If interrupted, state clearly ‘would you mind if I finish’?
• When the meeting ends, leave only after you have engaged with other people to build networks and goodwill.

Try this exercise
When making decisions as a member of a committee ask yourself:

Is this in the best interests of my organisation?
Is this in the best interests of our members?
Is this in the best interests of our discipline?
Not ‘is this in my best interest’?

PUBLIC SPEAKING

Great medical leaders are great public speakers who resonate with diverse audiences and facilitate attitudinal changes. Many doctors are nervous about public speaking, but this is a skill we all can learn. There are many good training courses and books on the topic, which often suggest speakers tell stories to illustrate their points, and be authentic, authoritative and brief.
Medical TED Talks can be an effective way of brushing up public speaking skills, and here are some of our favourites:

- How Do We Heal Medicine? by Atul Gawande
- A Doctor’s Touch, by Abraham Verghese
- Fake It till You Make It, by Amy Cuddy
- How Racism Makes Us Sick? by David R Williams
- On the Art of Medicine, by Ranjana Srivastava

Practical tips for doctors starting out in public speaking:

- Admit to yourself how speaking in public makes you feel, and ask yourself why?
- Practice as much as you can and gain experience in front of big and small audiences.
- Know your material so well that you can speak without notes.
- Practice delivering your speech in front of a mirror or a small safe audience at home.
- Turn up early so that you know your room and how the audiovisual equipment works.
- Make sure that you know who will make up your audience.
- When you speak, remember that you are the expert.
- Relax while speaking, turn your nervousness into positive energy and enjoy yourself.

MEDICAL WRITING

Like public speaking, medical writing takes practice, and generic writing courses can help. However, doctors often become writers by default through their advocacy on issues and their use of powerful patient stories.

An example is following story written by Leanne Rowe after her experience of working in an Aboriginal Controlled Community Health Service in Far North Queensland, but before she had ‘become a writer’. The language is simple, but the message is strong.

At the Aboriginal health service, I was given what seemed to be the simple task of helping to set up a ‘well kids’ clinic in an isolated settlement on the outskirts of a remote Far North Queensland town. Many babies and children were seriously underweight and underdeveloped. Families could not afford formula and mothers commonly fed their babies adult powdered milk or
cordial, rather than breastfeeding. Most children had never been immunised and many were covered in scabies and impetigo, including a three-week-old baby.

A five-month-old baby was delirious with meningitis. His young mother bravely took him to hospital – her other two children had died there of sudden infant death and during childbirth. I cared for a two-year-old child with chronic heart disease due to rheumatic fever, who died in hospital one week later.

Tragic for so many reasons, not the least being that so many young lives were destroyed by a lack of access to basic primary care.

In the first few weeks, the mothers replied to my questions with one-word answers and downcast eyes, sometimes just walking away to spit filthy phlegm through broken fly screens, chase dogs out of the clinic or retrieve my medical equipment from their toddlers.

Amidst the chaos and the dancing of eyes of mothers, aunties and grandmothers, I found it difficult to work out which child belonged to which parent. They all seemed to belong to everyone.

As the weeks went by, the women seemed to engage me with their eyes, slowly developing trust. The more I saw of how people lived in such difficult circumstances the more I admired their strength.

As I dropped my own children to primary school each morning, we often drove past homeless Aboriginal people living in the parks. It was difficult to answer my young sons when they asked why these people lived in public toilet blocks, and I found my son crying one rainy night because the park people would be getting wet.

I feel a great urgency to talk about what I have seen, but few non-Aboriginal people seem to want to listen. While many people with little knowledge of Aboriginal health don’t particularly care about my experiences, others ask the same questions: ‘Why did you leave your comfortable private practice to work in a low status job?’ ‘Why have millions of dollars been poured into Aboriginal health when it is hopeless?’ ‘How did you stand the smell?’

I can only answer that stereotyping and generalisations are extremely damaging, and a barrier to Aboriginal people accessing health services. For example, racist attitudes deterred many Aboriginal people from attending the hospital which meant they presented late with serious illness.

I asked all of my Aboriginal patients where they found the strength to carry on through such difficult circumstances and their answer was always the same – their hope for their children’s future.

The only smell I have experienced is the stench of racism.

Next time you feel strongly about an issue of injustice in medicine, try writing about it. The pen can make a difference. You will find it easier to get your article published than you think.
WORKING WITH THE MEDIA

Many doctors feel anxious about being interviewed by the media and concerned that their words will be taken out of context or that they will be made to look unprofessional.

If you are approached for a comment about a medical issue by a journalist, do not feel pressured to give an instant response. Ask if they can email you the background details to the request so that you can give the issue some thought before responding. Ask about the journalist’s deadline and commit to call back within an agreed time frame. Beware of the beat up – journalists can sometimes seek to set up conflict between interviewees from different organisations without you realising. Always have a strategy to hang up if you do not wish to be interviewed on this topic or feel you are being harassed.

In preparing your response to a journalist’s question, work out the three messages you want to get across, and also the three things you will not say. Practice what you will say before calling back within the agreed time frame. It can be helpful to practice saying your response out loud, or call a friend to prepare your response.

Formal media training can help doctors avoid media traps and work effectively with the media to advocate on important issues.

IN SUMMARY

Medical leaders need to develop their skills and knowledge, including formal leadership training, public speaking, medical writing and working with the media.

While formal training can assist doctors with the daily tasks of leadership, many of the higher-level leadership skills are developed through experience and with the support of wise colleagues and mentors.
Step off the medical training treadmill when you can. Seize opportunities to immerse yourself in other cultures; do so thoughtfully. Learn from different health systems and develop friendships with international colleagues. It can surprise, inspire and enthuse. It may give you a new perspective of your own health system and of how you could contribute to better health globally.¹

Dr Luisa Pettigrew

Our medical organisations are charged with the responsibility to advocate for many of the issues that affect our ability to deliver a high-quality service to our patients and our communities. These issues may range from areas of clinical interest, inequity in access to healthcare, clinical independence, education and training needs, or the impact of the environment on health.

By becoming involved in our membership organisations, even in a limited way, we can gain peer support, develop areas of special interest and learn how our organisations work. Our medical organisations can also provide opportunities for leadership training to support our roles in advocating for our communities and our patients.

There are many different organisations that represent the interests of medical practitioners and our patients. Membership of some organisations may be compulsory, for example local medical practitioner boards and medical indemnity or insurance providers. Membership of other medical organisations

¹ Dr Luisa Pettigrew is a general practitioner based in the United Kingdom. She has served as the representative of the World Organization of Family Doctors Council to the World Health Organization.
is voluntary and we need to consider which organisations we wish to support through our subscriptions.

While our diversity is one of our strengths as a profession, there are weaknesses associated with being represented by a complex and often-fragmented system of medical organisations. Sometimes different medical organisations are in conflict with each other, which reduces the effectiveness of their advocacy to government and other health funders.

There are many important professional issues that affect the day-to-day work of all doctors, and require strong advocacy by our medical organisations including the following.

**ACCESS TO CARE**

I invite you to consider, beyond our impact on individual health, our key role as a pathway to health equity. I see a community is extending beyond our borders and urge us to find ways to come together across borders and culture to share, learn and contribute as a global family medicine community together to the health of all.\(^2\)

Dr Katherine Rouleau

Inequity in access to health services is a concern for many people. Doctors, who work in disadvantaged communities, or with groups of vulnerable and marginalised people, face a daily struggle to deliver basic health services to their patients. Chronic underfunding of primary care services, mental health services, drug and alcohol services, dental services, and accident and emergency departments, are a continuing source of frustration for many doctors and their patients.

**QUALITY OF CARE**

Life's harshest realities affect a patient's care. Our priorities may differ from those who organise our health systems, and change can be slow despite the challenges, our position as family doctors remains one of privilege: we

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\(^2\) Dr Katherine Rouleau is a Canadian family physician at St Michael's Hospital in Toronto, and Vice Chair of Global Health and Social Accountability at the Department of Family and Community Medicine at the University of Toronto.
seek humanity at its most human. Realise your potential to positively affect patients, colleagues, health systems and society.³

Dr Shannon Barkley

All doctors are concerned about ensuring that their patients have access to the highest possible level of quality medical care. Adverse events are often the result of failures in healthcare governance and systems. Many of the most common and costly adverse events in hospitals and medical practices, including medication errors and hospital-acquired infections, can be prevented with appropriate resources and well-trained and supported staff.

CLINICAL INDEPENDENCE

Search for insight, knowledge and experience from life itself. Being aware that sound patient centred medicine presupposes deep understanding of your own self, enabling you to recognise when your own needs in the interplay with your patient, overshadow the needs of your patient. Develop your skills for self scrutiny. Make a commitment to understand your society.⁴

Dr Anna Stavdal

The World Medical Association has affirmed ‘the importance of professional autonomy and clinical independence, not only as an essential component of high quality medical care and therefore a benefit to the patient that must be preserved, but also as an essential principle of medical professionalism’.

Every day, doctors face considerable pressure from governments, health departments and health administrators seeking to influence clinical decision making, in ways which may not be in the best interests of our individual patients and our communities. Our medical organisations have a role in developing and disseminating evidence-based clinical guidelines, which are based on research, rather than on restrictions enforced by inadequate funding.

³ Dr Shannon Barkley is an American family medicine physician, working with the World Health Organization in Geneva. She has provided clinical care and education to underserved and refugee communities in the United States, Guatemala, Botswana and Kenya.

⁴ Dr Anna Stavdal is a Norwegian family physician and president of the European Region of the World Organisation of Family Doctors.
ACCOUNTABILITY

Health is about people – beyond the glittering surface of modern technology, the core space of every health system is occupied by a unique encounter between people who need services and those entrusted to deliver them. Trust is earned through a special blend of technical competence and service orientation, steered by ethical commitment and social accountability, which forms the essence of our professional work.5

Professor Donald KT Li

Doctors, of course, need to be accountable for their clinical decisions and actions. Our medical organisations should assist us to be aware of our obligations in relation to changing government regulations and accreditation requirements. Keeping up to date with changes can be time consuming and add to our daily stress. Medical organisations can also assist governments and other non-government organisations seeking to improve ways to effectively interact with medical practitioners and so work together to improve the safety and quality of healthcare.

ADVOCACY

As doctors, we recognize our social responsibilities. Each of us needs to advocate for social justice and human rights. We need to speak out for what is right, to say ‘this is not OK;’ and in so doing contribute to social change in our communities and nations. We need to contribute to ensuring equity of access to healthcare. We need to care for the health of our planet as well as that of our patients. After all, what is good for the environment is also good for our patients and communities. If doctors, with our privileged position in society, and our access to pretty much the entire population in our communities, do not stand up for these things, who will? Each of us has a set of values and principles that determine how we behave as ethical medical practitioners and as decent human beings.

Dr Michael Kidd

There are many important issues that require advocacy from our medical organisations. Medical leaders must work with many stakeholders including governments, private health insurers and other health funders, hospitals and other health organisations, and consumer representative organisations, on a diverse

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5 Professor Donald KT Li is a Hong Kong family physician, past president of the Hong Kong Academy of Medicine and president of the World Organization of Family Doctors.
array of issues including ethical dilemmas related to new technologies, e-health, health issues in the media and the threat of new and re-emerging diseases.

It is common for health issues to dominate elections of governments. As a united profession, doctors have considerable power and influence, especially when working with consumer advocacy organisations and bodies representing other healthcare professionals, to advocate for better access to high-quality medical and other healthcare services.

Unfortunately, few doctors understand how to access support from their membership organisations about the issues that affect them. Although many medical organisations provide excellent support for their members, many doctors do not utilise available services or feel able to make the time to visit their professional organisations’ websites or read their organisations’ publications to update themselves on new initiatives and activities.

Medical organisations are only as strong as the support of their members. We recommend that all doctors consider making a contribution to a group or committee of at least one medical organisation. By being involved even in a limited way we gain peer support, have the opportunity to explore an area of special interest, diversify our professional activity, and learn how our organisations work and how we can access future support. For example, by offering to join a clinical committee on an area of special interest, we will not only make a contribution to an issue we feel passionately about, but we will join with other doctors with a similar passion, and may meet senior doctors who could provide us with mentoring.

An extended family physician role, with clinical teamwork, can address the spiral in healthcare expenditure and the growing marginalisation of millions of people across the world. Every young family doctor needs to understand the sociopolitical world better and explore the strong social activist within to make the world a better place for all.6

Dr Shabir Moosa

THE IMPORTANCE OF BEING DIFFERENT

Professor Ian McWhinney has influenced the careers and attitudes of family doctors in all parts of the world and he led the development of the academic basis of our professional discipline.

6 Dr Shabir Moosa is a family physician based in Johannesburg, South Africa, and the incoming Africa Regional President of the World Organization of Family Doctors.
In the second chapter of his book, *Textbook of Family Medicine* he outlined the principles of family medicine, that opened my eyes to a new way of looking at my chosen career. The 9 principles articulated in clear terms what we do as family doctors, no matter where in the world we live and work. I have shared these 9 principles with so many medical students and residents over the years that I can recite them in my sleep.

The family physician:

- is committed to the person rather than to a particular body of knowledge, group of diseases, or special technique
- seeks to understand the context of the illness
- sees every contact with his or her patients as an opportunity for prevention of disease or promotion of health
- views his or her practice as a ‘population at risk’
- sees himself or herself as part of a community-wide network of supportive and healthcare agencies
- should share the same habitat as their patients if possible
- sees patients in their homes
- attaches importance to the subjective aspects of medicine
- is a manager of resources

These are 9 seemingly simple principles that encapsulate our role and our contribution as family doctors. For me, this is part of Ian McWhinney’s great legacy, his ability to describe with such clarity the important work we do.

As family doctors, we are all indebted to our teachers – our family doctor colleagues, like Ian McWhinney, who have taught us how to practice medicine in our communities using a combination of ‘scientific knowledge and tender loving care’. Indeed, this is the Latin motto of the Royal College of General Practitioners in the United Kingdom and my own college, the Royal Australian College of General Practitioners: *cum scientia caritas*.

‘With scientific knowledge and tender loving care’ is a motto to live by for the care of our patients and the care of our colleagues and ourselves.

Dr Michael Kidd

**IN SUMMARY**

We are privileged with unique insights into sociopolitical issues impacting our patients, and a platform to effect change. With this privilege comes a responsibility to advocate for advances in medical care and health equity and identify gaps in health services. When working with our medical organisations, we have
considerable power and influence to fulfil our role as an advocate for improvements in health and in our society.

When we engage with our medical organisations to create change, we can benefit from peer support, developing special interest areas, diversifying our professional activities and engaging in training opportunities. If mobilised effectively, medical organisations can fuel change in areas of accessibility to care, consistent quality of care and clinical autonomy, as well as helping doctors remain informed of their changing responsibilities as clinical decision makers in an evolving political realm.

Professor Ian McWhinney’s 9 principles of family medicine describe the role of family doctors in providing patient-centred care, understanding the populations in which we work and contexts of illness, prevention and health promotion. These principles reiterate the importance of creating better patient outcomes through tapping into the resources of medical organisations by doctors of all specialities.
Many years ago, I arrived at my sons’ primary school late after being delayed at work, attending to some challenging patients. My children had been sent to afterschool care as their mother had failed to turn up on time. I sat alone in the school yard contemplating why I work, feeling guilty that I was not getting the work life balance right and letting my work affect my family.

My heart sank when my son’s teacher called me in to the class to speak to me because I assumed something was wrong. To my surprise, that day the class had been asked to nominate people who have changed the world and there amongst the Queen, Gandhi, Mother Theresa and the Prime Minister, I recognised my son’s handwriting – ‘Leanne Rowe’ was also on the white board.

When I collected my sons from after school care, I admitted I was worried that my work was stressing our family. They said, ‘You have taught us to never give up – don’t give up’.

I have received a number of awards throughout my career but they pale into insignificance with this moment when my children recognised me as a leader in our local community.

Always remember, when we are finding our work challenging, we are demonstrating leadership, and we will find deep satisfaction and joy in responding with fortitude and courage.

Dr Leanne Rowe

A career as a doctor is rewarding and demanding. Why seek to be a medical leader as well?

Leadership is an inherent part of being a good doctor. Mostly, we demonstrate leadership by providing the very best care to our patients and their families. Sometimes, we seek other leadership roles to influence change in the environment in which we work including our clinics, health services, hospitals, medical organisations or communities.
By experiencing the challenges of leadership first hand, we develop a deeper awareness of the need to collaborate effectively and to support other leaders. Few of us take on national and international medical and other leadership positions, although most of us are more than capable of doing so.

As an individual, it is difficult to step outside the isolation of the consultation room and influence change. However, we can embrace a new definition of collaborative medical leadership, where every doctor recognises the strength of the collective medical voice in advocacy and making our medical organisations work.

Wherever we work, we can embrace some important principles of healthy everyday medical leadership.

**LIVE OUR SHARED VALUES**

Our shared values are articulated in our Hippocratic Oath, which was revised in 1964 by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University in the United States:

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say 'I know not,' nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can but I will always look for a path to a cure for all diseases.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.
If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

Which are the most important values of a great medical leader? Integrity, humility, determination, compassion come to mind. What are your values?

**BUILD STRONG RELATIONSHIPS**

Great doctors build strong relationships with colleagues, family and friends. As doctors, we face excessive demands on a daily basis. To get the job done, many of us try to manage each day by unsuccessfully attempting to complete endless ‘tick lists’ at the expense of our professional and personal relationships.

It is tempting to withdraw from contact with family and friends on time off if we have been interacting with hundreds of people during the week. While making time for solitude is important for self-renewal, withdrawing socially from people regularly is a sign of burnout, which can lead to mental health problems. We need to take time every day to nurture healthy relationships with our families, our patients and our colleagues, particularly if we are in leadership roles.

Which relationships are most important in your life and are you spending time with these people?

**PRIORITISE OUR OWN PHYSICAL AND MENTAL HEALTH**

We all need our own doctor, someone who we trust for our own medical care and advice. If we are going to prevent major health problems, we must attend our own doctor for regular comprehensive preventive health assessments to allow early identification and management of the symptoms and signs of physical or mental illness. As doctors, we deserve to have access to the same level of quality medical care that we provide to each of our own patients. Our families also deserve this standard of care.

To stay mentally strong, it is important to maintain feelings of control over our lives by focusing on the issues we can influence. We can take time to address the stresses in our lives and to transcend difficulties by

- Understanding our driven personalities and learning to take a break from these traits.
• Leveraging time and delegating what we can.
• Challenging our common negative thinking patterns and beliefs using positive psychology techniques regularly.

COMMUNICATE EFFECTIVELY

I would like it to be thought that I had listened carefully to what patients and others have told me – that I’ve tried to imagine what it was like for them, and that I tried to convey this.¹

Dr Oliver Sacks

The most important communication skill in medicine is listening.

To deal effectively with inevitable conflict, we can recognise it as an opportunity to build stronger relationships with people. If we have ever had a calm debate with someone over an important issue that concludes in a negotiated solution, we will recognise that our relationship with that person has become stronger than before. If we have ever amicably agreed to disagree with someone over an issue, we will recognise that the ability to have an open debate, even without resolution, has strengthened our relationship with that person.

We can become as expert at managing challenging behaviours and personalities, conflict and anger, as we can with managing other aspects of our professional work.

CONTRIBUTE TO A SHARED LEGACY

We can be proud of our profession. Each of us has the potential to be a role model for future doctors and contribute our own lasting legacy through the examples that we set in the way we live our lives, and practice medicine. We can also contribute to a shared legacy through the strong voice of collaborative leadership and effective advocacy.

We can enjoy the leadership journey by

• Finding simple beauty, joy and meaning in our everyday work in providing excellence in patient care.

¹ Dr Oliver Sacks (1933–2015) was a British neurologist, naturalist, historian of science, and author of several books including Awakenings and The Man Who Mistook His Wife for a Hat. Various articles by Oliver Sacks. Copyright © 2015, Oliver Sacks, used by permission of The Wylie Agency (UK) Limited.
• Living the qualities we admire in our inspirational role models, mentors and colleagues.
• Developing realistic goals for all aspects of our lives, beyond medicine.
• Supporting and caring for our colleagues and sharing our aspirations.

What is most important to you in your life? What do you care about deeply?

Tell me, what do you plan to do with this one wild and precious life?

Mary Oliver

BE OF USE

The first baby you deliver on your own, the first X-ray you read correctly, the first time you break bad news, will be amazing moments, and many of them will stay with you for decades – but you should know that the rewards only get deeper. That’s because the first time you do something as a doctor, in your heart of hearts, it will be mostly about you.

But each subsequent time, it will become more and more about the person you are helping. Observe yourselves as you evolve in this way. The less you worry about whether you are doing it right, the more clearly you will see the human in front of you. As your bravado fades, your compassion will grow. It is one of the many gifts this career will give you.

Not infrequently people – even your patients – will ask you, ‘how do you do it?’ referring to the 24-hour shift or the difficult procedure in the middle of the night. I predict that mostly you will respond with humility, but at times secretly you will be tempted to wear your fatigue and your beleaguerment like a badge of honour.

Huge numbers of physicians report signs of burnout these days – and there is a movement for work-life balance and personal wellness that is growing in response. We all have an interest in helping to build a resilient medical community, but the answer isn’t pizza parties or yoga classes.

As the Institute for Health Care Improvement in the United States puts it, – and I quote – ‘The most joyful, productive, engaged staff … appreciate the meaning and purpose of their work’.

There is now considerable evidence that when people know their work helps others, they feel less emotionally exhausted and their mental health is better. Physical health, too, improves when we help others. In other words,

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2 Mary Oliver (born 1935) is an American poet and winner of the National Book Award and the Pulitzer Prize.
knowing that you are of use is an energizing force that promotes personal resilience.

Of course, we all need to sleep enough, eat well, get outdoors, spend time with our families and recharge. Of course, there is more to life than work.

But the act of bringing your skills to help another person or spending time on a project that is meaningful is also good for you. It is not the alternative to your life. It is life. You will be able to say, through your entire careers, that in your work, you meet extraordinary people, you learn, you are humbled and moved, and you contribute. You are of use to others. This is what will inoculate you against burnout and cynicism.

Take heart in how useful you can be. Be of use as much as you can, as often as you can. That will fill you up.\(^3\)

Dr Danielle Martin

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\(^3\) Dr Danielle Martin is a family physician and Vice President Medical Affairs and Health System Solutions at Women’s College Hospital in Toronto. Her bestselling book *Better Now: Six Big Ideas to Improve Health Care for All Canadians* was published in January 2017.
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