Milestones and Transitions – Maintaining the Balance

ABSTRACTS

Monday 15 – Wednesday 17 September 2014
BMA House, London
# Abstract presentation themes

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CAREER CHANGES

158 POSTER
Reasons to quit among Swedish General Practitioners

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Background: General practitioners play a crucial part in healthcare as they provide the continuity of care that can prevent illness, and they most often represent the patients first contact with health-care. A current problem is however that there is a lack of general practitioners in several countries. Recruitment of general practitioners from abroad is essential to ensure the public’s physician access, but there are indications that this group has even greater quitting intentions than native-born physicians. The antecedents of turnover intentions may moreover differ in importance for native-born and foreign-born physicians respectively. Methods and participants: The authors examined five fundamental physician work factors in relation to intention to quit among native-born general practitioners (n=208), and foreign-born general practitioners (n=73) working in a primary care setting in a central area in Sweden. Linear regression analysis was performed with control for age and gender. The sample consisted of 64 % females. Results: Foreign-born general practitioners more often stated that they would quit today if they could than native-born practitioners (t_{278} = 3.73, p = .001). Regression analysis revealed that pressure from patients was related to an increased intention to quit in both groups. In addition, vacancies and pressure from financial goals were related to a higher risk of wanting to quit among native-born general practitioners. HR-Primacy was associated with a decreased risk of turnover intentions among the native-born general practitioners, while control of work pace was highly related to a decreased risk of turnover intentions among foreign-born general practitioners. Conclusions: General practitioners primarily experience pressure from patients and financial goals of the care-unit, which may provoke intentions to quit. Study suggestions are that care-unit financial goals are set in consent with physicians, and that control of work pace is encouraged.

COGNITIVE FUNCTION AND HEALTH

135 ORAL
Cognitive problems among physicians evaluated at the Colorado Physician Health Program: A review of cases 1986-2013

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Evaluating and managing physicians with cognitive problems is now a critical matter worldwide. Cognitive decline associated with aging is a common reason for career transition in work duties and career. Cognitive problems from any cause threaten a medical career. Accurately assessing concerns about a doctor’s cognition and intervening in reversible causes of cognitive problems is a challenge for physician health programs, hospitals and regulatory agencies. To begin to address these challenges, the Colorado Physician Health Program (CPHP) has reviewed all cases of physicians referred for concern about cognitive impairment, and all cases in which cognitive problems were discovered even if referred for other reasons. Our goal was to understand how such difficulties present, the diagnostic spectrum, clinical outcomes, and the impact on work and related transitions is career and personal life. Retrospective chart review found over 100 cases. Causes of cognitive problems included dementia, traumatic brain injury, various other neurological disorders, cancer, metabolic disorders, sleep disorders, psychiatric disorders, and side effects of many types of medications, including antidepressants. The authors will describe how different types of cases were diagnosed and managed, and their outcomes. A second aspect of this study is a review of the performance of the Montreal Cognitive Assessment instrument (MOCA), which CPHP has utilized in approximately 700 evaluations since 2011. Recommendations will be made for screening, intervention, and the monitoring of physicians with cognitive problems, including under what circumstances they can effectively work as physicians, and when they should not work. The relationship of these problems to various life and career transitions will be discussed. Relation to conference theme: Transitions in work and career coincide and sometimes are caused by
cognitive decline associated with aging. The advent of any illness or injury that causes cognitive impairment creates life and work transitions for doctors and their families. Managing such transitions, especially when cognitively impaired, is a matter not discussed in the scientific literature. Managing the underlying illness and work related matters are essential to managing the transition.

ORAL

Using cognitive assessments to inform fitness to practice and strategies to enable doctors to progress through key milestones and transitions in their personal and professional life

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Reduced cognitive functioning is well documented and evidenced in relation to many physical and mental health conditions. General and specific cognitive functions such as memory, concentration and attention along with executive cognitive functioning can be formally assessed and the outcomes can inform the level of cognitive impairment or otherwise. This information, along with observations made during the assessment can reliably inform decisions on fitness to practise and reasonable adjustments which enable the doctor to progress within their career utilising the appropriate support and strategies advised at assessment. Assessment can be used as a baseline to consider fitness to return to work, without risk to patient safety and levels of enhanced supervision / remediation required to successful continue in training. In the Belfast Health and Social Care Trust, Northern Ireland, an innovative and unique service was commenced in 2011 within the Trust’s Occupational Health Department. An occupational therapist was introduced to an existing team of professionals which lead to the introduction of standardised cognitive assessments. Screening and neurocognitive assessment are used for adults of working age. Research regarding the validity and reliability of these assessments is in abundance (JR Hodges, CM Kipps and MD Lezek ) making this type of assessment a valuable and evidence based tool to inform the doctors progress as they adapt to managing their health and wellbeing. This is particularly important where health impacts on performance. The outcome of the introduction of these types of assessments has resulted in evidence based decision making for the Consultants in Occupational Medicine. Consequently, trainee doctors throughout their career, from medical student up to completion of training, can access this service to inform and advise on future decisions in relation to their fitness for work, adjustments required to enhance the success of reaching CCTV and in their ongoing career. Using case examples, the Consultant in Occupational Medicine and specialist occupational therapist will outline the background, assessments, interventions, recommendations as well as outcomes for doctors who have been assessed during their Occupational Health journey, while ill, following recovery and on review; Cases will reflect doctors at various points in their training from F1 and through Specialty training where their health and/or wellbeing have been directly affected by personal or professional issues and in some cases both. The benefits to the doctor involved will be outlined and user experience feedback included.

CREATIVITY

POSTER

Tools of the trade: poetry for new doctors

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Being a new doctor is a stressful experience. In conjunction with the Scottish Poetry Library we have produced a little pocket sized book of poetry which was presented to every Scottish graduate this June. Our hope is that it will act as a friend and be source of comfort, inspiration and support. Some of the poems are sad, a few funny, some well known, some not. All offer insight into the demanding and privileged role of looking after people and sharing their lives. It can be difficult for doctors in emotional distress or who are suffering from mental illness to seek help. The BMA, the College of GPs and others are trying to make such help more easily accessible but the first step is for the doctor him or herself to recognise that there is a problem and to believe that others want to share it. One of my partners, an extremely caring and compassionate GP and a trainer and mentor to many young doctors, suffered in this way and the book is dedicated to him. It has been produced as a joint venture between the College of GPs in Scotland and the Scottish Poetry Library with input from the Edinburgh University Chaplaincy, and funded by contributions
from GP colleagues and others. The presentation will describe
the book as an example of the value of the arts and humanities
in the health care of patients and professionals. It will address
how such an initiative can encourage young doctors to explore
the art as well as the science of medicine, and to nourish their
emotional health during their working lives.

**DIFFERENT CAREER STAGES, DIFFERENT ATTITUDES**

**57 ORAL**

**Doctors’ attitudes to disclosing mental ill health to the workplace: understanding the difference: trainees to consultants**

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**Purpose:** Medicine is a career of continual transitions through varying workplaces, career development and relationships.
Doctors are known to suffer from high levels of mental ill health. At present we have only a rudimentary understanding of doctors’ attitudes to disclosure of their own mental ill health. There are many assumptions made to perceived obstacles and little is known about whether the stage of a doctor’s career, age and gender influence attitudes to disclosure. If services are to deliver effective and timely support and be equitable, they must be flexible to doctors’ differing needs. This study specifically investigated doctors’ fears and attitudes to disclosure of mental ill health. **Methods:** An anonymous questionnaire was constructed based on key areas identified through semi-structured interviews conducted with members of an expert panel. The major domains explored willingness to disclose, ‘who’ doctors might disclose their mental ill health to first, factors that influence disclosure, and ‘how’ doctors would disclose. In addition doctors’ own attitudes to mental ill health were explored. The questionnaire was tested for face and construct validity and published as an online survey. The questionnaire was disseminated widely across Great Britain (GB) to all doctors whether or not they had personally experienced mental ill health. Three analyses will be undertaken, the first will test the univariate association between age, career level and gender and the likelihood of disclosure (dichotomised) using a chi square test. The second will use multivariate regression to assess the influence of individual factors and their interactions, e.g. gender and levels of support on stage of career when disclosure occurs. The third describes the types and proportions of areas of good practice. **Results:** The survey is ongoing and to date there have been over 600 responses. Descriptive analysis so far indicates 57% of respondents were female, with 50.8% of respondents having experienced mental ill health in the past. 25% were aged under 30yrs, and 21.5% aged over 50yrs. 49.5% were doctors in training, 48.1% qualified in the last 10 years and 23% qualified in the last 30 years. **Discussion:** Data collection will continue until March 2014. The presentation will describe the analyses as described above on the complete data set, provide evidence across the varying transitions of career and discuss how future support for self-disclosure may be shaped.

**66 ORAL**

**Health behaviours and response to stress among non-consultant hospital doctors – barriers and solutions**

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High rates of psychological distress, depression and suicide have been reported among doctors. Furthermore, many doctors do not access healthcare by conventional means. There is a paucity of high quality data in this area. This study focuses on doctors in the early part of their careers. Its aims are to increase understanding regarding Non-Consultant Hospital Doctors’ (NCHDs’) health behaviours and response to stress, identify barriers to their accessing of supports; particularly their General Practitioner and explore initiatives to promote better health in this population. The four investigators had no direct contact with study participants. Medical Manpower departments in 58 teaching hospitals distributed an invitational email to 4074 NCHDs. This contained a link to an anonymous 25 item questionnaire hosted on an online survey tool, Survey Monkey. Quantitative data was analysed using SPSSv21 statistical software and the smaller qualitative component was analysed by thematic analysis. We received 708 responses, giving a response rate of 17.4%. Demographics were
representative of the Irish NCHD population. 60% (n=313) of NCHDs were unable to take time off work when unwell. “Letting teammates down” (90.8%, n=583) and “difficulty covering on-call shifts” (85.9%, n=553) were the leading reasons. Being too busy (85%, n=508), self-prescription (66.6%, n=398), and a belief that they should be able to self-manage (53.1%, n=318) were ranked highest in deterring NCHDs from visiting a GP. 22.9% (n=128) of NCHDs would not attend a GP with anxiety or depression until they began to feel hopeless, helpless or suicidal. 12.2% (n=68) would not seek help at all. Moving due to work, impacted negatively on respondents’ informal social supports (82.9%, n=384). A minority (35%, n=210) recalled education in self-care and stress management at undergraduate or postgraduate level. Participants were invited to evaluate 11 possible initiatives and make further suggestions in a comment box. Improved work structures were positively rated by 96% (n=564), a counselling service by 92% (n=536), a free GP check-up every one to two years by 85% (n=498) and a designated GP service within close proximity to the hospital, by 85% (n=502).

NCHDs are a vulnerable population. A willingness to attend GP and counselling services was identified and access to these should be improved. The culture of poor health behaviours must be addressed. Education in appropriate self-care should be made a priority.

203 ORAL
European Internists: changes in health and psychosocial status over the course of internal medicine training

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Background: Internal medicine in Europe is challenging and rewarding. The job can be stressful and exhausting at times, particularly with increasing workloads and financial restraints. These factors can impact a doctor’s health and wellbeing. There is little research comparing job content, physical health and psychosocial status of internists across Europe at different stages in their career. Methods: An online questionnaire was developed and distributed via a network of young internists. The countries with >10 responses were included in our final analysis. Internists were divided between young internists (YI) with 1-2 years training, experienced internists (EI) with 3-6 years training, and those completed internist training (CIT). Physical and psychological status was determined by: Satisfaction with Life Scale (SWLS), Revised Life Orientation Test (LOT-R), Job Content Questionnaire (JCQ), and International Physical Activity Questionnaire (IPAQ). Results: 333 participants from 10 countries; 107 YI, 193 EI and 33 CIT. The average age of YI is 27.5, EI is 29.7 and CIT is 39.6. The average working week is longest for YI (60.3h) compared to EI (53.0h) and CIT (51.1h). The average BMI is similar in all levels of internist (YI 22.9, EI 23.0 and CIT 25.0). Current smoking is lowest in YI and EI (15% & 13%) compared with CIT (24%). Regular alcohol consumption is highest in EI (57%) compared with YI (51%) and CIT (46%). Regular vigorous exercise is more common in CIT (64%) compared to EI (61%) and YI (55%) while all levels of internists walk regularly every week (>90%). Using the JCQ we found higher levels of job decision making with lower levels of job lassitude and job strain as doctors progressed from YI to EI and CIT. Although job demands, co-worker support, supervisor support and job security were the same for all levels of internist. The SWLS and LOT-R showed that all levels of internists were generally satisfied with life and had moderate levels of optimism. Discussion: The data suggests that all levels of European internists are generally healthy with normal average BMI, low rates of smoking, and high levels of regular exercise throughout their career. It is reassuring to find that all levels of internists find the same degree of support from colleagues and supervisors throughout their career. Interestingly with experience came less job strain and lower job related weariness. Overall internists were happy with life and optimistic which bodes well for future doctors choosing this career path.

182 ORAL
Residents versus physicians seeking help at a physician health program: differences between those in training versus those in practice and why they seek help

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Physician Health Programs (PHPs) exist to assist physicians, and often those in training (residents), with health conditions which may include psychiatric, substance use, emotional, behavioral or physical illnesses. The Colorado Physician Health Program
(CPHP), provides assessment, treatment referral and monitoring for all health-related ailments, and offers its services to all Colorado doctors along the professional continuum, including residents and practicing physicians. Several reports document the characteristics of the physician population seeking care from PHPs; however, to date, very little information exists about residents who present at such programs. This is a critical oversight because research shows residents face unique challenges at this stage in their professional career such as a high degree of stress combined with lower levels of problem-solving capacity and lower resiliency, very often all within a less supportive emotional environment. In a retrospective chart review, CPHP contrasted residents and physicians clients to better understand the problems with which they presented and to ultimately better identify, outreach and assess the issues residents face that differ from practicing physicians. We compared data from 299 residents and 1,361 physicians, examining demographic information (gender, ethnicity, marital status), referral source, and clients' primary reason for seeking PHP assistance. Comparisons were made using general descriptive statistics (Chi-square and student t-tests where appropriate). In preliminary findings, statistical significance was demonstrated in the rate of residents presenting at CPHP with emotional and stress-related issues versus their physician counterparts. On contrary, established physicians presented significantly more often with behavioral or physical problems than their resident counterparts. Both these findings confirm the researchers' original hypothesis that presentations between the two populations would be different. Identifying the reasons for seeking help by both populations will allow those providing assistance (in this case, PHPs) with greater understanding of more effective intervention and outreach opportunities for young medical career populations. The data offers preliminary evidence to the explicit differences in residents versus physicians presenting at a PHP, and will allow other programs to further explore increasing well-being of those in training.

It is common knowledge that physician emotional well-being and personal resilience habits are established early in a medical career. Acknowledging the difficulties in obtaining well-being in this stage comparatively to those already established will provide evidence for best serving those in the early milestone of a medical career, residency. This study will facilitate an early researcher in honing, guiding and catalyzing her future research endeavors into physician health.

DOCTOR TO PATIENT

45 WORKSHOP
Serious physical illness: when doctors become patients, the difficult transition

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It is well recognised that doctors struggle to reconcile themselves to their own illness, and it is often difficult to be the treating doctor. The institutional response to the ‘special’ patient can also be unhelpful. This workshop aims to open up the issues via vignettes and small group discussion and will hopefully encourage reflective practice. Presentation of 2 or 3 unidentifiable case vignettes: 1) young doctor with serious illness and treatment complications; 2) doctor with incurable malignancy; 3) doctor with a chronic relapsing condition with fitness to practice issues. Themes for small group discussion: Sharing personal experiences of treating serious physical illness in doctors; What are pitfalls in treating the doctor/patient?; Fitness to practice issues with the sick doctor.

251 POSTER
Assessing the impact of stigma on doctors with mental illness

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Background: Mental health problems are under-reported among doctors, and may be associated with stigma and self-perception issues. This study aimed to examine the experiences of doctors with mental illnesses when transitioning from
the doctor to the patient role. **Methods:** This qualitative, survey-based study was conducted among members of the Doctors’ Support Network (DSN) for three weeks in January 2014. The DSN is a charity that provides support to doctors with mental health problems in the United Kingdom. An online anonymous survey was distributed to DSN members to collect basic demographic data and personal experiences of stigma related to mental health diagnoses. The participants were asked whether stigma had affected: (1) how they felt about their illness; (2) their willingness to seek help; (3) how non-medical friends or colleagues interacted with them; (4) how medical colleagues interacted with them; and (5) how the doctors providing them with treatment interacted with them. The survey encouraged free text responses. All results were analysed qualitatively using thematic analysis. **Results:** In total, 458 DSN members received the invitation, of which 127 responded (28% response rate); most were 30–59-years-old, with seniority ranging from medical student to consultant. However, there was a female bias (100/127; 79%), and a specialty bias to general practice (45/127; 35%) and psychiatry (25/127; 20%). The most common diagnoses were depression and bipolar disorder at 79/127 (62%) and 36/127 (28%), respectively. Sixty-seven respondents (53%) felt that stigma had affected how they felt about their illness. The prevalent themes in the comments were “failure” and the “perception of the illness as a choice”. Seventy respondents (55%) reported that stigma had affected their willingness to seek help, and that this had delayed accessing support. Sixty-four doctors (50%) reported difficult interactions with non-medical colleagues. Thematic analysis revealed “denial” and “shunning” as common issues. Most respondents (79/127; 62%) reported problematic interactions with medical colleagues. Themes included “avoidance,” “lack of recognition of skills,” “problems returning to work,” and “dismissing legitimate concerns”. A minority (43/127; 34%) reported that stigma was an issue when seeking treatment from a doctor, with common themes identified as “dismissing symptoms” and “role confusion”. **Discussion:** This study supports the hypothesis that mental health stigma is a significant issue among doctors; moreover, it identifies interactions with medical colleagues as being the most problematic. Although this survey was limited by a small self-selected sample, the high incidence of perceived stigma demonstrates the need for further action.

**ECONOMIC WELLBEING**

**221 POSTER**

**Economic well being as a major determinant of physicians health and work/life balance**

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As physicians are required to provide holistic care to their patients, it is then important that their state of being is holistic and well balanced to be well positioned to give a high standard of care to their patients. Due to time and space constraints, I have decided to narrow this presentation to a determinant of vital importance which has a huge impact on the health and well-being of physicians and by extension, the quality of care they give to patients. However, this is an area that is very easily neglected by physicians until it is too late. It is what I call the missing component of the holistic chain. It is an area that many physicians do not have a hold on. Failure in this aspect of life can lead to various deleterious effects on the health of the physician including poor physical and emotional health. This all important factor is the economic well-being (personal finances management, incomes, debts, investments, etc) of the physician. Even though physicians are among the highest paid professionals, experience has shown that many of them struggle in the area of their finances. This in turn can have various adverse effects on their personal and professional lives which include worries, stress, burnout, depression and substance misuse. This has been revealed in some studies. A search of medical and non-medical databases revealed only a handful of studies that directly focused on the economic health of physicians from medical school through residency to retirement. However, a generally known trend is that many physicians graduate with huge student debts which they spend years paying off during their active professional lives. Also, their expenses easily catch up with and sometimes outstrip their rising incomes. As they reach age of retirement, they struggle to maintain the same standard of living and have to downgrade, with many having to continue working late into their lives. Other limiting factors include the long periods of medical education which involve little or no financial management education and the short active working life with huge taxes and little time for pensions to compound. This has come to be known as the typical trajectory of the average physician’s economic life. Physicians, like many other high earning professionals, are not immune to bad investments since they largely rely on so-called financial experts to handle their investments.
Aims: To present a game ('Thrive or Dive') as an innovative and fun teaching tool, which has been piloted with General Practice trainees and established General Practitioners. It is designed as an interactive exercise to stimulate discussion and reflection, aimed principally at those who are making the transition from trainee to independent practitioner. The game explores attitudes and behaviours in clinical practice and their impact on practitioner well-being. The evidence-base on practitioner well-being and stress is linked with real-life General Practice scenarios.

Content: Participants will play the game for an hour, with half an hour for discussion and feedback. Audience members will be invited to be co-panelists, or observers, and to feed back. The game is a board game in which teams aim to either ‘thrive’ (flourish or develop resilience) or ‘dive’ (burnout), thus exploring a breadth of possible responses, with some injection humour as we consider our worst possible responses. The teams are awarded points in response to their answer, and move up or down the board accordingly. The board also has snakes and ladders on it, reflecting the chance ups and downs of life. Two handouts will be shared afterwards one on the main evidence base used to support the answers to the game scenarios, and the other will be a brief literature review on the use of games as a teaching tool for health practitioners.

Outcomes: The game itself aims to help practitioners reflect on, and improve, their approach to work in order that they thrive, and be better able to identify warning signs in their approach that may indicate the need for reflection or support.

Relation to Conference Theme: A game is a non-threatening and fun way to learn. This game is aimed at trainees, who are at a stage of transition. By presenting real-life scenarios from General Practice, participants’ imaginations are linked to evidence-based findings. The game highlights skills and attitudes that support and sustain us, and ones that deplete us.

Quality: Formal feedback from the pilot: “It was very good at helping me think about how to change practice in a non-judgmental way.” “It was enjoyable and made the afternoon more light hearted.” At the ICPH workshop formal feedback will be sought, as well as more informal discussion-based feedback.

Objectives: To assess weekly working hours of Norwegian hospital doctors from 1994 to 2012 with special emphasis on the quality of postgraduate training and work-home balance, and compare with the requirements of the European Working Time Directive. Design: Longitudinal study based on self-reported average weekly working hours from an unbalanced cohort of 1,300 to 1,600 doctors in 1994, 1995, 1996, 1997, 2000, 2002, 2004, 2006, 2008, 2010 and 2012. Setting: Norwegian Participants Mainly Norwegian junior and senior hospital doctors at 11 different points in time, but also other Norwegian doctors. Main outcome measures Self-reported total weekly working hours and whether 45 weekly working hours were too short, sufficient, or too long to secure the quality requirements of obligatory postgraduate training. Results From 1994 to 2012, the number of weekly working hours was stable for senior (46-47 hours) and junior (45-46 hours) hospital doctors. The average number of weekly working hours has always been below the EWTD requirements. Significant predictors for having the opinion that a 45 hour work-week was not sufficient for securing the quality of obligatory postgraduate training for junior doctors, controlled for gender and weekly working hours, were age (OR 1.04, 95 % CI 1.01-1.08), being a senior doctor (1.07, 1.04-1.11) and working in the surgical domain (OR 1) vs. laboratory medicine (0.03, 0.01-0.25), internal medicine (0.31, 0.17-0.58), psychiatry (0.12, 0.04-0.36), paediatrics (0.36, 0.12-1.07), anaesthesiology (0.08, 0.02-0.39), gynaecology (0.07, 0.01-0.56) and others (0.39, 0.04-3.56). Significantly more senior (31 – 35 %) than junior (12 – 19 %) doctors worked more than 48 hours per week, our definition of a sub-optimal work-home balance. Conclusion: Norwegian hospital doctors work shorter hours than hospital doctors in other comparable countries, but the majority perceive the present situation with an average of 45 hours per week as sufficient for obligatory postgraduate specialist training. An increase in hospital doctor density over the past two decades, national regulations and cultural values might be important factors for these. Speciality
differences in perception of sufficient training time may call for more flexibility in working time regulations.

165 ORAL
Risking your health while saving lives?

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Purpose: Today, there is significant evidence to suggest that health behaviors may not only be a product of individual choice but influenced by workplace characteristics as well. Several studies have been conducted on physicians’ health, however most research and interventions have focused on job stress and mental health. Much less is known about preventive health and lifestyle behaviors among physicians. The purpose of this cross sectional survey was to study physicians’ protective and risky health behaviors and to compare these to health behaviors of other “front line” professionals working in healthcare and other sectors.

Materials and Methods: The sample of this study consisted of 1251 employees, 141 policemen (11.27%), 359 ambulance workers (28.70%), 444 doctors (35.49%) and 307 nurses (24.54%). The mean age of the sample was 40.41 years (SD: 47.18). Health behaviors were assessed with the Health Behaviors Inventory (HBI).

Results: Physicians adopted significantly more risky behaviors compared to other occupational groups: In specific, significant differences were found between physicians and all other professionals in terms of: eating breakfast (F(4, 1431)=5.7, p<.01), weekly consumption of fast food (F(4, 1415)=78.45, Pc<.01) weekly exercise hours (F(4, 1420)=5.764, P<.01), daily coffee (F(4, 1440)=11.17, P<.01) and alcohol consumption (F(4, 1421)=10.13, P<.01). However doctors scored the lowest in terms of number of cigarettes smoked per day (F(4, 1405)=8.63, P<.01).

Discussion/Conclusion: Findings indicate that physicians adopt unhealthier life styles even compared with other “front line” professionals such as ambulance workers or police men. The paper discusses the implications of these findings for physician health and patient adherence, as there is evidence to suggest that physicians’ health practices strongly influence patient health practices. Findings highlight the need to design interventions tailored to physicians’ specific needs within specific work contexts.

214 ORAL
Physicians’ perceptions of quality of care, professional autonomy and job satisfaction in Canada, Norway and the United States

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Purpose/Relevance: We lack national and cross-national studies of physicians’ perceptions of quality of patient care, professional autonomy, and job satisfaction to inform clinicians and policymakers. This study aims to compare such perceptions in Canada, the United States (U.S.), and Norway.

Methods: We analyzed data from large, nationwide, representative samples of physicians in Canada (n=3,213), the U.S. (n=6,628), and Norway (n=657), examining demographics, job satisfaction, and professional autonomy.

Results: Among U.S. physicians, 79% strongly agreed/agreed they could provide high quality patient care vs. only 46% of Canadian and 59% of Norwegian physicians. U.S. physicians also perceived more clinical autonomy and time with their patients, with differences remaining significant even after controlling for age, gender, and clinical hours. Women reported less adequate time, clinical freedom, and ability to provide high-quality care. Country differences were the strongest predictors for the professional autonomy variables. In all three countries, physicians’ perceptions of quality of care, clinical freedom, and time with patients influenced their overall job satisfaction. Fewer U.S. physicians reported their overall job satisfaction to be at-least-somewhat satisfied than did Norwegian and Canadian physicians.

Discussion/Conclusions: U.S. physicians perceived higher quality of patient care and greater professional autonomy, but somewhat lower job satisfaction than their colleagues in Norway and Canada. Differences in health care system financing and delivery might help explain this difference. Canada and Norway have more publicly-financed, not-for-profit health care delivery systems, vs. a more privately-financed and profit-driven system in the U.S. None of these three highly-resourced countries, however, seem to have achieved an ideal health care system from the perspective of their physicians.
Working with disabilities: experiences of being a doctor with different abilities

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Introduction: Under the Equality Act 2010 an individual is deemed as disabled if they ‘have a physical or mental impairment that has a ‘substantial’ and ‘long-term’ negative effect on your ability to do normal daily activities’. This definition fits a medical model of disability. The social model of disability suggests that the aforementioned definition should be used to define ‘impairment’, whereas the term ‘disability’ should be reserved for the barriers created in society. 

Frequently, individuals are able to overcome their own differences in abilities, but the attitude from colleagues and the inflexibility of the professional system can be harder to deal with. 

Method: Responses were gathered from Foundation trainees using a questionnaire. Physical copies were handed out to trainees and there was also an online version available. 

There were 74 questionnaire recipients: 58 responses were received. Case studies of doctors working with impairments were gathered from communications with the Action on Disability and Work UK representatives and from personal communication with authors. 

Results: Yes; No; Partially; Not sure. Do you consider yourself to have a disability? 2(3%); 52(90%); N/A; 4(7%); Have you ever worked with a colleague with a disability or long term health condition? 11(19%); 29(50%); N/A; 18(31%); Did you receive disability training at medical school? 19(33%); 39(67%); N/A; N/A; Do you feel comfortable caring for patients with disabilities? 15(26%); 1(1%); 38(66%); 4(7%); Do you/would you feel comfortable working with colleagues with disabilities? 16(28%); 2(3%); 16(28%); 24(41%); Would you like more training regarding coping with disabilities in your workplace? 24(41%); 26(45%); N/A; 8(14%). Of those respondents that identified themselves as disabled, none had received information regarding the transition from being a medical student to working as a doctor. 

Conclusion: 1. Disability and impairment awareness training needs to be part of the medical curriculum if we are to ensure good levels of care for patients and equal opportunities for all healthcare professionals. 2. Information and support needs to be given at key stages of an individual’s career, especially during the transition between being a student and becoming a professional. 3. Support is available to enable healthcare professionals with impairments to remain in work. 

taking, full transcripts were developed which were analysed thematically using NVivo software. **Results:** Dominant themes included: 1) Unrealistic Workloads, characterised by staff shortages, extended working hours, irregular and frequently interrupted breaks 2) Coping but discontent, the quality of patient care provided while sleep deprived was questioned, however little reflection was given to any impact this may have on junior doctors own health 3) Immunity/Detachment, insufficient training, intensive workloads and a perceived lack of power to influence change led to a build up of detachment among junior doctors to their surroundings. **Conclusion:** Respondents ascribed little importance to any impact current working conditions may have on their own health. They felt their roles were underappreciated and undervalued by policy makers and hospital management. They were concerned about the lack of time and opportunity for training. This study highlighted several ‘red flags’, which need to be addressed in order to increase retention and sustain a motivated junior doctor workforce.

**HEALTHY DOCTORS: HEALTHY PATIENTS?**

**39 ORAL**  
The NHS Choices ‘Couch to 5K’ Programme: an important tool to increase physical activity and improve health among physicians and other hospital staff

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**Purpose/Relevance:** Physical inactivity is the fourth leading risk factor for global mortality. Yet many adults, including doctors and other hospital staff struggle to exercise regularly (Kosteva, et al. 2012). NHS Choices has promoted a nine week ‘Couch-to-5K’ Programme since 2010, which trains novice runners to run continuously for thirty minutes. To try and increase physical activity amongst staff at my hospital, I set up a ‘Couch to 5K’ running club for all hospital staff.

**Materials and Methods:** Alongside the staff running club, I implemented a research project with volunteers, to quantify improvements in physical activity and health experienced through the programme. Physical, questionnaire and bleep test assessments were done at the beginning, middle and end of the nine weeks. **Results:** Twenty-five members of staff participated in the club, with eight volunteers (all female, aged 24-56) taking part in the assessment scheme. Amongst the volunteers, the most popular reasons for participating were weight loss (75%) and improving fitness (50%). All volunteers reported an increase in their weekly physical activity during the programme (Godin scale). 87.5% lost weight over the nine weeks (mean 3.2kg). 75% reported an increase in quality of life (WHO-5 scale). 50% of volunteers improved their performance on a 20m bleep test on completion of the programme. On questionnaire-based assessments, ≥50% reported improvements in their sleep quality, general health status and energy levels. All participants would recommend the programme to others. **Discussion or Conclusions:** The ‘Couch-to-5K’ scheme is a valuable, inexpensive tool to help increase physical activity, aid weight loss and improve quality of life. Participants can complete the scheme individually using podcasts and session plans, or via local versions of the scheme e.g. at workplaces, schools, GP practices. Workplace schemes for doctors and other healthcare staff can help to improve staff health and wellbeing, as well as potentially translate to increased promotion of physical activity to patients.
PA, and only 8% reported giving advice very regularly; The most common barriers identified to improving PA amongst doctors were lack of time, poor work-life balance and out-of-hours work. Strategies for increasing PA amongst doctors included exercise and changing facilities at work, and group sessions. **Conclusions:** Over half of doctors are not meeting PA guidelines, and there is a worrying lack of knowledge about PA. It is hoped that future interventions aimed at increasing PA and knowledge amongst doctors, will translate to improved confidence and frequency of patient counselling, and an improvement in population health.

**249 ORAL**

**We now know that Healthy Doc = Healthy Patient: transitioning to the next big physician health research question**

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This presentation will demonstrate that the relationship between physicians’ personal and clinical health practices is now well-established, and will present ideas for future research directions concerning interventions. The presentation will concentrate heavily on the findings from Frank E, Dresner Y, Shani M, Vinker S. 2013. The association between physicians’ and patients’ preventive health practices. Canadian Medical Association Journal. 185(8):649-653. http://www.ncbi.nlm.nih.gov/pubmed/23569163. **Background:** Although much has been written about the potential power of the association between physicians’ personal health practices and those of their patients, objective studies of this relationship are lacking. We investigated this association using objectively measured health care indicators. **Methods:** We assessed 8 indicators of quality of health care (screening and vaccination practices) for primary care physicians (n = 1488) and their adult patients (n = 1,886,791) in Israel’s largest health maintenance organization, the physicians were also patients in this health care system. **Results:** For all 8 indicators, patients whose physicians did and did not receive the influenza vaccine had mammography rates identical for patients whose physicians did and did not receive the influenza vaccine. **Interpretation:** We found a consistent, positive relation between physicians’ and patients’ preventive health practices. Objectively establishing this healthy doctor-healthy patient relation should encourage prevention-oriented health care systems to better support and evaluate the effects on patients of improving the physical health of medical students and physicians.

**24 ORAL**

**Prevalence of Risk Factors for Chronic Diseases among Nurses and Medical Doctors in R.I.P.A.S Hospital, Brunei Darussalam**

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**Background:** The prevalence of chronic diseases is rapidly increasing and this has posed a global health threat. The aim of this study was to study the prevalence of risk factors for chronic diseases of the nurses and medical doctors in Raja Isteri Pengiran Anak Saleha (R.I.P.A.S) Hospital, the main referral hospital in Brunei Darussalam. **Materials and Methods:** A cross-sectional study was conducted among the nurses and doctors in R.I.P.A.S Hospital using a self-reported questionnaire which was adapted from the World Health Organization’s STEPwise approach to chronic disease risk factor surveillance (STEPS). **Results:** Overall, 139 individuals (70 nurses and 69 doctors), from aged 20 years and above participated. The response rate was 54.1%. The prevalence of hypertension among nurses was 16.9% [95% CI: 7.8, 26.5] compared with 18.2% [95% CI: 8.9, 28.0] among doctors. The prevalence of overweight or obesity (BMI ≥ 25kg/m2) was 51.6% [95% CI: 39.3, 65.3] among nurses and 45.5% [95% CI: 33.4, 58.7] among doctors. Overall, 75.4% [95% CI: 64.9, 87.9] of nurses and doctors took less than five servings of fruits and/vegetables per day. Physical inactivity (spending less than 150 minutes of vigorous and/or moderate sports, fitness or recreational (leisure) activities per week) was reported by 58.3% [95% CI: 45.9, 72.6] of nurses and 44.6% [95% CI:
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32.5, 58.0] of doctors. Low prevalence of tobacco use was reported in both nurses and doctors at 2.9% [95% CI: 0.8, 7.2]. The prevalence of alcohol consumption in the past 12 months was 3.2% [95% CI: 0.7, 9.1] among nurses and 28.8% [95% CI: 17.9, 40.5] among doctors. Conclusions: Nurses and doctors are experiencing an increase in the prevalence of many risk factors for chronic diseases. The findings highlight the need to carry out further studies among them as to understand why they have many of the chronic diseases modifiable risk factors, despite their broad knowledge on health issues.

114 POSTER
Personal health practices, quality of life and patient counselling of German physicians in private practice

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Purpose: It has been shown in North America that physicians and medical students have healthier personal behaviors than the general population, and that physicians’ and medical students’ personal health practices significantly, positively, and consistently influence their patient counseling practices. Little is known about personal health practices of doctors in Germany, how these relate to patient counseling, and — regarding the conference theme — if there are differences according to years of professional practice. Methods: In 2010 we surveyed a representative sample of physicians in private practice in Schleswig-Holstein, Germany (N=414) using the Short Form-12 Health Survey (SF-12) and items about physicians’ personal health behavior and counseling practice. Results: Physicians reported significantly better physical but poorer mental health compared to the general population (GP, p>0.01). The majority presented with normal weight (47.9% male, 73.1% female physicians vs 24.5/41.0% GP), or overweight (47.5% male, 20.0% female vs 52.9/35.6% GP). Frequency of exercise and fruit and vegetable consumption was higher than in the GP. About 70% drank coffee or tea more than once a day, but only 13.2% of female and 21.8% of male physicians were current smokers (GP 20.1/30.5%). More than half (56.1%) usually or always counseled a typical patient on exercise vs. lower numbers on nutrition (47.0%), weight (45.8%), smoking (39.9%), and alcohol (30.0%). Except hemoccult testing (that increased with age) there were no significant differences in personal health practices related to years of professional practice. There was also no difference in counseling practice related to professional years. Doctors with better personal exercise, nutrition, smoking, and alcohol behaviors counseled their patients significantly more-often on related topics. Conclusions: These German physicians reported better physical health and health behaviors than the GP. However, there is room for improvement (smoking, overweight), which could be expected to positively influence the counseling practice and impact of doctors’ role modeling on patients.

247 POSTER
Teaching about physician health in a transitional era of partly-digitized, largely-globalized and still-humanized medical education

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Drs Frank and Puddester will explain some educational best-practices from online and traditional education, and talk about their implementation in NextGenU.org and ePhysicianHealth.com, two sites with educational materials for health providers that promote personal health for providers and for their patients. Site presentations will be live, and the last 50 minutes will be spent on discussion of these and other useful tools for teaching about physician health in our permanently transitional educational era. ePhysicianHealth.com is the world’s first comprehensive, online physician health and wellness resource designed to improve resilience for physicians in training and practice, in their personal and their professional lives. It is a product of the mission of this decades-long A-B-CMA International Physician Health meeting and of Canada’s leading physician health and elearning experts. Dr Puddester will talk about this tool and successes and barriers in its use. Dr Frank will present the physician health promotion micro- and macro-curricula being used (as of 2/1/2013) in 103 countries through NextGenU.org, including with a milestone cohort of 10,000 Family Medicine Residents in Sudan. In pilot tests of NextGenU’s emergency medicine course for senior medical students, in two U.S. medical schools, we found that NextGenUsers and traditionally-trained controls performed almost identically on the U.S. national Emergency Medicine test. USUHS students taking NextGenU’s training
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in academic year 2012-2013 (n=167) averaged 80.3% vs. 80.9% for traditionally-trained USUHS students in academic year 2011-2012 (n=163, p=0.4). UMissouri NextGenUsers in academic year 2012-2013 (n=35) averaged 71.2% vs. a national (n=415) 2012-2013 EM test average of 71.4% (p= 0.8). For the NextGenU MPH core Environmental Health course used at Simon Fraser University (in Vancouver, Canada) there were no differences (p=0.72) between NextGenUsers’ and controls’ knowledge scores (88.8% vs. 86.4%), and EH NextGenUsers (n=9) rated 4.7/5 for “overall I would rate this course as excellent”, vs. 3.7 (2012), 4.3 (2011), 4.1 (2010), and 3.9 (2009) for prior years’ traditionally-trained students. And among volunteer Physical Activity Counseling participants in Colombia, NextGenUsers (n=11) learned over twice as much (a 23.9% vs. 9.3% score increase, p=0.07) compared to controls (n=26), and offered positive qualitative feedback. This model should help promote physician and patient health, and addresses the meeting theme at its foundation – how do we transition to maximally benefitting from the knowledge transfer efficiencies of online education, while retaining the humanity that feeds us oxytocin, and makes us better doctors.

MEDICAL STUDENTS

99 ORAL

The transition to medical school: Mental health indicators of matriculating US medical students relative to the general population

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Purpose/Relevance: Existing information about the mental health of matriculating medical students (MMS), relative to age similar controls, is limited, dated and inconsistent. We conducted a multi-center survey study of MMS as well as a probability based sample of the general U.S. population to allow for comparison. Materials and methods: In 2012 all MMS at 6 U.S. medical schools were invited to participate in a survey via an e-mail link or to complete a paper survey. We also surveyed a probability-based sample of US individuals using the same questions in 2011. Individuals from the population sample who completed a 4-year college were used for comparison to MMS after stratification by age. Surveys included 2 validated items from the Maslach Burnout Inventory, the Prime-MD, and Linear Analogue Scales Assessment to measure burnout, symptoms of depression, and mental, emotional, physical, overall of quality of life (QOL), respectively, as well as demographics. Institutional Review Boards at each medical school approved the medical student study and the Mayo Clinic IRB approved the population study. Results: Demographic characteristics of the 582/938 (62%) responding MMS was similar to U.S. MMS overall. Relative to 546 age similar college graduates, MMS were more likely to be male and single and less likely to be white non-Hispanic or have children (all p<0.0001). MMS had lower rates of burnout (27.3% vs. 37.3%, p<0.001) and symptoms of depression (26.2% vs. 42.4%, p<0.0001) and had higher QOL scores across all domains relative to controls (all p<0.0001). These findings persisted on multivariate analysis adjusting for age, sex, relationship status, and race/ethnicity. Discussion: At matriculation, medical students have lower distress and better QOL than age matched college graduates. In contrast, previous studies suggest medical students, residents, and practicing physicians have greater distress than the general population.1,2 These results suggest that the process of training and practice environment contribute to the deterioration of mental health in developing physicians (i.e. a “nurture” rather than a “nature” problem). While helping medical students and physicians develop coping skills may be useful, these findings suggest efforts to improve the mental health of the healthcare workforce must include changes to the training process and practice environment. 1. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. Arch Intern Med. 2012 8; 172(18):1377-85. 2. Burnout among US medical students, residents, and early career physicians relative to the general US population. Acad Med, 89(3):443-51, 2014 Mar.
Mental health in medical students: exploring the relationship of mental ill health to wellbeing, course structure and year of study in two UK medical schools

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Purpose: If we are to support medical students effectively, we must know the extent of mental health problems (MHP), and understand potential triggers and predictors of MHP and their relationship to course structure and design. Our aims were (a) to measure levels of wellbeing and MHP in UK medical students and (b) investigate factors that precipitate and perpetuate MHP, obstacles and enablers to seeking support and the relationship between MHP, wellbeing and course structure. We also sought to identify whether specific transitional periods are related to an increase in MHP. Methods: This mixed method study investigated MHP and wellbeing in medical students across all year groups in two UK medical schools over two time periods. An anonymous questionnaire was developed using a risk assessment tool to help UK medical schools to reduce barriers to seeking support and recognise areas for more effective support. One area for consideration is whether students at different times during their training perceive areas of high risk to be different. This is an area that requires consideration if early intervention to mitigate for risk are to be effective. Results: Preliminary results from the study will start to unravel the differences between year groups and provide a clearer picture on how to support those early transitions more effectively.

Healthy Students: Healthy Doctors – medical students’ perspectives on factors that impact their wellbeing during training

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Purpose: Medical students have a higher incidence of common mental health problems than the general population. The aims of this study were to gain medical students’ perspectives of factors that impact on their health, wellbeing and performance during training and to develop a screening tool to help UK medical schools to reduce barriers to seeking support and recognise areas for more effective support. One area for consideration is whether students at different times during their training perceive areas of high risk to be different. This is an area that requires consideration if early intervention to mitigate for risk are to be effective. Methods: A mixed method study across UK medical schools took place in 2012. A questionnaire was developed using a risk assessment model (D.E.T.T.O.L.) that explores the ‘impact of work on health’. D.E.T.T.O.L stands for Demands, Environment, Time, Travel, Organisation and Layout. Focus groups across all year groups were conducted and thematically analysed. Multi level modelling was employed to analyse the questionnaire data. Results: 2,735 questionnaire responses were received, equating to approximately 6.7% of the total UK medical school population. Analysis confirmed this was a representative sample. The questionnaire was analysed across eight ‘domains’ that together encompassed the various aspects of studying medicine: work-life balance, safety, culture, acquisition of
knowledge and skills, perceived support for academic issues, perceived support for health/personal reasons, demands of the course, and travel and orientation. Results showed that all medical schools that participated function well in some areas, e.g. facilitating the acquisition of knowledge and skills, and much less well in others, e.g. ‘travel and orientation’. Areas of high risk varied across the year groups. The results also suggested that the biggest gain in wellbeing could be achieved through the domain of ‘culture’. Focus groups provided insight into students’ views on potential solutions to factors impacting on their wellbeing. **Discussion:** The major findings from this study were that the questionnaire ‘Cardiff Medical School Wellbeing Questionnaire’ designed has validity. The study enabled the development of a tool to assist medical schools to review key areas of risk and provide opportunities to learn from other schools’ experiences and best practice. The presentation will explore the data across year groups, differing styles of training and modeling to explore wellbeing through both qualitative and quantitative data.

142 ORAL

Maintaining balance when the earth is moving (Identification of at risk medical students following a major disaster and what may assist)

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September 2010 a 7.1 earthquake struck Christchurch, New Zealand followed in February 2011 by a massive shallow 6.3 aftershock which resulted in loss of life, major damage to the city and closure of the 7 floor medical school and a number of hospital wards. Over 10,000 aftershocks occurred in the year following. Despite this, all teaching and learning did continue with our medical students. Indeed, the 5th years had to sit a major common exam at the same time as their peers who had not experienced earthquakes as they were placed in Wellington and Dunedin. We decided to explore the effect of the disaster on the medical students and try to identify predictors of adverse psychological functioning and/or resilience via a quantitative and qualitative survey. We also wanted to understand what staff could’ve done to improve things for our students. Whilst this study is unique in that it followed a natural disaster, parallels may well exist when considering the effects of other major life events or traumas occurring for medical students. A questionnaire was completed on line by 78% of 4th 5th and 6th year students (ie 198/253) about 7 months following the major February quake. It included the Depression, Anxiety and Stress Scale, the Post Traumatic Stress Disorder checklist, the Eysenck Personality Questionnaire, the Connor Davidson Resilience Scale, the Work and Adjustment Scale. Likert scales assessing psychological functioning at worst and currently, and free text questions including what would have helped the students manage their learning. When results were analysed a substantial minority of students experienced moderate to extreme difficulties. Some groupings most at risk emerged, those 5th years who were having to cope with pressure of major examinations, those with a history of mental health problems, students not from the most common ethnic group (especially international students) and students with a high rate of neuroticism. The presenter will discuss the results and highlight the practical difficulties in identifying and assisting the at risk groups.

258 POSTER

Evaluating current techniques used to practically prepare final year medical students for becoming Foundation Year 1 doctors (FY1s)

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**Introduction:** Recent years have seen a variety of different initiatives being implemented to help improve the transition of final year medical students to life as a junior doctor. These include the Situational Judgement Test (SJT), trust wide induction programmes and prescribing skills exams. This study is an attempt to identify how successful these various measures have been. **Methods:** All final year students from a medical school in London and all Foundation Year 1 (FY1) doctors from the North East Thames deanery in London were invited to complete an online-based questionnaire via email and social media i.e. Facebook and Twitter. Students rated each of their responses on a 5-point scale. **Results:** A total of 100 individuals responded to the survey, out of whom 52% were final year medical students. Large differences were seen when assessing how many felt reasonably or very confident with presenting patients on a ward round (18% vs 79%, students vs FY1s), doing an on-call (13% vs 63%, students vs FY1s) and with their prescribing skills (9% vs 69%, students vs
FY1s). Smaller disparities were seen when comparing overall confidence levels (19% vs 24%, students vs FY1s), how many believed their medical school had given them a reasonable amount of future career guidance (6% vs 24%, students vs FY1s), felt reasonably confident with their communication skills (63% vs 84%, students vs FY1s) and theoretical knowledge (27% vs 42%, students vs FY1s) and reported that the SJTs had made them reasonably more confident for being an FY1 (9% vs 6%, students vs FY1s). 24% of FY1s believed that their induction day sufficiently helped them for being an FY1, with 12% reporting additional formal support thereafter. Discussion: Together, the data show that there is still sufficient scope to improve the current tools that are in place to practically prepare medical students for being an FY1 and to maintain and improve the standards at which current junior doctors are practising. These could include presentation skill courses, simulation courses for performing on-calls and a buddy system where each final year medical student is tied to an FY1 or senior house officer for a period of time. An induction course run by former junior doctors could also be organised, focusing particularly on what is expected of FY1s to be able to do, what is beyond their expertise and how best to deal with the practical aspects of the job.

58  POSTER
The Veterinary Transition Study: investigating the transition from veterinary student to practising veterinary surgeon: prospective cohort study

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Purpose: To investigate the transition from veterinary student to practising veterinary surgeon. Context/relevance: The veterinary profession has a suicide rate among the highest of all professional groups and three times that of the general population (Platt et al., 2010 and others). Recent studies of suicidal behaviour and mental health in vets have identified potential occupational stressors in veterinary working life which may contribute to risk and may be common with medics. Certain subgroups of veterinarians have been identified as being more likely to suffer difficulties of wellbeing. Female vets, younger vets and lone workers are at increased risk of suicidal thoughts, mental health difficulties and stress (Platt et al., 2012b). The time of transition to practice has been observed as a time of particularly poor wellbeing in veterinary working life. Among vets with experience of suicidal ideation or behavior, half report their first experience of suicidal ideation occurred at veterinary school or shortly after graduating (Platt et al., 2012a).

Methods: This poster presents the Veterinary Transition study, a prospective cohort study investigating the transition from veterinary student to practising veterinary surgeon. This is a longitudinal qualitative study utilising in depth interviews and following individuals over time. Study discussion: The study explores the ways in which veterinary student and new graduate vets’ expectations of veterinary work and support at work differ from their experiences, and examines the ways in which these expectations and experiences affect mental health and wellbeing. It aims to discover what factors are most salient in protecting individual mental health and wellbeing during the transition to veterinary practice, and will also consider the associations between career choice and wellbeing in veterinary students and new graduate veterinary surgeons.


194  POSTER
Reflecting on Character Strengths to Inspire the Development of Self-Awareness at Medical School Orientation

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Introduction: Motivating the acquisition of self-awareness can be a challenge both for medical educators and for those who assist physicians to improve their health. As they begin their medical training, many learners are focused on achieving the acquisition of external facts. This study reports preliminary findings from an educational intervention to improve learner motivation toward the acquisition of self-awareness, a key component of sustainable mental health. Methods: At orientation, entering medical students were asked to reflect individually on a list of character strengths, choosing priorities from the perspectives of self, colleague and patient. The anonymous data are tabulated and reflected back to students in a lecture format. Results: The priority that entering students attach to particular character strengths shows consistent variance with the perspective they are asked to assume. Discussion: The pattern of variance with assumed perspective is interpreted through the lens of basic psychological needs theory, a component of Self-Determination Theory.
Milestones and Transitions – Maintaining the Balance – Abstracts

Mental health and transition through medical school: online support

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Relevance: In 2012 a lecture on mental wellbeing was introduced at the start of the undergraduate medical course at the University of Dundee. The most common comment in the feedback was surprise at how common mental health problems are in medical students. Some students said that they didn’t know it was possible for someone with a mental illness to become a doctor. There is a plethora of available information about mental health but we believe that medical students need information tailored to their needs both when commencing medical school and when making the gradual transition into being a clinician with the responsibility to protect patients from risk caused by their health problems and use their adverse experiences to improve the care they provide. Methods: Medical Students’ Mental Health (www.medstudentmentalhealth.wordpress.com) was created on Wordpress to allow open access. The site provides emergency contacts, a wide range of resources for medical students who have a mental illness, resources for students supporting a friend, general advice on looking after your mental health and personal stories from medical students and doctors with mental health problems. In April 2013 the site was shared with University of Dundee medical students, teaching leads and psychiatry teachers. It was also publicised via the @DundeePsychr Twitter page, university Facebook pages and www.doctors.net.uk. We created linked Twitter (@medschoolMH) and Facebook (https://www.facebook.com/medstudentmentalhealth) pages recently. Results: Medical Students’ Mental Health has had 6,189 page views so far. We have received overwhelmingly positive informal feedback. The site was created for local medical students but it is being used by medical students from elsewhere, doctors and others who are interested in mental health. We have had particularly encouraging comments about the personal stories, with many site users stating that they are reassured that it will be possible to transition to the next phase of their career despite their health problems. The main purpose of the site will always be to support our local students but we are aware of it being put to a number of other uses we are delighted for it to be used in any way that helps to support people with mental health problems. Development of the Facebook and Twitter pages will depend on their success and how students use them. We may also explore other forms of social media. We also plan to provide resources for university staff and consider information for potential university applicants.

The competitive nature of medical students

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Purpose: Medical schools often select prospective students based on academic achievement and interview appeal. Once accepted and inhabiting their new environment, students tend to adopt particular attitudes and behaviours. Of note is the emerging and significant issue of competitiveness. Examples of competitive behaviour are frequently depicted in medically-related literature, art and film. These varied sources and unpublished anecdotes.

Materials and Methods: Sources of fictional and nonfictional accounts of medical school culture were explored with the aim of understanding why some students become competitive, and what effect (if any) this has on medical education. These sources include relevant art, film, literature, and both published and unpublished anecdotes. Results: The reviewed sources identified competition as neither categorically detrimental nor beneficial. Competition seemed to arise due to a variety of factors such as academically oriented personalities, rigorous university entry requirements and the foundation job ranking system. Although sometimes ruthless and unpleasant, competitive behaviour was in many accounts an important and strengthening element of social interaction. Conclusion: Competing generates enthusiasm and is a powerful drive towards accomplishment. It is a catalyst for personal growth, either relative to previous individual performance or by trying to outdo others. Educational establishments must recognise such behaviour and ensure that the learning environment is one that benefits most, if not all, students. However, competitiveness is not without its faults as vulnerable students may feel defeated and disillusioned. Regardless, students should be encouraged to participate in order to challenge themselves and learn from
their experiences. Society may not need doctors who will go to any lengths to be the best, but will certainly benefit from doctors who will work hard to deliver the best healthcare.

95 POSTER
Impact of medical education on student wellbeing

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Background/Goals: Medical school is characterized by multiple challenges to student wellbeing. Although students are typically healthy when they begin medical school, many experience significant changes in lifestyle over the course of their studies. Through a survey administered to medical students during the first year of medical school and again at the end of the third year, we attempted to quantify the impact of medical education on overall student wellbeing. Methods: A wellness survey including standardized questions on diet and lifestyle, as well as validated measures of stress (Perceived Stress Scale) and depression (CES-D) was administered to the Albert Einstein College of Medicine Class of 2014 during the first semester of their MS-1 year and again at the end of their MS-3 year. Statistical tests were run comparing the survey responses of the students in their first and third years. Because no identifiers were included in the surveys, the groups were treated as being independent rather than paired. Chi-square tests were conducted for all categorical items, and t-tests were conducted for all numeric items. Results: The charts below provide a brief summary of the questions on the wellness survey, which showed a statistically significant difference from the MS-1 to the MS-3 year. The survey was a required component of the students' coursework, and hence the response rate was over 98%. Overall, students in their third year of medical school had less time to exercise as compared to their first year, and they were more likely to eat certain foods to cope with stress. Although the overall scores on the CES-D depression measure did not change significantly, there were significant changes on a number of individual items, which may reflect the emotional stress of third year. This data was presented to the class as part of a session on balance and professionalism. Conclusion/Implications: Student well-being declines during medical education. Presenting medical students with data on their own personal wellness can provide a springboard for discussion on the topic of work/life balance, and hopefully begin to teach a life-long process of reflection on the ongoing challenge of finding physical, emotional, spiritual and psychological balance when confronting the demands of a medical career.

89 POSTER
An analysis of referrals to a medical student support service at Cardiff University: the importance of effective triage

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Aims and Introduction: The provision of support for medical students is an area of growing concern in the UK and internationally. The Student Support Unit (SSU) provides support for medical students at Cardiff University, Wales, UK who are struggling with health, personal or performance issues. Students may be referred or self refer to the SSU, which then signposts or refers the student to appropriate services and monitors their progress. The aim of this study was to review referral data to the SSU, to understand the needs of differing year groups, in particular transitional years, to improve support to students and highlight areas for training and development. Methods and results: This presentation will report on referrals to the SSU between October 2011 and February 2014. Reasons for referral were identified and recorded along with the issues identified at triage. Results from analysis of the first 16 months (69 cases) showed a discrepancy between the information provided at referral and the information gained at triage. A majority of students were referred primarily for educational reasons commonly exam failure. However in the clinical years wider educational issues were identified (e.g study skills, time management) alongside personal and social issues. 54% of year 1 students claimed that social isolation had been an important factor leading to their referral compared to 10% in year 3, and 0% in final year. Mental ill health was noted in 22% of referral data but raised as an important contributory factor in 60% of triage data. Preliminary analysis from cases referred during the current academic year Sept 2013 – January 2014 showed that for the preclinical years reasons for referral
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included personal issues (48%), academic issues (35%) and health issues (65%). For the clinical years the corresponding reasons for referral were (74%), (32%) and (53%).

Conclusion: Medical students like doctors often face multiple issues that can impact on their health, performance and wellbeing. Understanding how these issues impact on students at differing times in their training is important if institutions are to provide effective and robust means of support. This paper will describe the differences between reasons for referral at key transitions, the discrepancies between referral and triage data and new systems in place to improve access and services for students since its inception.

152 POSTER
Recognising and reducing stress in the transition from medical student to foundation trainee

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Purpose: The aim of the research is to evaluate the impact of an education programme and support for foundation year (FY) doctors, consisting of a workshop and follow-up small group work. These sessions were aimed to provide practical skills and strategies to enhance resilience and well-being, and to lessen stress in the transition from medical school to clinical practice at FY1. Existing research with junior doctors highlights this transition period as a time of stress and identifies areas of practice where trainees can feel less well-prepared.

Methods: Participants attended a workshop developed from the SAFEMED programme of education (Dr Margaret O’Rourke, University College Cork) followed up by facilitated small group sessions run by a FY2 ‘near peer.’ The sessions aimed to develop the workshop content and focus on particular issues that can impact on their health, performance and especially high stress situations. It has been reported that medical students present with higher levels of stress when compared with other people of the same age in other programs. However, maintaining a physically active lifestyle through this process increases the probability of physical activity becoming a sustainable outlet for stress. My main objective is to see if there is a correlation between physical activity and perceived stress among medical students at Memorial Medical School in St John’s, Newfoundland, Canada?

Purpose/Relevance: Physical activity plays a major role in prevention of chronic diseases like type two diabetes, hypertension, and cardiovascular disease. It has been shown to improved mental health by reducing depression, anxiety, and anger. These words of wisdom are not only important for patients but also for the people advising them. The road to finishing a medical education is filled with long hours and especially high stress situations. It has been reported that medical students present with higher levels of stress when compared with other people of the same age in other programs. However, maintaining a physically active lifestyle through this process increases the probability of physical activity becoming a sustainable outlet for stress. My main objective is to see if there is a correlation between physical activity and perceived stress among medical students at Memorial Medical School in St John’s, Newfoundland, Canada. Hopefully from the results of this study, the Wellness Committee at Memorial can find innovative ways for making physical activity sustainable among its population and thus helping its students better cope with stress.

Materials and Methods: There are currently 275 medical students enrolled at Memorial. By using two well-known questionnaires to measure physical activity (International Physical Activity Questionnaire)
and perceived stress (Perceived Stress Scale), each student will be asked to complete a survey on SurveyMonkey. Both tests will be analyzed to see if there is any correlation between physical activity and perceived stress. Comparisons will also be made by gender, and by year of study. A small set of qualitative questions will also be used to identify what factors prevent or motivate students to incorporate physical activity into their lifestyle. **Results:** A 74% response rate was obtained from all four years of study at Memorial Medical School. Although there was no significant linear relationship between amount of physical activity and level of perceived stress (p > 0.765), some interesting results were obtained. Using an ANOVA test, female medical students were found to have significantly higher stress levels than the male medical students in the study (p > 0.0001). We also assessed students’ changes in level of physical activity since starting medical school. There was a significantly lower perceived stress in the groups who stated their physical activity had increased (p > 0.029) or remained the same (p > 0.002) compared to those who had decreased their physical activity levels. Only 42% of students were happy with their current level of physical activity and 77% of the population responded that they thought exercising more could decrease their stress levels. Thematic analysis of barriers and motivators students faced in regards to exercising on a regular basis was also performed. The major motivators for students to exercise included for their overall health, maintaining their pre-existing fitness schedules, for mental wellness, to maintain their energy levels and to be role models for their patients. The major barriers students faced included time restraints due to school and personal commitments, school responsibilities, compulsion to study incessantly, and lack of energy or motivation. **Discussion/Conclusion:** There was no direct negative correlation found between the amount of physical activity a student participates in and their level of perceived stress. However, a decline in student’s individual level of physical activity increases his or her perceived stress level. The fundamental knowledge that exercising on a regular basis can reduce your stress level was observed in the majority of the students. Unfortunately, there are barriers that students face that prevent turning this knowledge into action. We identified certain barriers that may be more manageable so that students can find more time in their schedule to enjoy whatever modality of physical activity they enjoy. The results of this study are actively being assessed by the Student Wellness Committee at Memorial Medical School to assist students in stress management. **Funding:** Funding for this project was provided by the “Studentship in Medical Student and Physician Wellness” at Memorial Medical School in St. John’s, Newfoundland, Canada.
in four medical students, yet only one third of those affected receive help. The provision of mental health assessment and help in most medical schools is absent or limited. This applies not only to India but in other parts of the world including UK and USA. A timely support and help can make a huge difference in their well-being and future career.

244 POSTER
A retrospective, cross-sectional study of foundation doctors self-reported mental health experiences during medical school and effect on career choice

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Background: Mental health problems (MHP) are prevalent amongst medical students and qualified doctors. However, whether MHP prior to and during medical school persist to qualification and impact career choice, or service delivery is unknown. Aims: 1. Assess prevalence of MHP amongst medical students, and whether they persist into postgraduate training; 2. Investigate strategies employed by medical students and medical schools to tackle MHP. 3. Evaluate whether MHP influence clinical practice and career choice.

Method: Retrospective, cross-sectional study of foundation doctors (FYs) working within North East Thames Foundation School (NETFS) in 2012. FYs were invited to participate in an anonymous electronic survey by email. The study was approved by the Research and Development committee at Whipps Cross University Hospital, but did not require NRES approval.

Results and discussion: 126 (18%) FYs responded to the survey in whole or in part. MHP were present prior to (15%, n=7/110) and during (34%, n=37/107) medical school, and post qualification (19%, n=18/94). NETFS was aware of 6 FYs with MHP from this cohort. Pre-entry MHP were a risk factor for MHP during medical school (RR=3.6, P<0.0001). There was no difference in the academic progression of the respondents who sought help from the medical school, compared with other coping strategies. Prior MHP only accounted for 50% of postgraduate MHP but were a strong risk factor for them (pre-entry RR 4.53, p = 0.0005; medical school RR 6.78; p<0.0001). Amongst FYs, MHP were commonly self-diagnosed and self-managed. Only 4 respondents with postgraduate MHP had time out of training or sick-leave. The most common specialty intention of all respondents was Core Medical Training (CMT) however Acute Care Common Stem (ACCS) was highly represented amongst respondents with current or prior MHP. Current MHP with anxiety (RR 5.6, p = 0.0128) or depressive (RR 4.1, p=0.024) symptoms were particularly associated with an intention to apply for ACCS at ST1. Conclusions: MHP are prevalent amongst medical students and FYs with varied coping strategies employed. Seeking help from the medical school was not associated with altered career progression compared with other assistance, however this study only captured responses from those who had qualified and were working within NETFS. Reluctance to declare and self-management of MHP remains a problem amongst FYs. Despite the notion that MHP may influence career choice to lower-intensity specialties, ACCS was a common career choice amongst respondents with current or prior MHP.

PARENTHOOD

191 WORKSHOP
Doctors as parents; exploring the challenges and finding solutions, to support doctors in their transition to parenthood

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Aim: To cover the key issues relating to doctors who become mothers and fathers, mainly but not exclusively, for the first-time. Introduction: 10 minutes - an outline will be given of the challenges and practical issues for parents who are doctors; such as the need for pregnant doctors to maintain their well-being and safety in clinical situations. The psycho-dynamic factors will be described that affect the interface with other health professionals during antenatal care, birth and early parenthood when one or both parents are doctors. An outline will be given of mental health issues and mental health services for pregnant women and new mothers in the UK. Table discussions: 30 minutes – small groups. Scenarios will be used to promote discussions. Participants will be encouraged to identify relevant issues and to offer solutions
which will be recorded on flip charts for presentation to the whole group. Each group will discuss one of the topics below: Coping during pregnancy with tips for new mothers, with recommendations for Employers in Healthcare settings to make a proposal for an International Charter to support doctors who are parents. Identify demands associated with parenting a new baby, from the perspective of a mother or father, who is a full-time or part-time doctor identifying the support needed, especially if the doctor becomes unwell mentally or physically. Choices and challenges facing the parents of a young infant. Delegates will be encouraged to discuss various options for work and childcare, possible effects on a doctor's career and potential effects on the infant. Participants will be encouraged to suggest what information could benefit new parents returning to work or taking a career break.

Feedback session: 40 minutes - for all groups to feedback. Summary of key recommendations: 10 minutes - by facilitators.

Outcomes: Recommendations will be used to write a proposal for an international charter for parents who are doctors, an information booklet for new 'doctor' parents, to may be used to enhance the BMA webpages, and could form the basis for participants to start an on-line support group for new parents who are doctors. A handout will be provided with information about support services, about part-time working, taking career breaks, with research references. Presenters: For 5 years, the two lead presenters have run interactive workshops, on behalf of the Psychiatrists Support Service, at the International Congress of the Royal College of Psychiatrists, receiving excellent feedback.

Pregnancy planning in Anaesthesia

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Pregnancy can be an uncertain time in a prospective mother’s career. 48% of anaesthesia trainees registered in the UK are female [1] No study has proven a detrimental effect on mother or foetus of long working hours or night shift work [2]. Working patterns and individual experience of pregnancy vary. There is no NHS policy regarding how long to remain working on-call commitments. This is inclusive but may lead to uncertainty in prospective mothers unsure how pregnancy will affect their ability to work safely. It may also lead to staffing issues should on-call duties be stopped at short notice. Methods: An electronic survey was sent to female trainees in five London schools of anaesthesia known to have been pregnant within the last five years. Return rate was 97%.

Results: Data was collected on 53 experiences of pregnancy. Most respondents were pregnant as senior trainees and provided on-call cover for all anaesthetic subspecialties and intensive care. The median gestation at which respondents stopped daytime on-call work was 32.5 weeks (IQR [30-36]). The median gestation at which respondents stopped night duties was 30 weeks (IQR [28-32]). Trainees own concern about tiredness and ability to concentrate and physical difficulty in carrying out practical tasks were important considerations when stopping on-call duties. Rest facilities on-call ranged from the availability of a bed to improvised solutions with chairs. Discussion: On-call work in anaesthesia can be physically and mentally demanding. Senior trainees have a significant level of responsibility in life threatening emergencies. We have a duty to our patients to provide the highest standard of care and to look after ourselves and colleagues. This survey confirms that decisions around stopping on-call duties vary but demonstrates that from experience working on-call whilst pregnant many anaesthetic trainees choose to stop daytime on-call at 33 weeks and night shifts at 30 weeks. At these gestations factors which impact upon patient safety become of concern. The majority of respondents felt supported by their departments. The results of this survey reflect first hand experience and could be used to assist trainees and supervisors to make decisions when planning on-call commitments during pregnancy.

How can peer counselling contribute to doctors’ wellbeing, performance and resilience? A qualitative study

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Background: Organized peer counselling is readily accessible for doctors in Norway. The service aims to help doctors cope with different work- and private life situations, enhancing wellbeing, performance and resilience. Through the present study we wanted to define and evaluate this service. Methods: We conducted 14 semi-structured focus group interviews with peer counsellors (61 participants, 50% women). The transcribed interviews were analysed by systematic categorization and text condensation with a modification of Giorgi’s phenomenological approach. Based on the results from the first analyses the data were re-analysed according to a theory of formal and informal “institutions” (March and Olsen 1989, 2006). Results: Three emerging themes were: (1) Counselling is important as a readily accessible “emergency service” for doctors outside formal medical treatment. (2) Counselling was perceived as a contribution to a gradual change in medical culture towards the possibility of seeking help: “you don’t need to cope alone”. The peer counsellors describe their way of meeting and addressing colleagues as a more “sensible” medical culture, slowly gaining ground. (3) Doctors seek peer counselling for many different reasons. The counsellors are thus expected to master a diversity of helping roles. They need to balance between an informal role as a good colleague and listener to more formal roles of assessing and handling the risk of suicide or giving advice in relation to litigation. A continuous awareness and discussion about informal and formal aspects of peer counselling as an institution seems to be necessary to meet the needs of help-seeking doctors adequately. Conclusions: Experiencing the benefits of a readily accessible counselling service can change the professional culture among doctors towards seeking help when in need, contributing to an enhancement of doctors’ wellbeing, performance and resilience. To meet diverse and changing needs of help-seeking doctors, an awareness and continuing discussion is needed about the balance between informal and formal sides of the “counselling institution”.

201 ORAL
Peer mentoring to support Academic Foundation Programme trainees

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Background: The Foundation Programme is a two-year scheme introducing newly qualified medical graduates to a range of disciplines. The Academic Foundation Programme (AFP) is an opportunity for junior doctors to sample academic medicine before committing to an academic career path. (1) Since 2005, The University of Leicester has supported 26 trainees through an AFP in Paediatrics. In contrast to most AFP, Leicester does not focus on specific projects. Rather, the emphasis is on development of the academic competencies (2) and allowing trainees to explore a wide range of academic disciplines allied to child health. Trainees have thus developed interests in medical education, social science, and epidemiology, as well as more traditional lab-based research. Whilst providing a wide-range of opportunities for trainees, this less-structured approach has proved challenging for some. Trainees have struggled to determine their own learning goals and set objectives for the year. The aim was to find a solution which maintained the flexibility of the current programme whilst supporting trainees to develop as independent researchers. Intervention: A peer-mentoring project was established in order to support junior trainees. Peer mentoring has been successfully introduced for clinical trainees in a variety of specialities, and is a popular means of providing support. (3) Hosted by senior academic paediatric trainees, the scheme uses three approaches to support juniors: Face-to-face meetings are held on a monthly basis. Trainees can develop presentation skills in a supportive environment, as well as sharing their experiences and advice. Social media is used to keep in contact with trainees on busy rotations, allowing rapid dissemination of information of relevant information such as publications, courses, and conferences. Written information is compiled by trainees, offering information about the research and educational opportunities available at Leicester. Practical tips are also provided on choosing a project, working with an academic supervisor, and recording academic achievements in the eportfolio. Future Steps: Feedback from current FTP trainees indicates that they find this programme useful. A survey of past trainees is being undertaken to...
further uncover areas of difficulty in the AFP. **Discussion & Conclusions:** This approach uses mentoring to provide Foundation Trainees with a source of both peer support, and practical information to allow them to begin the transition to becoming independent researchers. (4) Future steps include formal evaluation from current trainees on a yearly basis to ensure that the programme continues to meet their needs.


169 **POSTER**

**Physician mentorship: design of a comprehensive program to support physicians**

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**Background:** The Cleveland Clinic Mentorship Program began in 2008 to address faculty members’ developmental needs throughout their career. At the time, physician turnover was higher than the national average. A survey of retained physicians identified lack of mentorship as an important unmet need. National data suggest that mentorship increases retention and productivity, as well as improves career satisfaction. **Purpose:** This presentation will describe our innovative mentorship program that teaches mentorship skills and provides a supportive environment to guide faculty in clarifying and achieving personal and professional goals. **Methods:** The Program was designed to develop future leaders, improve retention, increase job satisfaction, and reduce turnover costs. Eight critical factors (eg voluntary matching, mentor training, support from leadership) necessary to ensure a successful program were identified. A unique, three-tiered program structure, of Coach-Mentor-Mentee was developed. The coach and the mentee form a partnership to focus on the mentee’s overall career development. The coach can refer mentees to one or more mentors who are content experts, for time-limited help. A mandatory faculty development class explains the three roles of coach, mentee, and mentor and provides initial training in mentoring skills. After reviewing coaches’ bio-sketches, mentees interview prospective coaches and make a selection. **Results:** To date, we have delivered 15 Program orientation courses with 293 attendees since 2009. A total of 222 (76%) participants elected to join the Program thereafter. Currently, 190 members participate 118 (62%) females, 65 (34%) coaches, 55 (29%) mentors, and 141 (74%) mentees. Over one-third of members serve in multiple roles. There are 73 matched coach-mentee pairs. Faculty from all institutes within the organization are represented, acknowledging the need for mentorship across disciplines. A 2013 survey of Program participants revealed that 95% of mentees received valuable assistance from their Coach. Coaches provided the most assistance with networking and resource referrals. Coaches reported that the most frequent mentor referrals were to Education and Leadership Development mentors. Most requested professional development topics include time management, mentoring scenarios, tips for mentoring and coaching and conflict resolution. **Conclusion:** Mentorship Program participants are highly satisfied with this sustained, comprehensive mentorship program. We believe this is due to our unique coach-mentor-mentee structure, the focus on all participants along the career continuum, and the facilitated “self” matching. A multidisciplinary program may enhance physician retention and improve engagement. We believe that all professionals can benefit from mentoring throughout their professional careers.
PHYSICIAN HEALTH SERVICES

107 WORKSHOP Developing Professional Support: the challenges and opportunities in caring for medical professionals

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Goals/learning objectives
• To analyse evidence for effectiveness for doctors and the health service of educational programmes in communication issues and cultural change
• To analyse the effects on physician emotional health and resilience and implications for support for wider professionals
• To inform future educational and support strategies in changing times and populations, clinical and patient.

The Professional Support Unit (PSU) for London offers tailored educational programmes to address the learning needs of clinicians working in the diversity of the capital. Such support is offered in order to improve patient safety and quality of care while sustaining the workforce. It is sought by doctors in times of transition: to new career stages, those moving into leadership of clinical teams as new consultants or GP partners or on Clinical Commissioning Groups, changing roles or considering career or work/life balance changes, or are returning to work after a gap caused by such as illness or carer responsibilities or employment difficulties. Doctors may also be responding to patient, colleague or supervisor feedback or may have been advised to attend educational programmes addressing needs identified during appraisal or through patient complaints to the service.

A number of these doctors have been trained internationally and are managing a move to a new country where English is not their first language, and to a city where most doctors have a different first language to many of their patients. Patient and cultural expectations are variable and changing fast while the UK health service is undergoing major transformation. Clinical leaders are increasingly accessing PSU programmes so that they can in turn support their colleagues to deal with such upheavals; managers encourage this. Doctors can also access one to one and wider support through the PSU, including careers advice, mentoring, confidential counselling and faculty development, to supplement individual educational support and vice-versa.

We have been developing such programmes for over ten years, particularly in work addressing communication issues and also for a cohort of doctors specifically supported in induction or return to the UK health service. During our initial learning needs review, clinicians discuss the challenges and tensions arising from their transitions and changes and the effects. Learning scenarios are bespoke, learner-driven, with feedback informed by patient experience. They explore working with patients, families and colleagues more collaboratively, to share decisions, care and responsibilities appropriately.

Evaluation of current programmes through survey and interview shows benefits relating to participants’ emotional well-being and personal resilience. Summary revisiting of evidence from past programmes including external review of present work will be presented for discussion to understand further what is helpful and how. Reconsideration will inform future strategy for opening the programmes to multi-professional groups as service development and learning in London becomes increasingly interprofessional.

41 ORAL Physician wellbeing strategy for the Royal College of Physicians of Ireland

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Background: The Royal College of Physicians of Ireland (RCPI), with its Faculties and Institute, provides postgraduate medical training and professional development opportunities to doctors working in 25 specialties. Collectively, we are the largest provider of postgraduate medical training in Ireland. Strong links between well-being, compassion and patient care have already been established. The need for a comprehensive well-being strategy was highlighted through a number of different sources. There were internal and external reactions to media reports of poor mental and physical health, including self-harm, amongst doctors. The Irish Medical Council recent recommendations, following an evaluation of all postgraduate bodies included the following comments: “Support and supervision of trainees was perceived as being less effective and this situation was affecting morale amongst trainees. In addition, the trainees identified scope for improvement in the level of career guidance on offer”. “There are a number of other mechanisms to solicit trainee feedback in place during training, these include annual trainee survey, confidential feedback forms as part of…trainee engagement...”.

It is...
The College identified potential gaps including:
- The lack of well-being guidelines outlining roles and responsibilities of the College and its stakeholders
- Lack of sense of College identity and belonging including clubs and societies, social events, and a place to turn to for support, particularly amongst trainees
- Need for educational interventions assisting trainers and leaders with a focus on identification, management, follow-up and feedback
- The need for trained mentors/counsellors(medics)
- Lack of retirement planning and support.

Summary of results: The College has developed a strategy to minimise these gaps which was submitted to the College’s Council and has been approved and welcomed. Initiatives within this strategy fall into four categories of Policy, Education, Mentorship and RCPI identity. Conclusions: There is an evident need and readiness to engage with well-being activities. Trainees and Trainers alike are acknowledging the need for a comprehensive well-being strategy. There are direct links between doctors’ well-being and patient care which has been documented; however, the College asserts the importance of stakeholders to maintain their well-being for their own sake, first and foremost.

108 ORAL
Action for NHS Workforce Wellbeing

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In response to national reports (such as Boorman, Francis and Berwick) and workforce burnout and satisfaction studies of medical students, GPs and hospital physicians, a group of concerned healthcare professionals led by Dr Chris Manning, set up the Action for NHS Workforce Wellbeing Group in July 2013. This exists currently and primarily as a Basecamp-enabled internet group to enable sharing of work, documents, research, activities, events and thinking, as well as to provide mutual support. There is a face-to-face network of the group that has held two meetings in London (Sept and Dec 2013), with the intention, in due course, of these being set up across the country and probably being held on NHS/GP/Public Estate. To date Dr Chris Manning, and others from the Group representing it, have met with a number of organisations including GMC, BMA, RCGP, RCPsych, IoP, Point of Care Foundation, Work Foundation, Healthwatch, College of Medicine, NHS Alliance, NHS Clinical Commissioners and HEE. Many of the Group are qualified physicians and/or accredited trainers already delivering approved, evaluated and accredited programmes to medical students, GPs and other physicians in academic and clinical settings. Any work that members of the Group develop would be fully evaluated and most, if not all of it, is likely to occur as a result of it being designed for, and delivered in NHS settings. The poster and short presentation will both highlight the purposes and activities of the Group up until conference date and invite people to join the online group so that they can benefit from peer-support and knowledge and expertise sharing and co-develop interventions and programmes. The poster will serve as a hub for constructive conversations, whether people elect to join the Group or not. Conversation outputs will all be used to inform the Group about matters of interest and concern to conference participants to ensure that the Group is assisting as far as possible all those individuals and organisations active in the field of physician health as part of its Strategic Plan which is to: enable collaborative, collated and sustained action for the optimal health and wellbeing of the NHS workforce and physicians as a vital and major element of that.

241 ORAL
Communicating in the capital in the 21st Century: supporting clinicians to achieve collaboration with patients and colleagues for healthier outcomes for all

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The Communication Skills Resources team in the London Professional Support Unit (PSU) offer tailored programmes to address the learning needs of clinicians working in the diversity of the capital, aiming to improve patient safety and quality of care while sustaining the workforce. Clinicians access similarly holistic approaches to professional and personal development through the PSU, including careers advice, coaching and mentoring, psychological counselling and return to practice and induction schemes.

Developed over many years with, now, several hundreds of doctors, our communication programmes continue to attract
doctors and trainees in transition: to new career stages, including moving into leadership or educational roles, or when changing roles, speciality or work/life balance, or returning to work after a gap through illness, carer responsibilities or employment difficulties. Others participate in response to feedback during appraisal or from complaints. Some are international medical graduates managing their move to a new country where English is not their first language, nor the first language of many of their patients.

During learning needs review, participants face the challenges and tensions that obstruct empathy and relationships at work. Patient and wider cultural expectations are changing fast while the UK health service is undergoing major transformation. The health workforce must respond to service delivery change and pressures for quality improvement, whilst embedding safe and compassionate care. During ongoing financial restraints, maintaining morale can falter.

Increasingly, our learning groups are multi-professional and facilitated in the workplace as well as educational venues. Experiential learning scenarios are explored in groups or one-to-one, bespoke to context and individual, informed by patients’ experiences and voices and learner-driven. Encounters focus on cultural awareness and flexibility and reflect on improving workplace communication systems as well as individual skills. Personal feedback from patients and peers stresses working collaboratively with patients, families and colleagues for an uncertain world where shared decision-making, care and responsibilities are flagged. Sessions encourage openness to clinicians’ concerns, autonomy, reflection and creativity, developing self-understanding and response to others, by highlighting personal strengths to make change and plan next steps.

Survey, interview and analysis of learning records illustrate benefits for participants’ confidence, change of perspective and practice, emotional well-being and personal resilience. We discuss how significant shifts in attitude, feeling, behaviour and experience occur despite obstacles, particularly in the context of other support within the PSU, and the implications for future strategy as we promote compassionate care through professional development support for the whole workforce.

202 ORAL
Promoting a healthier medical community: the seven-year experience of two community-based physician wellness programs in British Columbia

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This paper reviews the experience of grassroots physician wellness advocacy in two communities and provides a rationale and model for local physician-run wellness programs. In the two communities, both of which had experienced physician suicides, wellness-focused activities were introduced to connect and support local doctors, promote and educate on physician wellness, and act as an early-detection mechanism for physicians in distress. ‘Lead Physicians’ in each community organized educational and social events, advocated for physician wellness, and provided a connection to expert resources. The communities were similar in population (110,000 and 100,000), number of physicians (130 and 100), and number of acute hospital beds (146 and 125). Modest funding was provided by the Health Authority and Divisions of Family Practice. The Lead Physicians also helped create a small network of like-minded physicians from the province to share support and ideas, connecting through monthly teleconferences.

Methods: To evaluate the impact of seven years of physician wellness activities, Lead Physicians completed written surveys of open-ended questions to describe the program, feedback received about events, their colleagues’ changing attitudes towards physician health, and factors important for successfully introducing community physician wellness programs. Periodic reports generated for Health Authority funding applications were also reviewed. Results: Both communities experienced health promotion activities positively, with increasing acceptance and interest over time. Educational events addressing issues such as burnout, resiliency, and transition and retirement planning were well-received. Social events improved collegiality and goodwill amongst colleagues. Colleagues were seen as looking out for each other. Lead Physicians became ‘go-to’ persons for those colleagues seeking advice or support regarding workplace or personal issues and those with concerns about colleagues. Factors important for the program’s success included having
determined physician leaders who were connected with like-minded colleagues, some administrative support, and modest financial support. **Conclusion:** Physicians who participated in two community-based physician wellness programs felt connected to and supported by their colleagues, key factors in preventing stress and burnout. These two programs developed out of the awareness and passion of a few doctors, without previously established infrastructure or templates, and with minimal funding. This experience can serve as motivator and model for other medical communities wanting to create community support networks.

**264 ORAL**

**The Canadian Physician Health Institute: Transitions and emerging milestones of a program to enhance the health and wellbeing of physicians**

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Physician health and wellness remains a major concern for both the medical profession and healthcare system. The 2008 Canadian Physician Health Study noted several trends; 23% of physicians reported feeling depressed, 33% admitted their work causes stress, and 60% acknowledged that excessive work hours interfered with personal and family interests. In recent decades, the Canadian Medical Association (CMA) and Provincial and Territorial Medical Associations (PTMAs) have invested considerable resources for programs that provide assistance to physicians in need. Although largely successful, there was a sense that more could be offered to complement these services on a national level. As such, the Canadian Physician Health Institute (CPHI) was established as a national program governed by the Canadian Medical Foundation (CMF), the CMA, and the PTMAs in order to increase Canada’s collective capacity to address issues associated with physician mental health. **Purpose/Relevance and Methods:** Approaching the end of its initial mandate, and transitioning into its next phase of existence, reflecting on CPHI’s accomplishments with the greater health community is necessary. Using a holistic case study design (Yin, 2003), with an emphasis on specific milestones and transitional activities, this paper will present how and why CPHI was conceptualized and created, summarize early milestones and associated challenges/success, and outline proposed future transitions and milestones. Multiple data sources will inform the analysis, including documentation reviews (e.g., reports, proposed and evaluated projects) and direct observations (e.g., debriefings with stakeholders and personnel). **Results:** Identified milestones will be addressed, including the establishment of an advisory committee, the development of promotional materials (e.g., website and videos), and the two rounds of special project funding competitions. System-level milestones such as; the formation of the Forum of Canadian Physician Health Programs, design and implementation of national and international conferences and other learning activities, participation in the development of national standards, and development of learning tools and resources will be evaluated and discussed. **Discussion/Conclusions:** Early analysis suggests that ongoing transitions in physician health highlight why it will be critical for CPHI to maintain its momentum through innovation, influence and strategic partnership. CPHI appears to be well positioned to continue making positive steps in its mission of promoting physician health and wellness at the national level – working with and through partners, helping them to connect, share information, and build knowledge.

**46 POSTER**

**Psychiatrists’ Support Service**

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**Introduction:** Psychiatrists’ Support Service (PSS) was launched by the Royal College of Psychiatrists in 2007 to assist doctors who had experienced difficult professional situations such as exclusion from work, mental health problems and disciplinary issues. The Specialist Advisor Lead and doctor advisors (senior members of the College) advise on cases and respond to calls from psychiatrists. The PSS is free, confidential, telephone-only and available to College members. The role of PSS is to support and advise on a range of professional difficulties, to include bullying and harassment, disciplinary issues, exam difficulty (for trainees), exclusion from work, health problems, GMC or NCAS involvement – this is not an exhaustive list. **Method:** PSS Manager verifies the caller is a College member, explains confidentiality, how the service works and what it can and cannot provide. Cases are discussed anonymously and confidentially with the specialist advisor for PSS, who makes a decision about how the doctor is supported. The PSS is unable
to provide: counselling and treatment, financial and legal advice, advice normally given by another organisation such as a medical defence union, the GMC or NCAS. **Discussion:** The PSS has supported over 600 doctors in 5 years, across all grades and specialties of psychiatry. All cases are evaluated (if caller is willing). Here is some of the feedback we have received:

- Very prompt and helpful advice;
- Good response and call back;
- Supportive and helpful;
- Very good. People all responded very quickly and were sensitive and intelligent at handling my problem;
- I felt very reassured that I could talk openly about my problem;
- It was good advice which helped me plan for how I would deal with the problem;
- I was reassured that I was doing everything I could to cope with a rather difficult situation;
- Since the issues for me were dealt with by an experienced psychiatrist, I felt that it was someone who understood my working world. I think that talking to someone from the same specialty helped a lot. I felt that consideration had been given to my issues and the ‘right person for the job’ had been chosen.

**Development of the Bedfordshire and Hertfordshire LMC Pastoral Care Team**

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The Bedfordshire and Hertfordshire Local Medical Committee (LMC) has always provided personal, one to one support for colleagues for a host of reasons; ranging from difficulties faced in the practice through personal issues at home to performance procedures at the Area Team or the GMC. Due to an increasing need to provide more care for colleagues, we responded by forming a team of General Practitioners (GPs) to provide pastoral care. Pastoral care includes peer support and counselling within the capability of the team member. All team members are GPs and thus have core skills. The role is subject to a formal selection process, including an interview by a multidisciplinary panel to identify candidates with the skills and attitudes necessary to be effective. As the team has grown and developed we are aware there are specialist skills available including interests in psychodynamic psychotherapy and practitioner health. The team is dedicated to personal development and mutual support for team members, meeting regularly to facilitate this. We aim to develop a small local team of GPs confident and qualified to care for ill practitioners. Once contact between the team member and the doctor requiring support has been established, it is between the two how, when and where the support is offered. It is expected that this support will amount to one or more telephone conversations followed by a meeting or several meetings as agreed between the two doctors. It is expected that the team member gives up to 7 hours of support spread over an agreed timescale. Text message, email and Skype are becoming increasingly common methods of contact. An important part of the role is to assess whether the support necessary is beyond the capabilities of the pastoral care team member, requiring professional counselling, mediation, conciliation, medical care or referral to another professional. In the last year we have been aware that the rates of diagnosable mental ill health and substance misuse, exacerbated by self diagnosis (and in some case self-treating), are increasing. The ability to pick up early signs of significant, potentially serious mental or physical illness that might put patients or the doctor at risk allows the team member to support the doctor in seeking formal help from both primary and secondary care.

**Leveraging existing physician support programs to create a coordinated resource centre**

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**Background and Relevance:** The Cleveland Clinic is a multispecialty group practice that employs more than 5000 physicians and scientists, including 2000 clinical and research trainees. In the past twenty years, a number of programs were developed to address the professional development,
personal health, professionalism, mentoring and transition support needs of the professional staff and trainees but there was no centralized management process. Physicians were unaware of support programs and individuals being referred to external resources in increasing numbers. The need for new mechanisms for triage, collaboration and expansion of services became apparent. **Methods:** At the request of the Chief of Staff, individuals representing physician support programs and interest groups met for three half-day sessions. Current activities, gaps in services and opportunities for improved processes were discussed. A report was presented to institutional leadership and recommendations were implemented. **Results:** Participants recommended establishment of a coordinated Resource Center with a Triage Team comprised of physicians managing support services. One of the team members makes initial contact and provides direction to appropriate resources. The triage team member follows up with the individual and makes additional referrals as necessary. Oversight of the Resource Center is provided by an Advisory Group representing various programs and constituencies. This group meets quarterly to exchange information, review referral patterns, and suggest development of additional services. The first major recommendation of the Advisory Group was establishment of an Advanced Peer Coaching (APC) program. APCs are able to offer generic support as well as specialized expertise in topics such as professionalism, resilience, transitions, and malpractice/risk management support. **Conclusions:** Development of the Resource Center should improve the quality of support, reduce duplication of services, provide assistance appropriate to the institutional culture, and facilitate tracking of utilization and outcomes.

**80 POSTER**

**Are General Practitioners aware of support services and local referral pathways for practitioner patients?**

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From our time as medical students, to junior doctors, established practitioners and those approaching retirement, we may require care for physical and mental health conditions. The presentation and management of such conditions in doctors can be distinct from other patients in the community. Our needs may change as we travel through our working lives, but at all stages are we willing to seek help if we feel depressed, do we hide our excess alcohol intake from our colleagues, or do we seek help if family issues impact on our sleep? **Method:** In 2012 I completed the Royal College of General Practitioners (RCGP) Certificate in Practitioner Health, part 2. I surveyed 18 General Practitioner (GP) colleagues, at varying stages of their careers, who attended an educational group. I assessed their awareness of support services and referral options for practitioner patients. Results were discussed with colleagues who have an interest in the wellbeing of doctors. **Results:** GPs working in partnership, salaried and locum roles completed the survey. 3 doctors (16%) knew the RCGP has a certificate in practitioner health programme. None of the doctors knew how to contact their local Occupational health team. 1 doctor (5%) knew a psychiatrist with an interest in managing practitioner patients. 4 doctors (22%) were aware of the London based Practitioner Health Programme, although most worked within its referral boundary. 5 doctors (28%) knew their Local Medical Committee (LMC) in Bedfordshire and Hertfordshire has a pastoral care team. The BMA counselling service and BMA Doctors for Doctors scheme were the most well-known support organisations (44% doctors aware). There was little awareness of other services e.g. British Doctors and Dentist Group (no doctors aware). **Discussion:** This is a small survey but it highlights the limited awareness of support services for practitioner patients amongst a group of GPs at different stages in their career. The results suggest a need to provide doctors with information on support organisations and local referral pathways for their practitioner patients, as well as their own needs if they become unwell. **Conclusion:** I anticipate this survey promoting discussion amongst attendees at the conference to review support options and local referral pathways for themselves and their practitioner patients as they progress through their careers. We should remember that as doctors we, and our colleagues, can become the patient in need of support and advice.
Purpose/Relevance: In order to help inform the development of such a program for PGME learners as the Northern Ontario School of Medicine (NOSM), a needs assessment study was designed and implemented to assess the wellness needs of learners using a holistic wellness framework adapted from an existing wellness program (Drolet & Rodgers, 2010). It conceptualized wellness through physical, social, emotional, intellectual, and occupational lenses. Another objective was to assess the wellness needs of learners at a distributed and rural medical school, as this has been largely unstudied in the relevant literature. Methods: A total of 33 participants from NOSM were recruited, representing three groups; PGME students (n = 10), faculty members (n = 12), and administrative personnel (n = 11). Using semi-structured interview guides data were collected through a series of five focus groups and 14 individual interviews, and analyzed using a combination of the framework approach (Richie et al., 2003) and constant comparisons (Horne et al., 2013). Results: With respect to the wellness framework, core needs were identified including: Better access to primary care (physical) policies and training for management of unprofessional/disruptive behaviour (occupational); opportunities for social modelling, and coaching and mentorship programs (social) continuing medical education (intellectual); and accessible mental health services (emotional). A series of unique needs related to NOSM’s distributed model of education, and geographical isolation (e.g., on placements in northern communities) were raised as important determinants of wellness. Discussion/Conclusions: Overall, results of this study lend support to the holistic, conceptual wellness framework adapted from Drolet and Rodgers (2010), and will play a central role in informing the development of a wellness program at NOSM for PGME learners as well as other learners and Faculty members. Furthermore, emerging issues related to NOSM’s distribution warrants special consideration of the unique social, emotional, intellectual, physical, and occupational needs related to geographical isolation.

PHYSICIANS IN DISTRESS

18 WORKSHOP
Facilitating a group for doctors after a physician colleague has died by suicide

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In keeping with the conference theme ‘Milestones and Transitions: Maintaining the Balance’, one of the most difficult transitions for physicians is coping with the sudden death of a medical associate by suicide. Given that physicians do kill themselves at rates higher than the general public and that they often leave several survivors in their wake, we need to
consider the well-being of those left behind. It is well known that losing a colleague to suicide is much more complicated than losing someone to natural causes or accidents. This is especially relevant in group medical practices, academic departments or rural communities where the complement of doctors is not large and most physicians know each other, certainly professionally and often personally. Reconciling the self-inflicted death of one of their own can be totally discommodulating. There are a plethora of emotions, thoughts and behaviours that occur in a grieving medical community. These include: various manifestations of mourning, systemic anxiety, guilt and blame, erratic function, diffuse anger (plus rage at the deceased), acting out of unrecognized emotions and protective defenses like denial, intellectualization and rationalization. The service of a professional who can provide an ‘arm’s length’ appraisal and guidance is often essential and salutary. In this workshop, after a brief overview summarizing his research in this area, the presenter will use prompts, role plays and enacted scenarios based on disguised situations that he has encountered in his outreach to medical groups. Attendees will come away better equipped to assist if/when they are called upon to provide direction and sustenance to a group of physicians in need of understanding, hope and restoration of equilibrium. Although this program has not been evaluated by blind reviewers, it was included in the book ‘The Physician as Patient: A Clinical Handbook for Mental Health Professionals’ and subjected to review by peers designated by the publisher American Psychiatric Publishing, Inc.

100 ORAL
**Client characteristics, treatment recommendations, and outcomes for suicidal physicians presenting to a Physician Health Program**

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**Relevance:** Physician suicide rates have repeatedly been documented to be higher than that of the general population. 1-5 Factors such as female gender, 2, 3 a history of depression, 6 and job difficulties 7 are important indicators of elevated risk in this group, although many associated characteristics remain largely unexamined. Peer-led physician health programs (PHPs) are available across the globe and are an important avenue for addressing the problem of physician suicide. While each PHP is unique, physicians who present to such programs may receive a thorough psychiatric and medical evaluation, treatment referrals, and other support services. Moreover, PHPs address doctors’ concerns about the implications of seeking mental health treatment on their professional practice. While many PHPs have experience working with suicidal physicians, few – if any – have released data about this population. For those interested in better understanding and improving services for the suicidal physician, this is a critical oversight. In this presentation, we will discuss client characteristics, treatment recommendations, and program outcomes for suicidal clients presenting to a PHP. Emphasis will be placed on how these factors might differ at various phases of the physician’s career. **Methods:** This study will combine a mixed methodology, gathering both quantitative and qualitative data. In the first half of the presentation, we will review the general sociodemographic (e.g., gender, age) and personal characteristics (e.g., family history, support system) associated with suicidal clients. The results will be compared to a sample of physicians without a history of suicidal ideation to aid in the significance and interpretation of the findings. Second, we will present chart review findings from a sample of PHP clients presenting with a history of suicidal ideation. Programmatic information, such as treatment recommendations and client outcome data, will be provided to demonstrate practices that have been successfully employed with this population. **Results:** The analysis phase of this project is currently in progress but preliminary results suggest that there exist distinct differences between the suicidal physician group and non-suicidal physicians, at least in terms of family history, specialty, and marital status. Individual chart reviews suggest positive outcomes for physicians who expressed suicidal ideation at intake. **Discussion:** Physicians who report to PHPs with suicidal tendencies can be successfully evaluated and have promising outcomes. By improving our understanding about the characteristics and effective treatment strategies associated with suicidal physicians at different point in their career, we hope to further advance care management practices for this population.

274 ORAL
**Even the best physicians can lose balance throughout transitions**

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Our presentation will explore physicians’ coping strategies in the light of career transitions with huge work pressure and...
tough competition. Based on interviews with a number of both chief physicians and younger physicians we found that what was initiated as ‘coping strategies’ and thought of as a temporary practice in order to stay calm in challenging work situations or to find rest after stressful days can be accelerated by various transitions i.e. career transitions into an abuse. Our particular interest is to get an understanding of the point in time where the work-life balance topples and physicians’ temporary self-medication on e.g. medicine, alcohol or other drugs is made an everyday habit that may become an abuse problem to some. Throughout the presentation we will explore inter-relations between career transitions, work-life balance, self-medication and abuse. Our study is the first Danish study of physicians use and abuse of medicine, alcohol and drugs and with a mixed method research design. We are currently running a survey among 4000 physicians and have presently made in-depth interviews with 12 self-selected ex-abusing physicians.

153 ORAL
Assessing burnout risk in doctors using the online version of the Oldenburg Burnout Inventory in Great Britain

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Background: The Doctors for Doctors unit of the British Medical Association (BMA) put the Oldenburg Burnout Inventory (OLBI) on their homepage for giving interested doctors an opportunity to check their burnout risk. The OLBI was developed by Demerouti et al. (2003) including positively and negatively framed items to assess the two core dimensions of burnout: disengagement and exhaustion from work. Method/Participants: The questionnaire including OLBI, information about gender, speciality, working hours and working experience is on the Doctors well-being page of the BMA website. Everybody visiting this page can access and complete this questionnaire. The Oldenburg Burnout Inventory (OLBI) consists of 16 items with answering categories from “strongly agree” to “strongly disagree”. Between November 2011 and January 2014, the questionnaire was completed in 7218 cases. Results: Of all cases, 57.6% (n=4161) were female, 50.6% (n=3649) were working as General practitioners (GP) and 43.9% (3166) had less than 10 years of working experience. Regarding the working hours, 43.7% (n=3151) stated to work between 40 and 50 hours per week and 18.1% (n=1307) even more than 50 hours per week. In the OLBI, 2.1% (n=152) reached a low score on burnout. An average score on burnout was 19% (n=1374). A high to very high score on burnout was reached by 78.9% (n=5692) of all cases. Significant differences were found in the OLBI regarding gender, speciality, working hours and working experience. The group with a high to very high score on burnout were more likely to be female (p=.000) and had less working experience (p=.000). Conclusion: Offering the opportunity to assess online its own burnout risk was widely accepted. The questionnaire is open to any doctor accessing the web page. However, the problem that one person might have filled in the questionnaire twice cannot be ruled out. Of all cases (n=7218), 78.9% had a high to very high score on burnout indicating that feelings of exhaustion and personal distancing from work existed. Therefore, it was shown that an online questionnaire offers the possibility to screen for burnout risk, give feedback and even provide links for more information about burnout.

Acknowledgements: We would like express our gratitude to E Demerouti for providing the Oldenburg Burnout Inventory.

151 ORAL
Estimating the prevalence rates for problematic drinking in physicians

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Background: One important issue in physician’s health is problematic drinking (at risk drinking, abuse, dependence). In order to save time, studies estimating problematic drinking use screening questionnaires such as the Alcohol Use Disorders Identification Test (AUDIT) or its short-form AUDIT-C. However, false positive or negative screening results may overestimate the occurrence of problematic drinking to a great extent which could be shown in a previous study. A large study on physicians will be used here to further elucidate this finding. Method: At the Congress of the German Association of Psychiatry, Psychotherapy and Psychosomatics, 2005 in Berlin, 1800 questionnaires, which included the AUDIT-C, were distributed among the attending participants. 936 questionnaires (52%) were returned. The screening results will be presented and compared to the values when using a correction formula using data from a general population sample on sensitivity and specificity of the AUDIT-C. Results: Based on the results
of AUDIT-C and using a cut-off of 5 for both sexes, 24.1% of the sample of 887 physicians are problematic drinkers (14.7% in female and 32% in male physicians). Using a correction formula leads to markedly lower rates: 6.1% (all), 3.7% (female), 8.1% (male). **Discussion:** In this large sample, findings clearly confirm that uncorrected screening results lead to severe over-estimation of the prevalence of problematic drinking in physicians. The corrected prevalence rates are lower than in the general population.

118 POSTER

**Reasons for living in in-patient physicians and nurses: differences between suicide attempters vs. non-attempters**

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**Introduction:** A high score in the Reasons for Living Inventory, RFL (Linehan et al., 1998) has been inversely correlated with the possibility of attempting suicide. There are no studies on this topic in health professionals with Mental Disorders. **Objective:** To analyze if there are differences in the reasons for living between inpatient physician and nurses who attempt suicide versus non-attempters. **Material and methods:** We will present data of an ongoing case-control study with health professionals admitted to the Barcelona Psychiatric Inpatient Unit for Health Professionals. We conducted a preliminary analysis of a sample of 59 patients consecutively admitted from May 2012 until March 2013. Ten patients a suicide attempt (SA) the month prior to their admission (cases). Patients were diagnosed according to DSM-IV criteria. All patients completed the Spanish version of the RFL at admission. The RFL has the following subscales: 1) Survival Coping Beliefs; 2) Responsibility to Family 3) Child-Related Concerns; 4) Fear of suicide 5) Fear of social disapproval and, 6) Moral Objections. ; All hypotheses were two-tailed with a risk alpha of 5% and all analyses were performed using SPSS version 18 (Chicago, IL). **Results:** The median scores of the RFL for the suicide attempters were significantly lower in: subscale 1 (77.50 vs. 115.0; Mann Witney's U=126.500; p<0.05) and total score (146.50 vs. 179.0; Mann Witney's U= 116.000; p<0.05). There were clinically but not statistically significant differences in the median scores of subscales 2 (29.00 vs. 33.00) and 3 (9.00 vs. 14.00). **Conclusion:** The RFL could be a used as a complementary strategy to assess physicians’ and nurses’ suicidal risk. Follow-up studies with a bigger sample size will help confirm this statement.

192 POSTER

‘A Patient’s Guide To Physician Wellness’

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The Canadian Medical Association has identified “Burnout” as a significant barrier to physician wellness, affecting 46% of Canadian physicians. Burnout in healthcare may lead to serious consequences when job performance is impaired. Both physicians and patients agree that burnout negatively affects the quality of patient care. We have developed a working prototype of a pamphlet, directed at patients, that explains the concept of physician wellness and burnout, why it's relevant to patients, and ways patients and physicians may work together to improve mutual wellness. This pamphlet has been produced through a review of the existing relevant literature in this area of physician wellness. This pamphlet was presented to our colleagues and instructors and has been well received as a useful medium for communicating with the patient population.
Risk factors at medical school for later hazardous drinking: A 10-year longitudinal, nationwide study (NORDOC)

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Objective: The aim of this study was to investigate possible risk factors at medical school for future hazardous drinking among Norwegian doctors. Methods: Two cohorts of graduating medical students (N=1052) from four Norwegian universities (NORDOC) were approached and surveyed in the final year (1993/94 and 99) of graduation (T1) and then followed up 4 (T2) and 10 years later (T3). Hazardous drinking (drinking to intoxication) was measured as drinking of total 60 g of ethanol at least 2-3 times per month. Prevalence and predictors of hazardous drinking were studied. Predictors included in logistic regression models were alcohol problems in parents, having children, religious activity, use of alcohol to cope, personality traits (Basic Characteristic Inventory), in addition to controlling for cohort. Results: Longitudinally 50.5% (562/1052) responded at all 3 time points. Prevalence of hazardous drinking was reported at T1 by 14.2%, at T2 by 9.4%, and at T3 by 7.9%. There was a significant decline in the prevalence of hazardous drinking from T1 to T2 (p = 0.001), but not from T2 to T3. Unadjusted significant predictors of hazardous drinking at T2 and T3 were age, gender, no religious activity, alcoholic parents, personality traits (intensity, control) and in addition use of alcohol to cope with tension and hazardous drinking at T1. In the adjusted analysis, only male gender (OR = 2.0, 95% CI = 1.0-4.1, p = 0.04), use of alcohol to cope (OR = 2.2, 95% CI = 1.0-4.8, p = 0.03) and previous hazardous drinking (OR = 9.8, 95% CI = 4.9-19.5, p < 0.001) remained significant predictors of hazardous drinking at T2. Significant adjusted predictors of hazardous drinking at T3 were older age (OR = 1.1, 95% CI = 1.0-1.2, p = 0.01), male gender (OR = 3.6, 95% CI = 1.6-8.2, p = 0.002) and previous hazardous drinking (OR = 7.5, 95% CI = 3.4-16.7, p < 0.001). Conclusion: Male gender, use of alcohol to cope with tension and previous hazardous drinking remained significant predictors of hazardous drinking 4-years after graduation whereas older age, male gender and previous hazardous drinking were the only significant predictors of hazardous drinking 10-years after graduation. Medical students should already in the curriculum be taught more about the risk of hazardous drinking behaviour and other factors identified for future problematic drinking.

Burnout in UK general practice and consequences for the consultation length and the practice management

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Over the last decades, burnout has become increasingly important amongst people in the health profession. Burnout is classically defined as the combination of three components: emotional exhaustion, depersonalisation and lack of personal accomplishment. Recent changes in the general practice have generated increased workload and stress and have negatively impacted on mental health and job satisfaction. Here we report the data from the survey of 564 UK-based general practitioners completing the Maslach Burnout Inventory (MBI). Respondents were stratified according to their MBI scores and patient survey and tape-recording of consultations were performed for a subsample of the participants. Gender and duration of General Medical Council registration were also obtained. We found that high levels of burnout were reported, that 46% doctors reported emotional exhaustion, 42% reported depersonalisation and 34% reported low levels of personal accomplishment. Furthermore, a range of variables relating to the individual doctor and their practice could predict doctors’ depersonalisation scores. We will present data to support the findings that gender plays a significant role in the way family physicians respond to emotional exhaustion. Our findings also highlight a striking difference between male and female practitioners in the way their emotional exhaustion level affects consultation length. Consultations were shorter for male doctors scoring low for emotional exhaustion and the opposite situation was observed for female practitioners. The relationships between six important determinants of the consultation in general practice will be investigated: the length of the consultation, the gender of the doctor, the years of experience of the doctor, the doctor’s MBI level of emotional exhaustion, the gender of the patient, the patient-centeredness. Finally, the need to offer help and support for doctors experiencing burnout, to prevent burnout development and to take into account the gender of the doctor when considering doctors’ education and management will be discussed.
The experience and influence of psychological distress in General Practitioners

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Background: Within Clinical Psychology the impact of personal distress on professional practice has long been recognised. One in 3 consultations in General Practice has a mental health element and 90% of mental health problems are treated in primary care, but there is little research into the effects of personal distress on General Practitioners (GPs) or its effects on their ability to care for patients with mental health problems. This qualitative pilot study aimed to examine: How do GPs experience their own personal mental health difficulties and the reactions of colleagues to such difficulties? How do GPs come to understand their professional identity following such difficulties? How do GPs feel their interactions with patients with mental health problems have been influenced by their own personal experience of difficulties?

Methods: Participants were recruited from volunteers replying to an advertisement sent to members of the Doctors Support Network. Data was gathered through a semi-structured interview. The interviews were audio recorded and transcribed verbatim. Interpretative Phenomenological Analysis (IPA) was used to identify themes within the accounts. Results: 10 common themes were identified which can be organised into 4 domains: A. Initial Experience of Mental Health Problems 1. Initial distress 2. Self doctoring B. Experience of reactions of other doctors to distress 3. Mutual denial 4. Difficulties acknowledged through crisis 5. Suspicion over mental health status C. Influence of treatment and support 6. Understanding self through diagnosis and treatment 7. Understanding self through the difficulties of other doctors D. Experience of clients with Mental Health Problems 8. Separatism: Mental illness as alien 9. Fusion: Patient as Self 10. Separate yet Connected: Standing in the Spectrum Discussion: This analysis demonstrates that the experience of mental ill health in GPs is inherently linked to their identity as doctors. A culture of autonomy and a lack of acknowledgement by colleagues of distress led to participants perceiving the need to self doctor and hide their personal difficulties. After they had received a psychiatric diagnosis participants felt that their clinical competence was questioned. Through reflecting on their difficulties GPs felt more able to relate to the experience of patients presenting with mental health difficulties and this ultimately led to increased perceptions of competence in treating this patient group.

PLANNING WELL FOR SENIOR CHOICES

56 WORKSHOP
Milestones, Competencies and Retirement: Helping Physicians Transition

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Introduction: Milestones are important markers in medical education for students and trainees while maintenance of certification assures ongoing competency for practicing physicians. Currently, there are no published articles on milestones or competencies of academic faculty transitioning into retirement. Likewise, the literature around transitioning physicians into retirement is sparse. Retirement is a challenging time for some and many are not prepared. The Center for Professional Health developed a step-wise approach to help physicians transition into retirement. A half-day retreat provided faculty members with a step-wise approach to prepare for retirement. This workshop advances discussions on transitioning into retirement by focusing on milestones and competencies for retiring physicians. Workshop Goal: The goal of this workshop is to develop competencies and milestones for retiring physicians. Workshop Objectives: Participants in this session will: 1. Review and expand a preliminary retirement timeline based on personal situations, i.e. country and medical culture. 2. Engage in small group discussions to define and list competencies needed for retirement. 3. Write culturally specific milestones for retirement. Workshop Description: Participants in this session will discuss retirement and competencies needed for a smooth transition. Topics of the workshop will include reinventing self, methods to change practice to accommodate for normal aging, managing retirement funds, and the mental effects of transitioning into retirement, etc. Because there are no formal academic requirements that prepare physicians to transition into retirement, we will utilize the CPH timeline as the basic structure to guide developmental milestones and competencies. This discussion may lead to a working team interested in continuing this work. Proposed Workshop
Milestones and Transitions – Maintaining the Balance – Abstracts

Abstract: Patients were identified from a wide range of social, employment and ethnic backgrounds reflecting the diverse nature of the local community. There was a special emphasis on Dr Ockrim’s extensive experience of community obstetrics with home deliveries in the early years giving way to births in nursing homes and latterly in a hospital based general practitioner unit. The oral history tapes, comprising 160 hours of recordings, were transcribed in 1991 but the formal study of this rich seam of medical history has only commenced during the past year. This oral material, a unique account of the doctor patient encounter, illuminates the attitudes of patients to such issues as general practice before and after the introduction of the National Health Service, maternity provision in hospital and the community and the role of women in medicine, especially during the 1940s and 1950s. Retirement is a major mile-stone. This study records the inner fears of one Glasgow general practitioner at the end of her medical career and her resilience which produced the transformative study which provides an insight into medicine in the community as her lasting legacy.

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The ‘Letters to No-one’: The Retirement of a Glasgow GP

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Following the death of Dr Hetty B Ockrim in August 2007 a series of letters was discovered in her handwriting headed ‘Letters to No-one’ outlining her hopes and fears as she decided that she was to retire. Approaching the age of seventy she had spent forty three years as a general practitioner in the Ibrox area of Glasgow. The first letter was dated April 1989 and a final one in October 1989 just a few weeks after retiring. In April she described her busy life in practice as ‘rushing and running’ and wondered what was to be when this stopped. She worried about the patients she had cared for over the past four decades whose personal problems, even more than their strictly medical ones, affected her deeply. Focussed firmly on the present she saw little value in celebrating retirement but contented herself that she had established a thriving medical practice, living the life of an urban Glasgow general practitioner touching the lives of many people, overwhelmed by their affection and involved in all aspects of their care. Dr Ockrim’s retirement in September 1989 was followed by participation in an oral history project, with Wellcome Trust funding. She interviewed some 75 former patients and all the employed and attached staff between October 1989 and February 1991. Patients were identified from a wide range of social, employment and ethnic backgrounds reflecting the diverse nature of the local community. There was a special emphasis on Dr Ockrim’s extensive experience of community obstetrics with home deliveries in the early years giving way to births in nursing homes and latterly in a hospital based general practitioner unit. The oral history tapes, comprising 160 hours of recordings, were transcribed in 1991 but the formal study of this rich seam of medical history has only commenced during the past year. This oral material, a unique account of the doctor patient encounter, illuminates the attitudes of patients to such issues as general practice before and after the introduction of the National Health Service, maternity provision in hospital and the community and the role of women in medicine, especially during the 1940s and 1950s. Retirement is a major mile-stone. This study records the inner fears of one Glasgow general practitioner at the end of her medical career and her resilience which produced the transformative study which provides an insight into medicine in the community as her lasting legacy.

59 ORAL
Physician preferences for end-of-life planning and care: The Johns Hopkins Precursors Study

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Background: Preferences for life-sustaining treatment elicited in one state of health may not be the same in another. Moreover, how one’s decisions are made may be as important as what one chooses for treatment. Methods: In a longitudinal cohort study of medical students in the graduating classes of 1948 to 1964 at Johns Hopkins University, 818 physicians completed a questionnaire concerning their end-of-life preferences given a brain injury, every 3 years (mean age at baseline, 69 years). We estimated the stability of preferences for end-of-life treatment across 6 years (1999-2005) and whether declines in physical functioning and mental health were associated with changes in preferences for end-of-life treatment, and for how decisions were to be made. Results: Physicians changed their preferences with time. The probability that physicians were in the same category of preferences at follow-up as at baseline was 0.41 for ‘most
aggressive,’ 0.50 for ‘intermediate care,’ and 0.80 for ‘least aggressive.’ Physicians without advance directives were more likely to transition to the most aggressive cluster than to the least aggressive cluster during the 3-year follow-up (odds ratio, 1.96; 95% confidence interval, 1.11-3.45; Arch Intern Med 2008;168:2125-2130). Preferences for decision control from physician-participants were compared to terminally-ill patients studied by Nolan and Sulmasy (J Am Geriatr Soc 2007;55:1981-1988). If too sick to speak for themselves 39% of terminally-ill patients would rely on their doctor’s judgment similar to 29% of Precursors participants who would. The same proportion of Precursors participants as terminally-ill patients would rely on the judgment of family members over personal wishes namely, 20%. For cancer, new onset was not significantly associated with transitions but chronic cancer (i.e. cancer first diagnosed long in the past) was associated with transition to preferences for more aggressive care compared to persons who never reported cancer. Participants with diabetes, whether new or chronic, compared to participants who never had diabetes, were about four times as likely to transition to the ‘most aggressive’ category of care rather than to the ‘least aggressive’ category. Point estimates related to heart disease suggested transitions to more aggressive preferences but were not statistically significant by conventional standards.

Conclusions: Periodic reassessment of preferences is especially critical for patients who desire aggressive end-of-life care, for persons with changing chronic conditions, or who do not have advance directives.

217 ORAL
The Senior Physician Initiative (SPI)

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Purpose/Relevance: Senior physicians (SPs) represent an increasing sector of the medical workforce. Following a wellness scan of our Department of Medicine (DOM) revealing the increasing importance of the SP role, the Senior Physician Initiative was established to develop SP career opportunities for the benefit of the members, the department, patients and trainees. Methods: The SPI task force members (researchers, academic and community SPs) reviewed the existing literature and related resources and policies. With support from local, provincial and national medical associations, fifteen SPs’ perspectives were accessed through focus group discussions around their suggestions for SP career options. We interviewed DOM Division Chiefs to gain perspective on issues such as the proportion of SPs within their division, and if and how those physicians were accommodated differently than other members. Results: A wealth of insight and ideas emerged. The focus group sessions provided constructive suggestions about potential modifications of work content, schedules, teaching assignments, work environments, and remuneration models for SPs. Most Division Chiefs reported no formal policy around on-call requirements or retirement for SPs. Informal agreements about work transitions were reached on a case by case basis. “Adapted” positions were created for those wishing to reduce their work hours or workload, based on the needs of the division and the SPs’ skill set, age, efficiency, proficiency, physical and intellectual stamina. Division Chiefs felt it was feasible for SPs to participate in part time work, sessional work, job sharing, and locums as long as they “shared a commitment to sharing care”. Based on these findings, the SPI task force members created a summary document with formal recommendations to the DOM. Discussion/Conclusions: SPI provided opportunities for dialogue and discrete recommendations to the DOM including: that SPs be recognized as valuable members who often possess enhanced skill sets derived from breadth of experience, that the DOM and health region collaborate to produce innovative practice opportunities for SPs, that the DOM provide assurances that affirmative initiatives for SPs will not compromise other physicians and that support of reduced on-call service expectations for SPs be based on principles of mutual agreement, collegiality and flexibility. SPI has provided the impetus and foundation for the development of a recent document, the DOM’s Career Adaptation Guidelines, in which the SPI scope has been expanded to include other circumstances where reduced or modified contributions to the DOM may be requested by a member.
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**The final transition: Canadian physicians and end of life care**

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**Background:** Euthanasia and end-of-life care remains a high-profile and controversial subject in Canada. While euthanasia or physician assisted suicide is currently not legal in Canada, a court case is before the Supreme Court of Canada to determine the constitutionality of this stance. One province (Quebec) has enacted legislation to permit euthanasia within the context of end-of-life care. The Canadian Medical Association (CMA) has a policy opposing physician involvement in euthanasia or assisted suicide. In the spring of 2014, the CMA led a dialogue with the public and its physician members to ascertain societal views on end-of-life care issues including physician-assisted dying, palliative care and advance directives. No data currently exists on Canadian physician views on what life-sustaining measures they would choose if terminally ill.

**Objective:** To determine Canadian physician views on their own preferences for life-sustaining treatment if terminally ill: Secondary objectives to determine Canadian physician views on the current CMA policy on euthanasia and assisted suicide and attitudes towards advance directives and palliative care.

**Methodology:** A secure website for members of the CMA (practising physicians, residents and medical students) was established in February, 2014 and active until the end of May, 2014. The 80,000 members of the CMA were invited to participate in one of three surveys posted to the website: their views on the current CMA policy on euthanasia and assisted suicide, their personal preferences on what life-sustaining measures they would choose if they were terminally ill, their views on advance directives and palliative care.

**Results:** Results from the surveys will be presented at the conference.

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47 WORKSHOP

**The doctor and the sick or dying family member: personal and professional role conflict**

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In the MedNet service, we have had a cohort of doctor/patients who struggle with their personal and professional roles in relation to a seriously ill or dying child, spouse, sibling. Other family members have particular expectations of the doctor/family member: they may be asked to interpret medical information, make crucial decisions about care, and their own emotional response may be neglected. The workshop would open up these tricky areas via:

1. Compiled case vignettes would include: The doctor whose partner has a terminal illness, The doctor/parent with a chronically sick child; 2. Facilitated small group discussion: Shared experiences of being a doctor and family member? What are the family's expectations of the doctor/family member? What made the double role easier? How did you adapt your language, vocabulary, tone according to the different conversations? Are there any general conclusions/guidelines or are these experiences too individual to generalise? 3. Feedback to the large group.
This presentation concerns the professional identity of newly qualified doctors in the UK: exploring how early years practitioners form their sense of self-as-doctor as they enter work and the structural, educational, social and personal influences on this formation. With identity formation and professional development framed as situated, socio-cultural and developed within and through practice as an iterative process of becoming, this qualitative study, conducted in the interpretivist tradition, revealed that new doctors begin to establish their professional identities through the interlinked processes of learning, belonging and becoming. Developing professional competencies, learning ‘medicine’ and a re-contextualisation of existing knowledge allows them to ‘figure’ who they are and what is expected of them. Belonging, although always partial, affects not only what can be made of experiences but also what can be carried forward. Becoming orientated to being a ‘good doctor’ has both outward-facing and personal aspects and is stimulated by responsibility, influenced by the personal history and planned trajectory of the doctor and the affordances of workplaces. It is delayed by the fragmented nature of the early years of work. Much of this learning, attempting to belong and to become a good doctor is not directed at their eventual doctor role but at the here and now. This work provides telling insights into the socio-cultural dimension of becoming a doctor and the potential effects of recent workplace and education reform on identity, professional formation and ultimately, practice. It develops ways of theorising how medical professional identities develop, questioning notions of a simple novice to expert trajectory and suggesting novice doctors maintain a rather peripheral participation in their communities during the early years of work. This presentation will conclude by suggesting both pedagogical approaches in medical education and the conceptualisation of the medical workplace as a site of learning and formation would benefit from review in light of these findings.

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The tradition of considering Doctors and Patients as in some way fundamentally different leads to an unhelpful dichotomy in which one holds knowledge, power, competence and answers and gives them to the other, often caricatured as ‘the medical model’. Yet Doctors are people too and many are drawn to medical practice by empathic interests based on personal and family experience. Our training provides much knowledge and many skills but we commonly embark on practice with our personal experience and vulnerabilities unconsidered and given little value. We are well qualified and technically competent but may struggle in practice with the complexities of human relationships and the reality of suffering and long term conditions. The traditional training of healers is somewhat different, valuing as it does their personal experience and qualities as a foundation for practice. The ascendant ‘Recovery Movement’ in mental health has arisen from the stories of people with lived experience of severe mental health problems and has highlighted how personal experience can develop into expertise as a highly valued contribution to health care. This values-led emphasis is at the heart of the present national development programme of ‘recovery-oriented services’ accompanied by innovations such as peer-support workers and recovery colleges. It has taken much of my 33 years working in the NHS, the last 23 as a consultant psychiatrist in Devon to fully recognise and value that I was drawn to medicine due to my personal and family experience. Over the last decade I have worked as part of the National Project Team on ‘Implementing Recovery through Organisational Change’ at the Centre for Mental Health and led on Recovery for the RCPsych (2005-11). Previous teaching and publication on burnout, mentorship and the value of narrative approaches in medicine have led to reconsidering the story of the ‘wounded healer’. This supports promotion of the possibility of developing a medical identity that is alive to and values our life experience of struggles and difficulties (2012), for which we are surrounded by supportive symbolism from the BMAs ceremonial staff to the letters denoting our qualifications. My presentation would be a reflecting on all these matters, offering a challenge and suggestions for those who may consider training as, ‘Recovery Oriented Practitioners’ (Roberts and Boardman, 2014) able to accept, reconcile and value their life experience as part of their professional qualification and development, offering a foundation for co-producing health and wellbeing with those they serve.

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The self-less doctor – ideal and danger

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The medical education and the ideal of a doctor require selfless dedication to the profession and to patients. The downside of this ideal is the loss or the lack of development of a centre of the personality of doctors in training. That is to be seen in doctors who have not been able to develop an idea of their beyond the trajectory given by the medical career. This is not only impoverishing their personal lives. By lack of an internal regulating agency they are in danger of severely not developing or losing a liveable life-work balance with negative consequences for their ability to work responsibly. Although these consequences might not be immediately visible, the forerunners can be observed in a striking manner. This paper describes these issues, illustrated with disguised clinical material which will be organised in a specific way. This is followed by a brief discussion of which interventions might be helpful when talking to doctors presenting with this constellation.

Competing identities: why do medical students smoke?

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Doctors are role models for society and medical students, as physicians of the future, are in a position to influence society’s habits, specifically with regards to smoking. Cigarette smoking is the leading cause of preventable deaths and has been identified as an anti-social behaviour. Using qualitative interviews, this paper explores why medical students of a large UK medical school smoke and the professional aspects associated with their habit. Peer influences were found to be initiators of smoking habit however exploration revealed inconsistencies. The paper highlights how deviance created social groups and smoking was still seen as ‘social’ behaviour. This paper identifies the strategies used to rationalise behaviour: by distancing oneself from evidence; by seeing smoking as a necessity due to stresses of studies; and most significantly, using smoking as a way of seeking a ‘normal’ student identity. Though accepting the responsibility of a role model, which led to feelings of hypocrisy, students appealed to being people as well. Medical school added little to ones smoking-related knowledge and a multitude of feelings with regards to advising patients emerged. More broadly, this paper highlights the complexities in understanding why medical students smoke and contradictions in their rationale.
the doctor lost relatedness at work and at home, adopting a “protective shell”. The inhumane busyness and challenge of training years led to strengthening of defences into a professional false-self with limited self-expression and loss of authenticity. A realisation of isolated vulnerability brought them to face reality and either personal therapy or psychotherapy training, to which all experienced negative or critical responses. Entering therapy the doctors learnt a language to express feelings and combat the alexithymia of their medical careers with a change in their self-worth and personal relating, as well as in patient relationships and interactions. Both patients and families noticed improved listening skills and the doctors described becoming more open and better able to support and protect themselves. Mentalisation led to the awareness of transferences from other trainees and the shadow archetype of medicine in society. Subjects described the integration of true and professional selves with benefits both to medical practice and teaching and training roles. Conclusion: These results demonstrate the Cartesian split of bio-medical training and the attrition on the persona of the doctor. Even later in a career, debriefing the traumata of medical school, training and working is beneficial. Psychological clinical supervision should be introduced into medical practice.

PROFESSIONALISM

268 WORKSHOP
Peak performance training for doctors

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This workshop will introduce participants to the field of peak performance. While extensively used in the training of elite athletes and other high-performance settings, mental readiness is a significant factor in achieving winning results. Medical training and practice are demanding and at times stressful. Having skills that help an individual to be present, focussed and able to manage distractions are critical. Being able to ‘perform’ optimally is a goal for any physician. Peak performance training has been used extensively in preparing athletes and top performers to consistently be at their best, optimize conditions, and achieve excellence. A specific balance was found between technical, physical and mental readiness skills to succeed in “challenging” operations. These studies, and others that incorporate “mindfulness”, have concluded that mental readiness skills can be measured, taught and will improve performance. Broadening this approach to life in general can lead to better enjoyment of everyday activities. This systematic skill-development is based on seven high-performance indicators of mental readiness—commitment, confidence, mental preparation, visualization, full focus, distraction control and constructive evaluation. This workshop will introduce aspects of peak performance training and mental readiness specifically aimed at demanding situations in medicine, such as executing difficult procedures or surgeries, or managing complex patients. Practical exercises combined with group discussion will ensure participants comprehend specific mental readiness skills such as: focused attention, distraction control and visualization. Each individual will have the opportunity to learn and practice specific skills on their own, in dyads and in a facilitated group. These skills are applicable to physicians and resident trainees in specific instances such as with a difficult procedure or surgery, or with a complex patient. The readiness skills are also a useful way to approach routine aspects of one’s day. Participation of all individuals will be encouraged by using meaningful work or personal-life experiences to apply practiced skills. Each individual will be invited to create their own action plan indicating how they will use the new information and learned skills. Thus participants will discover how peak performance training can enhance everyday living both inside and outside the medical practice.

216 WORKSHOP
When physicians’ practices change: how to effect career transitions while considering the individual’s responsibilities, capabilities and skills and the collective healthcare delivery obligations

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Background: Physician members of any group bring particular expertise to their clinical and academic work. Individual roles vary and evolve throughout a professional career.
Circumstances that may necessitate a temporary or permanent change in physicians’ practices often happen as part of life. Contributing factors include health (e.g., illness, disability), career stage (e.g., senior physicians, junior physicians with young families), personal situation (e.g., family member ill health, financial stressors) or personal preference (e.g., desire to curtail work hours). These circumstances may alter physicians’ abilities to carry out their work by imposing restrictions upon certain activities (e.g., specific procedures or rotations) or by limiting work hours (e.g., total, consecutive, or on-call hours). However, the group has a collective obligation and professional responsibility to provide services to the healthcare system. Rather than arbitrary responses to changes in physicians’ practices, groups can foster a spirit of openness, preparedness, and flexibility, by considering in advance how to balance collective healthcare delivery obligations with individual physicians’ responsibilities, capabilities and skills. The aim of this workshop is to build a framework that physician groups and individual physicians may use as a guide during these career transitions. **Outline of session format:** 00:10-00:20 Overview of background and relevance of topic (PLENARY PRESENTATION). 00:20-00:40 Share experiences of how physician practice changes challenge individual physicians and the healthcare system (GROUP DISCUSSION). 00:20-00:40 Share successful experiences of career transitions from the perspective of individual physicians and healthcare systems (GROUP DISCUSSION). 00:40-01:10 Develop foundation principles for a framework that addresses career adaptation in this context (SMALL GROUP DISCUSSION). 01:10-01:30 Share small group ideas (TURN TAKING FOR EACH GROUP). 01:30-01:50 Discussion and summary (GROUP DISCUSSION). 01:50-02:00 Evaluation (FEEDBACK AND EVALUATION FORMS). **Intended outcomes:** Participants will 1) consider how career transitions relate to physician wellness and gender and generational shifts in the medical profession 2) share models of how physician career transitions are handled and 3) integrate workshop ideas into a vision of career adaption guidelines for themselves and their physician groups. **Details of similar workshops:** This is the first attempt at this workshop content. We have previously conducted a workshop of the same format (Canadian Conference on Physician Health 2013) aimed at guiding participants’ development of physician wellness programs and interventions. Evaluations were very positive and outcomes included multiple ongoing correspondences with individuals from across the country to further their program development.

**1 WORKSHOP**

**Maintaining Compassion in Medical Practice – the benefits for patients and doctors**

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There is currently significant concern both within and outside the medical profession about apparent loss of compassion amongst doctors. This workshop will consider the need for compassion in practice, present evidence for its positive impact on the health of both patients and doctors, and enable participants to reflect on and learn how they can prevent loss of compassion in their workplaces, and practically resource themselves for maintaining compassion throughout their professional lives. The workshop will take the form of an introductory illustrated presentation of the importance of compassion in practice, followed by participant group work on what makes them more (and less) compassionate in the workplace, with feedback to the whole group. There will then be a short further presentation on maintaining compassion and resourcing ourselves appropriately for it, followed by further group work where participants identify positive techniques and strategies for themselves. The ideas generated will be shared in the whole group. Participants will be encouraged to write down three things they will do in future to practice compassionately and resource themselves for doing so in future. This workshop has been run a number of times with junior and senior doctors and has received very positive comments in the evaluations.
Is it possible to combine being a ‘good doctor’ with taking care of one’s own health? A qualitative study of the importance of professionalism among hospital doctors

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Purpose/relevance: Doctors tend to seek treatment late in the disease process and take sick-leave more seldom than the rest of the population. Can doctors’ own expectations of being a ‘good doctor’ influence these issues?

Materials and methods: We conducted 7 focus groups and 4 in-depth interviews with hospital doctors from three specialties. We had a total of 48 participants; 22 senior house officers and 26 chief specialists; 56% women. Themes for discussion were introduced according to a check list. The semi-structured interviews were recorded and transcribed, then analysed by systematic categorization and text condensation based on Giorgi’s phenomenological approach. Results: ‘High level of professionalism’ and ‘display of a large work capacity’ emerged as two important prerequisites for becoming and being a ‘good doctor’. Strive to gain medical competence and gather experience of patient-related work were described as the means to attain a high degree of professionalism. This necessitated a large capacity for work, and adaptation of daily activities to the workload. Long hours of work attendance were expected by colleagues and oneself. Both residents and chief specialists described work attendance as a reason not to take account of their own needs or health, not to take breaks during the day, difficulties with maintaining a work-home balance and a reason to come in to work even when ill. There was, however, a tendency towards a generational difference in how to describe being a doctor. Some chief specialists said that being a doctor was more of a lifestyle than a line of work, whereas several of the residents in specialty training said they thought it was important to have a private life besides being a doctor. Discussion/conclusions: To attain and retain professionalism through the doctor career is described to require a great capacity for work. The doctors’ own, and their colleagues’ expectations of being present at work, together with marginal staffing and high workloads promote long work hours. To give priority to the doctors’ own needs – time for lunch, time for breaks, work-home balance or to refrain from work when ill – thereby becomes difficult. The long hours of work are partly called into question by the younger doctors. This could lead to a discussion about the criteria of what a “good doctor” is. Maybe this could also lead to increased legitimacy to acknowledge and take care of one’s own needs as a “good doctor”.

Hung out to dry: a support group for suspended doctors and dentists

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The Practitioner Health Programme in London has been running a group for suspended doctors and dentists since its inception in 2008. The group meets monthly for 90 minutes and is currently facilitated by a psychodynamic psychotherapist. Some of the themes emerging from the group are: loss, shame, frustration, persecution, exclusion, loss of direction, and a general sense of unfairness. These professionals feel that their voices are unheard. They feel unseen, that they are being punished and that the punishment is out of proportion to their circumstances. Most have had some form of mental health problem and have made a good recovery by the time they start in the group. Membership of the group helps to give them a sense that they are being heard, that they are not alone, that they are being taken seriously. Membership of the group depends on how long they are suspended but is in the region of 6-18 months. Suspension is very difficult transitional experience for healthcare professionals. The presentation will expand on the above themes and present feedback from doctors who have attended the group.
In recent years there has been increasing attention placed upon physician behaviour in the workplace, mostly in a negative sense. As a result, a variety of approaches have been developed to address so-called disruptive behaviour by doctors. Less has been written about the understanding and promotion of a desired style of physician behaviour which can be conceptualized as civility. Civility is about more than politeness and courtesy, although it begins there. High quality professional comportment is essential for healthcare teams to function effectively. Physician incivility, often revealed at times of tension, can cause stress, distress and poor productivity in co-workers of all kinds. Incivility can propagate itself and erode the very culture of a workplace, and, indeed, a profession. On the other hand, civil behaviour results in positive social interactions. Civility amongst colleagues is associated with lower rates of professional burnout. Civil collegial relationships create comfortable and energizing workplaces with lower turnover rates and higher worker satisfaction. Everyone, including patients, benefits from civil professional behaviour.

The impacts of civility (and its absence) in the professional environment, even if self-evident, have been demonstrated by research and the evidence will be reviewed in this paper. Even so, the various dimensions of civility are not always surfaced in a deliberate manner in medical training and beyond. It appears, then, that a civil approach to physician behaviour in the workplace has merit, but there are questions to explore. While most doctors interact with others in a civil manner most of the time, anyone can experience lapses occasionally, and the literature reports that it appears that some doctors lapse more often than others. When the many dimensions of civility are reviewed, it appears that there are specific strategies that can be adopted to foster civil behaviour in doctors, even at times of risk. A practical selection of these strategies, grouped into five categories as “Five Fundamentals of Civility for Physicians” will be described in this paper. They are: 1. Respect others. 2. Be Aware 3. Communicate Effectively 4. Take Good Care of Yourself 5. Be Responsible. These Five Fundamentals are offered as a framework for the promotion of civil professional behaviour in doctors at all career stages. A variety of ideas as to how to build upon this framework and achieve this goal will be presented.
groups, using odds ratios and confidence intervals. 261 medical student, 66% who were female, undertook the survey with a roughly even spread across the different year groups. From the survey, the majority of responders reported that they had either witnessed or experienced discrimination, abuse and/or harassment at medical school or in the clinical setting, but with only a small minority (4.9%) having actually reported this. The focus group and free text analysis were coded by emerging themes by two independent researchers. The main themes to emerge were the use of humour and discriminatory language in cases of discriminatory, abuse and/or harassment, the common experience but significance of ‘everyday sexism,’ barriers to reporting this behaviour including perceived intent of behaviour contrasting with the possible but significant outcomes of reporting, and finally the lack of reporting of experienced or witnessed discrimination, abuse and/or harassment. The synthesis of all the above results were finally combined in a matrix to determine validity and reliability.

**Discussion:** This study shows that unfortunately different forms of discrimination still exist in medical school and the clinical settings despite advances and policies. This ranges from ‘everyday sexism’ in humour and language to discrimination of opportunity for subtypes of students to more serious events. There are many barriers to reporting, but if it is done by medical students then it is predominantly to close peers only. By exploring the issue and suggesting structural, attitudinal and empowering solutions, this study is a crucial, positive step towards reducing harassment and discrimination and their consequences on tomorrow’s doctors’ health.

**54 ORAL**

**Transitions from sexual misconduct: a systematic case review of transitions to unrestricted clinical practice after sexual complaint in the US**

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Because of the numerous and somewhat volatile public and professional attitudes regarding sexual boundary violations, especially when criminal charges are involved, this presentation examines the publically available data regarding 172 physicians with records of sexual misconduct who subsequently were licensed or re-licensed to practice medicine. Using records of State Medical Boards, abstracted from online state medical board disciplinary actions, internet searches for key words, public news sources and specific related web sites, available data were accumulated with regard to the nature of complaints and violations, including contact vs. non-contact offenses, the impact of criminal justice involvement, the level of Board involvement, the length of time from initial Board action to re-licensure and the percentage of physicians regaining unrestricted re-licensure. The results of these data will provide information with regard to the impact of a verified history of sexual misconduct on reinstatement of medical licensure. Among sub-categories to be discussed will be physicians with criminal charges, physicians with contact offenses, physicians with non-contact offenses, and physicians with offenses against victims under 18 years of age. In the sub-categories, the data will include comparisons of physicians who were suspended, summarily suspended, surrendered their license or had their license revoked. An overview of state-to-state variability will be reviewed. In each arena, the duration of revocation, the mean and median duration of revocation, likelihood of and path to reinstatement will be reviewed. Finally, based on this experience, the presenters will examine the potential implications for developing feasible structured pathways to reinstatement of licensure after sexual misconduct.

**79 ORAL**

**B-29©360° assessment of a physician’s workplace behavior**

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**Purpose:** Physicians with unprofessional behavior can benefit from specific and clear feedback about their behavior. This feedback can help them to make needed changes and contribute to a culture of safety in the workplace. A valid and reliable instrument was created to track and assess behavior change over time that can be used to complement and augment patient complaint data within the institution. The B-29© is a 360°assessment of a physician’s workplace behavior. It provides objective data for both the physician and the institution or practice setting. The B-29© is based on the American Board of Medical Specialties and the Accreditation...
Council for Graduate Medical Education (ABMS/ACGME) six core competencies. We present the psychometric properties of the B-29©. We hypothesized that the B-29© could distinguish between the index and control physicians. Methods: Using a matched case-control design (N=9 pairs) we conducted analysis to determine whether there is a significant difference between the physicians referred to the CME course. Program for Distressed Physicians, at the Center for Professional Health (index cases) and the control physicians. Participants were matched for age ± 5 yr., specialty, graduation date from a medical college, and gender. Human subjects' approval was obtained from the Institutional Review Board at Vanderbilt University. The four factors were derived from a previous validation study: Factor 1-General Personal Demeanor Factor 2-Willingness or Ability to Meet Hospital/ Clinical Timeliness and Tasks ; Factor 3-Avoids Egregious Behavior Factor 4-Patient & Family Orientation & Empathy Results: Nine matched pairs (N=18) of participants consisting of 16 male and two female physicians completed the study. The average age of the matched-pairs was 49-50 with at least three different specialties represented. Factors 1 through 3 revealed a highly significant main effect for ‘Type’ meaning that the control cases were rated higher than the index cases with a p < .001. Factor 4 also significant but at the p=.085. Conclusions: Physicians referred to the CME course for unprofessional behavior have consistently scored below average on all four factors compared to the control group. The B-29© is a validated and easy to use 360° assessment instrument utilizing a core competency framework. Our findings support that the instrument is sensitive to whether an individual demonstrates unprofessional behavior.

138 POSTER
Undermining behaviour: why it’s better to prepare and prevent, that repair and repent

Co-Author: Shaarifa Raza

Research shows that bullying is still a problem within the NHS. Trainee surveys including the GMC Survey have shown that it is most rife amongst Foundation Year trainees but also occurs more commonly in various specialties, primarily Obstetrics and Gynaecology and A&E. This is important for several reasons. Not only does it lead to low morale, but it has been shown to increase sick leave absences, thus impacting productivity and most importantly leading to leading to poor patient care. Bullying and harassment has been noted to occur at all levels with the NHS, affecting the most junior members of staff right through to senior registrars. Several high profile cases in the media have shown that such behaviour in the past has had huge implications on patient safety. This includes The Bristol Heart Inquiry and Northwick Park Report and also most recently the Francis Report. It is difficult to quantify bullying and harassment but we were able to assess the impact, and potential effects during group discussions held in our workshops. Whilst most NHS trusts have formal anti-bullying policies few know how and when to action them. Our aim was to develop and deliver an anti bullying workshop to explore these issues in greater detail. The workshop looked at exploring definitions of bullying, discussion around various cases of undermining behaviour in both junior and senior doctors, highlighting how this may affect patient safety and finally advising trainees how to avoid bulling and promote assertiveness against undermining in the future. Relevant trust policies and guidelines were also discussed. The workshops comprised of open discussion to encourage doctors to discuss their own ideas on the matter and facilitating small group work allowing doctors to share their personal experiences. Audio-visual material highlighted how undermining behaviour may manifest and equipped trainees with practical tips on recognizing and handling bullying.

157 POSTER
Work environment and harassment among primary health care physicians: Does ethnicity matter?

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Background: Harassment and degrading experiences are frequently reported in the nursing workplace and is believed to be more common in highly demanding contexts (Fornés et al., 2011). Perceived discrimination based on race or sex could contribute to less engagement to work and more burnout (Volpone & Avery, 2013). Studies concluded among Canadian physician students showed that significantly more foreign-born students experienced harassment or discrimination on the basis of ethnicity or culture (Crutcher et al., 2011). In
Sweden, 15 percent of the population is born abroad and integration is important to promote in the working life. There is uncovered ground among active physicians who experience harassment and unequal treatment in primary health care, why additional studies are needed. **Method and participants:** Participants in this cross-sectional study were primary health care physicians in central Sweden. The outcome variables were perceived harassment and unequal treatment at work, among general practitioners (N = 302). In the sample there were 64% females and 26% foreign-born. **Results:** Among male physicians, almost 14% of the foreign-born, compared to 3% of the native-born, reported being subject to harassment or mobbing during the last 6 months ($\chi^21 = 3.983, p = .04$). There was no such difference between female foreign-born and female native-born physicians. Nearly 27% of the foreign-born thought the basis for unequal treatment to be ethnicity compared to barely 9 % of the physicians born in Sweden, which is significantly less ($\chi^21 = 6.944, p < .01$). There were no differences found among Swedish female and male physicians. **Conclusions:** There is evidence that foreign-born physicians working in primary health care in Sweden experience harassment and unequal treatment. Harassment and unequal treatment could affect physician health, and attention must be paid. The gender differences could also be a sign of gender inequality, which need to be examined more thoroughly.

**REPORTING HEALTH PROBLEMS**

101 POSTER
**Silent wellness of doctors: a comparison with the general population of homogeneous social class**

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**Introduction:** Medicine is a profession with a strong social commitment that frequently entails a great involvement in work and doctors need to face the pressure from various sources for maintaining the balance. Meanwhile doctors physical health appear to be good, there is some evidence of higher vulnerability to psychological disorders stress related. There is little research about the perceived state of health and job satisfaction among doctors in the Mediterranean countries. Moreover, scarce data are available comparing those items in the general population. **Purpose:** To analyze the perceived health, health conditions, life style and job satisfaction among Catalan doctors in comparison with the same social class (social class I). **Methods and material:** A survey was conducted in 2006 among active doctors registered in the Catalan medical councils (response rate 31.5%, n=762). The questionnaire was design in such a way that it could be compared with the Health Survey of Catalonia from the same year (n= 603 general population social class I). The main areas included in the study were: perception of one’s own health, health conditions, life style, and job satisfaction. A bivariate followed by a multivariate analysis was conducted in order to obtain the more significant variables. **Results:** No statistical differences concerning age and gender were found among doctors and general population social class I. Medical sample showed more job non-satisfaction (9 vs 47.5%, p<.001), more week hours of work (40.5 vs 49, p<.001), fewer hours dedicated to home tasks (1.9 vs 0.5, p<.001), less chronic diseases (81 vs 49%), less body mass index (24.5 vs 24.1, p=.03) but less health quality perception (10.4 vs 6%, p=.003). Moreover they exhibit less sleep hours (7 vs 6.9, p<.008), more benzodiazepines and hypnotics consumption (4.5 vs 9.6; p<.001 and 2.7 vs 5.9; p=.006 respectively) and higher probability of psychological risk (7.3 vs 18.8; p<.001). After logistic regression analysis, the variables that remained significant were: week hours of work, daily hours of domestic tasks, health perception, chronic diseases, sleep hours, hypnotics use and psychological risk. **Conclusion:** While doctors seem to be objectively healthy, their perception of health is worse compared to the rest of the general population in the same social class. A higher psychological risk and a fewer job satisfaction may be involved in those perception and deserves future research to be conducted in order to obtain a more comprehensive model of this discrepancy.
**RESEARCH STUDIES**

**36 WORKSHOP**

**How to conduct rigorous studies of doctors' wellbeing across the continuum from student to physician in practice**

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An understanding of rigorous study methods is essential to researchers. In this workshop, we will use examples from studies conducted of medical students, residents, and physicians in practice to introduce participants to an array of instruments that measure physical and emotional wellbeing and personal resilience. Participants will gain an understanding of basic survey approaches as well as interventional study design and the importance of a control group and randomization. Participants will work in small groups to select appropriate study designs used to answer common welbeing research questions using a provided algorithm. There will also be time for participants to share their personal research experiences and learn from each other about how to overcome obstacles. Practical take-home messages and handouts will be provided. **Time:** Section 10 mins Background information/Introduction, 20 mins Review of instruments with hands-on task, 30 mins Basic survey approaches & interventional study designs, 15 mins Task & debrief, 15 mins Sharing of best practices: Group discussion of successes and challenges, 20 mins Optimizing response rate and reducing study bias, 10 mins Discussion, Q & A, Evaluation.

**50 WORKSHOP**

**Transitions and milestones in physician health: Perspectives from the Johns Hopkins Precursors Study (1948-2014)**

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The Johns Hopkins Precursors Study, initiated in 1947 by Caroline Bedell Thomas to identify the precursors of cardiovascular disease and premature death, represents 57 years of a longitudinal cohort consisting of 1337 students who matriculated into the graduating classes of 1948 to 1964 of The Johns Hopkins University School of Medicine. The Johns Hopkins Precursors Study is one of the oldest continuously functioning longitudinal studies in the world. In medical school, participants underwent a standardized medical history and physical examination including measurement of height, weight, and blood pressure. Follow up consists of validated annual mailed questionnaires covering a range of assessments, including health behaviors, social support and household composition, physical functioning, mental health, work strain, preferences for end-of-life care, cognitive functioning, and retirement. Yearly response rates average about 73% with 90% of the cohort responding at least once every 5 years. A life course perspective contends that lifestyle and behavior in youth and middle age exert their influence on health later in life through established patterns and accumulation of effects that may take years to develop. In this interactive workshop, we will select specific studies employing a life course perspective illustrating how exposures and habits in medical school and middle age are reflected in outcomes in late life. We will draw from published and unpublished work done in the areas of cardiovascular disease, mental health, planning for end-of-life care, and retirement. Examples to illustrate the life course perspective and stimulate discussion show how: (1) sleep disturbance in medical school predicted onset of clinical depression (2) BMI in medical school and change in BMI over time correlates with the development of hypertension in late life (3) preferences for end-of-life care and decision making are associated with development of chronic diseases and, (4) health and functioning are associated with retirement patterns. The overall hypothesis being tested is that factors measured over the entire life course influence outcomes in late life. The overarching goal of the workshop is to provide an informal venue for bidirectional exchange of ideas between the investigators involved with the Johns Hopkins Precursors...
Study and investigators and program leaders interested in physician health. Participants may raise questions about long-term outcomes in an area of interest that could be answered with the Precursors data. Precursors findings may inform the development or timing of interventions of interest (e.g., timing of interventions according to milestones to affect long-term outcomes).

THE OCCUPATIONAL HEALTH APPROACH

174 ORAL
The development of an occupational health service integrated psychology assessment and treatment service for doctors and other healthcare staff based on the trauma model

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There is an increasing awareness of large numbers of healthcare staff, including senior and junior medical staff and students, suffering distress in the workplace secondary to mental illness. There is an increasing recognition and acceptance of the ‘trauma-based’ model of psychological disturbance to which high achieving perfectionists such doctors are particularly susceptible. Stigma, professional culture and shame prevent many individuals from seeking help at the appropriate time so that chronic, low-grade distress can lead to an acute breakdown and other negative sequelae such as substance abuse and suicide. Sufferers can fail to respond to traditional and accepted treatment modalities such as medication or medication with standard talking-therapies. Many return to their workplace, or University courses, after periods of time-off without change in their condition yet the root cause of their distress and the underpinning psychological disorders have not been accurately identified and addressed. EMDR and the trauma model have a scientific research base which is recognised and validated within the body of psychological treatments and endorsed by UNITAR and the WHO. Five years ago we recognised potential to improve psychological treatments for NHS staff and created a service based on a psychological trauma assessment model including elements of CBT (Cognitive Behavioural Therapy) and elements of EMDR (Eye Movement Desensitisation Re-processing). This was led by the Lead Cognitive Behavioural and Trauma Therapist EMDR Europe Approved Practitioner and a Consultant Occupational Physician, NHS Highland Occupational Health Service.; The service has run since 2008. The number, occupation and presenting issues of staff (including doctors and students) have been recorded. The CORE Outcome Measure questionnaire was used to assess treatment impact. The data is being analysed currently to identify the range of staff seen, their presenting problems and the degree of benefit obtained from treatment. ’ We have also begun to see and treat medical students with student support ‘workshops’ to help staff identify and refer students who are suspected to have a mental health issue. Across the U.K., Universities’ Schools of Medicine are seeing a significant rise in the number of students seeking help through counselling and who are ultimately found to have a form of mental health illness. High proportions of these students have significant ‘trauma’ histories including mental, physical and sexual abuse, separation, family breakdown, bullying and financial worries. We wish to report on our experiences in developing this service including the outcomes for patients and the barriers we have encountered.

32 ORAL
Doctor and dentist contacts with an NHS occupational health service

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Background: There is increasing acceptance that management of ill-health in doctors can be patchy and is not always optimal. Health can impact on performance and fitness to practice, placing an important responsibility on occupational health (OH) services. Aims: To improve our understanding of OH contacts by doctors and dentists and make some comparison of this with available sickness absence records. Methods: A retrospective descriptive evaluation of all doctor and dentist encounters with the OH service between April 2009 and March 2010 was undertaken. Doctor and dentist encounters from our electronic appointment system were analysed using Microsoft
Excel. Comparisons were made with management-reported sickness absence data for this period. **Results:** Blood tests, immunizations/immunization updates accounted for 49% (295) of contacts. Management and self-referrals accounted for 26% (157) of all OH contacts. Mental health conditions were the main reason for referral (approximately one-third of all cases referred). In this group, a much higher number presented to OH, absent from work, than were recorded with sickness absence by management. Musculoskeletal, infection and skin complaints were other predominant reasons for referral. **Conclusions:** Doctors and dentists do utilize this OH service and the issues for which they need services are wider than those of mental health. Inconsistency in the reporting of sickness absence in doctors with mental health problems has also been highlighted. This baseline information is a useful stepping stone to identifying and meeting the specific needs of doctors and dentists and can be used as a benchmark in other organizations.

77 ORAL
The occupational health approach – can it benefit doctors in transition

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Medicine is a demanding profession, doctors are experiencing increasing pressures and are starting to refer themselves to occupational physicians either as a first port of call for career advice or for signposting, regardless of whether or not they are undergoing medical treatment. They can be students with health problems contemplating a career in medicine, doctors in training who are experiencing difficulties at work, established practitioners who have developed medical conditions or disabilities or older doctors thinking about part-time work or retirement. Doctors whose performance is giving cause for concern are also being referred to occupational physicians by employers and regulatory agencies for an assessment of whether and how health issues should be taken into account when dealing with the case. National Clinical Assessment Service data informs the assessment principles gleaned from 12 years of experience, the Gateways guidance from the General Medical Council is aimed at students and doctors with disabilities and the Faculty of Occupational Medicine now runs practical courses on how to deal with the health concerns of health professionals. The Boorman Review deals specifically with the health and wellbeing of the NHS workforce as a whole. The increasing demand for occupational health advice suggests doctors perceive it to be potentially useful to them. Perhaps they realise that occupational physicians will have developed unique expertise drawn from a) being referred “underperforming” doctors in order to assess the health component of their problems and b) are trained in the specifics of the nature of work and of work-related illness and disability. The precepts of occupational medicine are, broadly, not primarily concerned with medical treatment but with functional assessment and its relationship to the task in question—the interplay of work and health, in other words. This presentation will therefore describe the functional assessment of doctors—physical, mental and behavioural and how the assessment can be used to help or plan when health, ability or work opportunities are changing. I would expect the discussion to also cover the evidence for health & wellbeing initiatives in the workplace and ways to develop emotional resilience – initiatives often delivered by occupational health services. High on the occupational health agenda at present is how to manage an ageing workforce and lessons from this can inform the planning of career trajectories for doctors.

162 ORAL
A review of trainee doctors obtaining Occupational Health support in 2013

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Postgraduate Medical Trainees may have pre-existing health conditions / disabilities or develop health issues which require additional support as they transition from medical school through foundation school and into specialist postgraduate training. It is increasingly being recognized that the modern training environment has the potential to lead to high levels of pressure which in turn can affect the health and well-being of vulnerable trainee doctors. Shorter working hours, less experience, a loss of home base, shift work and a lack of support are some environmental factors thought to lead to reduced continuity of care, reduced experience, clinical confidence and difficulty making decisions. The 2013 GMC Trainee survey has highlighted specialties with increased reporting of for example bullying and harassment, with Obstetrics and Gynaecology having the highest reported issues. There is a perception that young female doctors are increasingly accessing services for support. Some reasons hypothesized are increasing awareness, an increased
willingness to seek help and possibly reduced stigma in admitting they may have mental health issues. Belfast Trust Occupational Health service has seen an increase in the number of trainees being referred and seeking support since a previous survey in 2010. This is thought in part to be due to increased awareness of early warning signs, through education of supervisors and enhanced Deanery Support. In a previous review of doctors attending the Belfast Trust Occupational Health service in 2010, 47 postgraduate trainees attending within a 1 year period with 64% having a mental health cause. The highest rate of mental health presentation was in F1 doctors, with 80% of the 5 F1s attending having anxiety or depression. In 2013, 72 trainee doctors attended the Occupational Health Service. This is an increase of 53% in the 3 years. This presentation will present a number of factors about the population of Trainee doctors attending occupational health in 2013, their previous health status, their route of referral, reason for referral, demographics, grade and specialty, common risk factors, support they have received and outcome in relation to return to or continued training and fitness for work in transitioning through the rest of their postgraduate training.

TRAINEE AND RESIDENT TRANSITIONS

111 WORKSHOP
‘What’s Up Doc?’ Following a junior doctor with depression-a skills based workshop

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Introduction/Aim: The author runs this workshop for groups of established doctors to help them consider their own workplace and personal health and wellbeing. It has been put together following several years of trialling different tools and techniques. Method and Results: The workshop follows the journey of a junior doctor with depression from the point they were referred to Occupational Health and told they were unfit for work, through their rehabilitation plan and back into the workplace. The case is an anonymised amalgamation of many similar cases seen over several years. The workshop looks at precipitating stressors/life events both at home and at work for a junior doctor struggling to juggle the needs of her work and family life in a two doctor household, particularly after the major life event of having two children in quick succession. The workshop starts with a brief overview of cognitive behaviour therapy (CBT) and explains the assessment tools and techniques used to help the junior doctor. As each tool is introduced the case history is halted and the participants are shown how to use the tools and techniques for themselves. The tools include: 1. ‘Hot date’ group exercise to understand principles of CBT 2. Workplace stress risk assessment (based on UK Health and Safety Executive Stress Management Standards)-personal assessment using quick questionnaire 3. Learning how to challenge negative thoughts-paired exercise 4. How to ergonomically set up a computer workstation-handout 5. Upper body Pilates based exercises-group exercise 6. 4-7-8 breathing-group breathing exercise 7. Prevention and management of needlestick injuries in workplace including short film telling true story of a nurse who contracted Hepatitis C following an injury 8. Balance wheel coaching exercise - paired discussion. Consideration of 3 changes they might make to improve their own work life balance. Discussion and Conclusions: Doctors have traditionally learned through presentation and discussion of case histories, and are therefore comfortable with this method of education. The case also illustrates the important role of Occupational Health in the case management and rehabilitation of doctors with health problems in the workplace. Evaluation: The workshop has been run and evaluated on a regular basis. A recent workshop run for 40 family doctor trainers on an away day scored 3.4/4 for content and 3.5/4 for quality of presentation where 1=poor and 4=excellent. Comments included “best learning session I’ve had for years” and “good fun and interactive”
How can the transition process from medical student to junior doctor be improved in order to better prepare junior doctors for starting their first job?

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The transition process from final year medical student to junior doctor is a rite of passage experienced by thousands of individuals annually. However, this process is not always smooth and commonly is referred to as a “survival experience”. The hospital workplace is a very busy environment and patient care is always paramount. Evidence suggests that during this transition period, high levels of stress, anxiety and in some cases initially compromising patient care are experienced. Other factors such as poor preparation for dealing with acutely unwell patients, ineffective communication with others and lack of formal training for clinical and non-clinical aspects of the job influence this transition process.

Suggestions for improvements for these problems are made based on the experiences of a foundation trainee having completed the two year programme. These include use of clinical apprenticeships during the induction time, use of simulation teaching and better training for communication would overall have a positive outcome. With an improvement in the transition process, patient safety and care could improve, tensions in the workplace may decrease, and all members of the team would benefit through individual and institution engagement in the transition process. Several factors are addressed in this piece of work with regards to barriers faced during the transition process from medical student to junior doctor and suggested improvements focusing primarily on the induction programme by the receiving institution.

This is relevant to the conference theme in terms of transition processes and career milestones, is based on a foundation trainees experiences and links to evidence based medical education and discusses various options linking to the theories of Lave and Wenger in order to better understand how to improve this process in order to ease transition and sustain high quality care delivery to patients. This can include being a workshop presentation through a short introduction to the milestone, a real life example of experiences and linking this to the literatures and break-out into small groups for discussion and interactive participation of problem solving this transition process and coming together to summarise and conclude on outcomes.

Outcomes are expected to essentially allow attendees to appreciate the importance of this milestone for the junior doctor, the institution itself and consider working to better engage in a smoother transition for the future.

The transition from study to work: Findings from a national mental health survey of the Australian medical profession

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Background: In February 2013 beyondblue (www.beyondblue.org.au) conducted the landmark beyondblue National Mental Health Survey of Doctors and Medical Students. The survey provides an unprecedented insight into the mental health of Australia’s doctors and medical students, and the best ways to support them. Purpose: The purpose of the survey is to: understand issues associated with the mental health of Australia’s doctors and medical students; increase awareness across the medical profession and broader community of issues associated with the mental health of doctors and medical students; inform the development and delivery of mental health programs, services and supports for the medical profession. Method: The survey questionnaire and methodology were guided by input from a Project Advisory Group, comprising leading expert in doctors’ mental health. The Australian Health Practitioner Regulation Agency, the national registration authority for health professionals, sent out the anonymous survey questionnaire to approximately 50,000 doctors and medical students using a sampling frame based on their geographic location. A market research company collected and analysed data. Results: Over 14,000 Australian doctors and medical students participated in the survey. Key findings include: One in five medical students and one in 10 doctors had suicidal thoughts in the past year, compared with...
one in 45 people in the wider community. Young doctors work longer hours (50 per week on average), are far more psychologically distressed, think about suicide more and are more burnt-out than their older colleagues. Male doctors work longer hours (46 per week) and engage in more risky drinking but female doctors are more psychologically distressed and think about suicide more often. Perceived stigma is rife with almost half of respondents thinking doctors are less likely to appoint doctors with a history of depression or anxiety and four in 10 agreeing that many doctors think less of doctors who have experienced depression or anxiety. Discussion: The transition from study to work appears to be a particularly stressful period with higher rates of distress and burnout in younger doctors in comparison to more experienced and older doctors. There is a need to consider initiatives which address the stressful working environment and provide groups at risk (e.g. young, female and Indigenous doctors) with additional support. Drawing on broader research, stigmatising attitudes may be reduced by promoting the personal experience of doctors with mental health conditions.

132 ORAL
A year in transition: resident narratives of wellbeing and adaptation throughout the first year of training

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Purpose: It is generally accepted that trainees experience significant stress during first year residency, yet there is little information on variations in stress and wellbeing over the transitional year or those factors that contribute to these variations. This qualitative study explored the trajectory of wellbeing described by PGY1 residents in the context of challenges, supports, and adaptations over time. Materials and Methods: In-depth interviews were conducted face-to-face with 17 PGY1 residents at the University of Toronto. Participants drew a visual graph of their wellbeing over the course of the PGY1 year and described critical periods of challenge and adaptation. Interviews were audio-taped and transcribed. Results were organized into a thematic analysis using NVivo software. Results: Residents described a pattern of wellbeing that varied in accordance with changes in rotations. Wellbeing increased where residents perceived high levels of team support, felt competent, and experienced valued learning opportunities. Wellbeing decreased with low team support, high work demands, few learning opportunities, and poor orientation. Anxiety and excitement in the beginning of the year gave way to heightened confidence but increased fatigue and apathy towards the year's end. Residents used a number of cognitive, behavioural, and self-care strategies to cope with transitional challenges. Conclusions: Residents identified multiple transitions, which they linked to rotational changes. Residents’ wellbeing varied according to levels of supervisor and colleague support, feelings of competency, learning opportunities, and work demands. Trainee wellbeing may be improved by focusing on strategies to increase team support and learning opportunities, improve orientation processes, and bolster individual coping strategies.

156 ORAL
Longitudinal study on junior doctors health in Catalonia (2013-2017)

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Galatea Foundation, in collaboration with the Catalan Society of Occupational Health, is developing a study on junior doctors health, lifestyles and working conditions in Catalonia. The principal aim is to learn more about this target and to design and develop interventions to promote a healthier medical performance. Therefore, the Occupational Health Services of the main training health centres in Catalonia asked junior doctors who started their residence last May 2013 to join to this cohort study. We got baseline data from 465 junior doctors (participation rate of 56%), as well as their permission to contact them next May 2014, when they finish their first year training, and in May 2017 when they reach their specialty. In the baseline interview we asked them about personal characteristics as: demographic data, specialty chosen, lifestyle (physical activity, alcohol and tobacco consumption), health (self-assessed health, chronic conditions, height and weight, sleep, risk of mental disorders (GHQ)), health habits, and also about personality traits, personal events and satisfaction with various aspects of life. We have compared results of baseline
interview with a previous study on medical students (Health, lifestyles and academic conditions of medical students in Catalonia, Galatea Foundation, 2010): We can conclude that new junior doctors before starting their speciality training have a better self assessed health status than 4th year students. Their risk of mental disorders is also much lower. They have also reduced their tobacco and alcohol consumption. Nevertheless, they have less physical activity and more overweight. There is a relevant demographic data to take into account: more than a third of new junior doctors come from other countries, mainly from South America, and most of them have studied their degrees abroad. With collected data at the end of their first year of speciality training, we will be able to learn if their health status and lifestyles conditions have worsen after having been exposed to the training psychosocial risk factors. We want to analyse the relationship among junior doctors burnout, working conditions and personal characteristics.

211 POSTER
The impact of less than full time working on you and your team

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Over recent years, a number of articles in the media have raised concerns about the impact of the growing numbers of females entering medical school. The concerns were related to the assumption that many of the female students would later wish to work part time, based around the fact that the vast majority of those currently working part time are female. However, there are many reasons for a doctor to apply to work less than full time, including family and health reasons, all of which could apply equally to both male and female staff. Trainees navigate many transitions during their training, often moving posts every 4 or 6 months. The transition to working part time will have a significant impact, amongst other things, on how trainees work, how they are viewed by others, and the length of their training. Many opt to work less than full time to get a better work-life balance, but then find themselves part time in a full time post where the expectations of the consultant and team as to what they should be able to do during their work time can vary considerably. This poster will detail the reasons that trainees decide to apply to work less than full time and examine both the potential benefits of flexible training as well as the many issues that are encountered by these doctors. The impact that these challenges have on the trainees will be discussed and sources of support examined. As the number of trainees working less than full time continues to rise, the issues raised in this poster are likely to be relevant to all doctors.

253 POSTER
Stress and anxiety in junior doctors

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Introduction: Stress and anxiety in junior doctors has been much-studied. Dudley (1990) states, ‘it is recognised that graduation marks a sudden translation from a protected world, into real life, where stress is inevitable’. Work-related stress affects health and morale, results in poor decision-making and communication, and poor relationships with colleagues and patients which may negatively affect patient care (Riley et al, 2004). It is very difficult to predict when stress levels become detrimental to both junior doctors, and the whole NHS. Here, we examine stress and anxiety in foundation doctors, in relation to sick leave, as well as difficulties in talking to colleagues and family/friends. While there are studies investigating junior doctors’ sick leave due to infection (Perkin et al, 2003), there are none to our knowledge, examining sick leave and stress or anxiety. Our study therefore offers a novel health economic perspective on this problem. Methods: An anonymous, online questionnaire was sent to foundation trainees in 4 midlands hospitals. Participation was entirely voluntary. The questionnaire consisted of 7 ‘yes/no’ and ‘Likert scale’ questions, which examined anxiety and stress levels, as well as sick leave behaviour. Results: When asked if they had ever knowingly taken a day off due to stress or anxiety, 3.2% of respondents (n=1) reported that this was the case. Interestingly, 16.1% (n=5) reported taking a day off that they later realised was due to stress or anxiety. 58.0% of respondents reported ‘extremely high’ or ‘quite high’ anxiety levels at the start of FY1, dropping to 38.7% at the time of data collection (mid-year). On rating ‘stress’ levels, 61.3% reported ‘extremely high’ or ‘quite high’ levels of stress on starting as a FY1, dropping to 48.4% at data collection. No participants reported having a diagnosed stress/anxiety disorder. 41.9% of participants reported finding it difficult...
to talk to colleagues about work-related concerns. Similarly, 32.3% also found it difficult to talk to family/friends about such issues. **Conclusions:** Our findings have implications in terms of supporting junior medical staff. There is obviously a significant proportion of junior doctors experiencing high levels of anxiety and stress at the start of FY1. In addition, with 16.13% of junior doctors in this study reporting taking a day off they later realised was due to stress/anxiety (a figure that may well be under-reported), this raises the need for further investigation into this important area, and the need to encourage junior doctors to seek support. Clearly, there are also issues with support networks, with 32.3% unable to talk to family/friends about such work-related issues.

**226 POSTER**

**Depersonalized but vigorous residents: implications for patient- centered care**

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**Purpose:** Patient-centeredness is one of the key components of Quality of Care (QoC) as identified by the Institute of Medicine (IOM). Patient-centered care entails respect of individual patient preferences, needs, and values, and ensures that patient values guide all clinical decisions. Burnout in health professionals is associated with decreased well-being, more perceived medical errors and compromised provision of care. These results are more evident among medical residents. In this study we examined which types of job demands, burnout and engagement are predicting the provision of patient-centered care. Methods: A survey was conducted among residents in 5 countries; Greece, Bulgaria, Romania, Turkey and FYROM. Self-reported data on demographic characteristics, workload, patient-centered care, burnout, job engagement were collected. Four types of workload (physical, emotional, cognitive and organizational job demands), were measured with the Hospital Experience Scale (HES). Burnout was measured with Maslach Burnout Inventory (MBI). Engagement was measured with the Utrecht Work Engagement Scale (UWES). Bivariate correlations were conducted to examine the relationships between independent job demands, burnout, job engagement and patient-centered care. Mediation analyses were conducted to assess whether burnout/engagement mediate the relationship between job demands and provision of patient-centered care Results: The sample consisted of 550 residents 262 males (47.6%) and 288 females (52.4%), from 5 different countries Greece (n=191), Bulgaria (n=55), Romania (n=119), FYROM (n=67) and Turkey (n=118). The mean age of participants was 30.4 years (sd= 4.9), the mean working experience at the hospital was 1.87 years (sd= 2.2) and at the hospital unit was 1.56 (sd= 1.81). No significant differences were found between males and females with regard to job burnout or job engagement results. Thirty six percent of the participants reported burnout symptoms. Depersonalization and vigor mediated the effect of organizational and cognitive demands on patient-centered care. Discussion: The results confirm existing knowledge linking burnout with compromised quality of care. Organizational and cognitive job demands were found as a significant source of depersonalization and less patient-centered care. Preventing burnout and fostering vigor in residents can be a strategy to increase the patient-centered care in hospitals.

**187 POSTER**

**Transition from student to foundation doctor: a survey of coping mechanisms used by foundation doctors**

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**Introduction:** The transition from being a medical student to a foundation doctor can be stressful [1,2]. A poor work-life balance amongst doctors can have adverse effects on a doctor’s performance, educational training and ultimately patient outcomes [3,4]. Here we assess the effects that the transition from medical school to junior doctor has had on the work-life balance of some junior doctors and the coping mechanisms used to address this issue. Method: An anonymous questionnaire consisting of 10 questions was sent to 41 Foundation Year 1 Doctors asking them to rate certain aspects of their work-life balance. In total 25 replies were received. Doctors were asked to list their coping mechanisms and give advice for future foundation doctors in dealing with the transition from being a student to a doctor. Results: An average score of 2.72 (out of 5) was given to the experience from being a medical student to a junior doctor from a personal perspective. Work-life balance was very important (average score 4.88 out of 5). Coping mechanisms ranged from socialising/speaking to family and friends - most frequent to alcohol – most infrequent. Most candidates (64%) did not feel...
their coping mechanisms had changed from medical school. Those who felt it had changed felt this was due to a lack of time. Advice for future foundation doctors included keeping up one’s own interests/ hobbies, taking regular annual leave, and handing over jobs effectively. **Conclusion:** The findings indicate that some junior doctors may find the transition from student to foundation doctor difficult from a personal point of view. Coping mechanisms may change when making this transition, primarily due to a lack of time. 1. Brennan N, Corrigan O, Allard J, Archer J, Barnes R, Bleakley A et al. The transition from medical student to junior doctor: today’s experiences of Tomorrow’s Doctors. BMC Medical Education. 2010;4(5):449-58. 2. Amanda McNaughton. The transition from medical student to junior doctor: an A to Z guide. BMI Careers; 31st July 2004 3. M. Brown et al. ‘The impact of shift patterns on junior doctors’ perceptions of fatigue, work/life balance and the role of social support.’ Qual Saf Health Care 2010. 4. Philippa Gander et al. ‘Work patterns and fatigue-related risk among junior doctors’. Occup Environ Med 2007;64:733–738

### 133 POSTER

**‘This is an important topic that we don’t often address’: Resident evaluations of a wellness curriculum in Postgraduate Medical Education**

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There are few curricular programs that assist PGME trainees in sustaining well-being and performance. As a result, little is known about educational interventions that best meet the needs of trainees. The Office of Resident Wellness (ORW) at the University of Toronto developed and delivered a wellness curriculum to 25 training programs during the 2011-13 academic years. A research project evaluated trainee responses to the curriculum. The objective was to increase our understanding of the educational needs of trainees, and improve workshop effectiveness. At the end of each workshop, participants were asked to complete an evaluation form consisting of quantitative and qualitative questions. Participants identified what was most and least valuable, whether or not the workshop met their expectations, what they hoped to do differently afterwards and any barriers they foresaw to making these changes. We performed descriptive statistical and thematic analyses of the evaluation data. The workshops were very well received by residents with a large majority (86%) indicating that they were satisfied or very satisfied with the sessions. A thematic analysis identified the opportunity to discuss these topics, practical skills development, and knowledge acquisition, as the most valuable characteristics of the workshops. Suggestions for workshop improvements were to decrease their length and smaller groups. A few participants did not feel comfortable sharing their feelings in a group context. Insufficient time due to service demands was the most commonly identified barrier to implementing knowledge acquired in the workshops, followed by personal barriers such as lack of motivation and fatigue. Another barrier commonly mentioned is the culture of medicine and the lack of faculty support. Overall, the workshops have been very well received by residents and their programs. The evaluation data has provided an opportunity for an iterative process of workshop improvement.

### 82 POSTER

**The experience of professional role transition for newly licensed independently practicing physicians**

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**Purpose/Relevance:** There is little research exploring physicians’ transitions across career stages, and thus we lack an understanding of the impact of these transitions on physicians’ understanding of their roles, relationships, responsibilities and knowledge application. This study aims to explore the experience of physicians’ transition from learner to that of independently practicing physician. **Methods:** Semi-structured interviews were conducted with participants at 1, 4, 8, and 12 months post career transition. The 1 month interviews are the focus of this paper. Six participants were recruited from a cohort of physicians at a Canadian university hospital as they transitioned from post-graduate training to independent practice. Interview transcripts were analyzed using a grounded theory approach to identify and abstract key themes. **Results:** Participants described a shift of their professional persona during the first-month transition into independent practice, with three key components identified. First, the new persona assumed ultimate accountability for patient care,
and due to this enhanced responsibility, “mistakes take on a different flavor”. Second, the new persona demanded an enhanced professional image so that others would perceive them as competent. Participants admitted to insecurities about their competency and suggested that they put on a brave face and tried to “be the calmest one in the room” even when unsure. Third, their new persona was granted membership to the professional community of their new peers. Participants described how they sought and experienced collegial support, and felt invested in and accountable to this professional community. The overall persona shift was experienced differently by different physicians. For some it was abrupt, described as “like ripping off a Band-Aid”. Others felt the shift was more gradual, in particular if they believed they were well prepared for the role through residency or fellowship training. Participants experienced uncertainty and a steep learning curve around less familiar areas such as administrative tasks and healthcare policies. While they described experiencing increased work-related stress, they also enjoyed the satisfaction of achieving their professional goals, the freedom of professional autonomy, more control over their lives, and improved remuneration. Discussion/Conclusions: The physicians experienced a shift in their professional persona during the first month of independent practice, and it will be interesting to see how this experience evolves over their career transition. Knowledge from this study could help educate physicians about what to expect while undergoing this transition and help us to understand what resources may be helpful during this period of transition.

205 POSTER
Should formal stress management teaching be incorporated into the first year of a doctor’s practise?
A career transition study of British foundation year 1 doctors

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Purpose/Relevance: The first year as a doctor in any country represents a major career transition in any physician’s life. During this period, many physicians concentrate on obtaining clinical skills but may not obtain the important skills necessary to cope with stress. In this study we elucidate stress levels amongst FY1 doctors regarding: transitioning into specialty career choices, working in the NHS and anxiety about future career success. Methods: A prospective single blinded analysis of foundation year one (FY1) trainees using a non-mandatory online questionnaire was distributed. No exclusion criteria was applied. The only inclusion criteria was the doctor was in a full time FY1 post and this was their first job in the UK. A total of n= 22 doctors were included in the study. After data collection, statistical analysis using chi squared testing was applied. Results: The large majority of FY1 doctors (72.7%) already knew what specialty they wished to pursue (p=0.0001). With regards to their future careers 45.5% of FY1 doctors stated “above average” stress levels. The majority of FY1 doctors (64.3%) stated their stress levels working in the NHS were either “above average” or “high”. Finally, 81.8% of respondents know colleagues who have been put off from pursuing specialties due to the stress of competition.

Conclusions: A large majority of FY1 doctors already know at this early stage what area they would like to specialise in. With this in mind, a large proportion have above “average” levels of stress with regards to securing this future career path. The most worrying finding is that 64.3% of FY1s stated they had “above average” or “high” stress levels working in the NHS. We therefore recommend formal stress management education to be incorporated into the foundation programme curriculum.

109 POSTER
Referral of medical trainees with health issues to the Professional Support Unit in Wales

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Doctors with health problems face unique problems in obtaining help. It has been reported widely that ill-health and disability are particular issues for a large percentage of medical trainees and the stigma associated with such problems might explain, in part, their difficulty in obtaining assistance. There are many reasons why a doctor’s performance might be affected: Factors associated with performance, safety and quality, communication, maintaining trust and progression in training can contribute to health problems. The Wales Deanery introduced the Professional Support Unit in 2008 to provide a range of support and guidance to trainees affected by physical and mental ill-health and/or disability. This support
includes pastoral care and support, proactive identification of the issues, review of the support available, and adjustments to the working environment. A review of a sample of 100 closed cases of trainees referred to the PSU showed that 27% of trainees had ill health with common reasons being; psychological problems, stress, anxiety, dyslexia and 4% had a disability. We found the majority of these trainees were able to, with support from PSU, continue in their training and attain CCT. A very small minority decided to make a change of career. We believe that with early and proactive identification of the issues, trainees with ill-health and/or disability can with the support of the PSU learn to address their health issues, continue in training and this has a positive effect on retention of doctors in Wales.

195 POSTER
Forced early specialty choice and negative perceptions of career breaks: is the Foundation Programme harming junior doctors' health and wellbeing?

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Background/Aims: Junior doctors in the UK Foundation Programme (UKFP) are now strongly encouraged to decide their career path within eighteen months of qualifying from medical school. Furthermore, an unspoken culture of aversion towards career breaks seems to prevail regarding future employability. This study aimed to evaluate the attitudes amongst Foundation Year 2 (FY2) doctors towards forced early career choice during this important transition year. Additionally, we sought to evaluate the perceived impact of taking natural career breaks after FY2, and the desire amongst junior doctors to take time out of training to improve physical and/or emotional health. Methods: A prospective single blinded study was conducted in two different UK university hospitals in Manchester and Southampton. A non-mandatory questionnaire was circulated amongst FY2 doctors at these institutions. Specific areas evaluated included: certainty regarding future specialty choice, stress regarding future specialty choice, desire to take time out of training to improve physical and/or emotional health, and fears regarding the repercussions of this upon their careers. Inclusion criteria were doctors employed in a full time FY2 post. No exclusion criteria were applied. A total of n=24 physicians were included in the study. Results: Over half of the cohort (58%, n=14) felt certain about their future specialty choice. However, 58% (n=14) felt stressed or anxious about making the wrong decision in this regard. Only 38% of respondents (n=9) expressed anxiety about actually securing a specialty post. An overwhelming majority of 79% (n=19) agreed that FY2 was too early to be making definitive decisions about a specialty, and the same number desired a system in which such decisions could be delayed until later in training. Significantly, 92% (n=22) agreed that taking time out of training would benefit their physical, emotional and/or mental wellbeing. Unfortunately, the same number also felt that employers might look unfavourably upon those taking time out for non-medical reasons. Conclusions: Specialty applications are an important milestone in medical career progression. Almost half of FY2 doctors are uncertain of what specialty to pursue and most feel stressed or anxious about making the wrong career choice. Over ninety percent felt a career break would benefit their physical or emotional health, but feared that future employers might perceive this negatively. We therefore propose prolonging the Foundation Programme to three years and suggest an option of a one-year career break to improve health and wellbeing, with no ensuing repercussions for future employability.

TRANSFORMING INTENTIONS INTO ACTION

112 ORAL
The Doctors’ Health Access Pathway – an educational framework to improve health access

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Purpose: Physician health studies have focused on documenting the prevalence of doctors’ health issues and listing barriers that doctors confront when accessing health care. This paper moves the discussion forward by offering an innovative approach for educating doctors about their help-seeking behaviours to facilitate their health access. Methods: This study draws upon a strong evidence base established through a series of research projects: a systematic review of the literature, a review of the narratives of doctors’ illness
experiences, and an Australian qualitative study into doctors’ health access. The findings from these studies were then mapped onto an established sociological model of health access, the lay referral pathway. Through this integrative process, doctors’ health access behaviours were compared with those of the lay community and a model of doctors’ health access was constructed. Using this model, a framework was developed for a targeted educational programme designed to enhance doctors’ health access.** Results:** The Doctors’ Health Access Pathway is an innovative framework that enables doctors to proactively anticipate and address barriers that they may confront when seeking health care. Rather than focusing on a series of rules and boundaries, this approach provides a strong rationale for positive health behaviours. The sociological lens offers unique insights into specific health behaviours such as self-treatment and corridor consultations. Five points are identified where doctors are more vulnerable as they journey along their pathway to care. Practical solutions for reducing these barriers are presented. Socio-cultural aspects of medicine that potentially reinforce many barriers are highlighted. By contextualising these understandings of health access, this framework also enables doctors who care for doctors to move beyond the use of labels (such as delay, denial and delusion) towards a deeper understanding of the complexity behind many self-care decisions. This approach facilitates the establishment of a patient-centred consultation.** Discussion / Conclusions:** Barriers to doctors’ health access have concerned the profession for decades. Many current interventions aim to enhance wellbeing or provide care for physicians with mental health problems. Few interventions have focused on facilitating health access. This study offers an innovative framework that empowers physicians to maintain the necessary balance between self-care practices and accessing healthcare when addressing their personal health needs. It has the capacity to engage doctors at every milestone – whether they visualise themselves as ‘doctor-patient’ or ‘treating-doctor’ – and offers a novel way towards a healthier culture in medicine.
interusions that delayed or prevented their self-care efforts. **Discussion/Conclusions:** The results suggest that there were many instances where physicians were able to successfully effect and role model wellness behaviors; however, despite an apparent increased awareness of wellness issues, there were instances of a disconnect between the physicians’ intentions to effect wellness strategies and actually transitioning them into action. This disconnect appeared to be at least partly related to the nature of the physician role and the work setting. These results highlight the need for future research on strategies to better support physicians in the workplace, thereby enabling transitions of wellness knowledge and intention into action.

237 ORAL

*i don’t want to be looked after by doctors who do not even know how to look after themselves!* Helping first year medical students to understand how self-care can enable them to work in partnership with their patients

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We have a tradition at Leeds of embedding patient/carer perspectives into the MBChB undergraduate curriculum. The shift from eager student to student-practitioner upon course entry is huge and can be daunting for all concerned. This oral presentation will describe some of the interventions and innovations that we have developed in order to try to address this challenge. We support students by centering them early on patients’ needs/perspectives and their impact not only on patients, but on their own thoughts, feelings and behaviors. Early patient/carer involvement includes clinical placements, Patient Mentors, patient/carer classroom and home visits and self-care exercises. The Patient Mentors aim to give students a wider perspective about key issues in clinical encounters and the space to explore the personal impact of care delivery. The rationale is from the GMC which requires doctors to work in partnership with patients and that some of the first teaching/learning comes from patients, demonstrating their capacity to do some of their own healing/health management, beginning to remove the burden that the doctor must provide all the knowledge, wisdom and expertise. Trust is key to this partnership. In one Leeds study, workshops were held with mental health services users, aiming to develop teaching materials for medical students. Their priority, early in students’ training, was to develop an embedded self-care package to address their overwhelming concern: ‘i don’t want to be looked after by doctors who can’t even look after themselves!’ Part of the preparation of the patients/carers is a Learning Journey to become learner-centered, give student feedback, recognize/value their own expertise, and develop empathy for the students. Bayne (2011) wisely noted that in order for medical students to give empathy, they must first receive it from teachers and patients. All our students come to medicine with an excellent track record of intelligence and academic achievement yet a significant proportion will fail as students and later doctors. To help out students cope better with the professional world of medicine we have developed supporting materials, delivered early in the course, to help them understand themselves better and look to acquiring new coping strategies that will help them survive the demands of a career in medicine. In particular we focus on developing awareness of emotional intelligence and resilience. General Medical Council. (2009) Tomorrow’s Doctors. Good Medical Practice: Doctor Patient Partnership. London: General Medical Council. Bayne HB. Training medical students in empathic communication. J Spec Group Work. 2011 36:316-329.

222 ORAL

The development and integration of a self-care ‘Health and Wellbeing Curriculum’ in the medical school at the University of Auckland

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The MBChB programme is one of two medical programmes in New Zealand. Significant curriculum changes were introduced in 2013 as the first part of a process of phasing in a reinvigorated curriculum into all year levels of the University of Auckland medical programme. Part of this curriculum includes a ‘health and well-being’ (HWB) component which aims to equip medical students with skills and attitudes which are relevant to their own health and patient care. Medical students’ and doctors’ self-care and health behaviour has an impact on
the way they counsel patients about preventative health, and doctors’ ill-health or poor help-seeking behaviour can impact on patient safety. This underlines the significance of the HWB curriculum. **Aim:** To explore the development of a new HWB curriculum and its’ integration into the medical programme at Auckland University as part of the Personal and Professional Skills Domain. **Methods:** A critical review of relevant literature of medical student well-being was undertaken, and key themes and possible topics were identified. A further search identified literature describing self-care programmes within medical school curricula. The findings were used to inform the development of the HWB curriculum sub-themes and learning outcomes for years 2-6 of the Auckland programme. Preliminary evaluation of the programme was undertaken by student survey, and staff and student feedback was used to enhance the programme at the end of 2013. **Results:** The HWB curriculum sub-themes which were developed were Stress, Mindfulness and Reflective Practice, Emotional Intelligence, Practical Skills, Help-Seeking for Self and Others, Healthy Relationships, and the Science of HWB (components of the Monash University ESSENCE programme). A spiral curriculum was developed with topics revisited and built on, to reinforce prior learning and to emphasize their clinical relevance in the latter years of the programme. Themes were identified from students’ reflective writing, which were used to further develop the curriculum. Preliminary evaluation of the Year 2 programme showed that 65% of students agreed or strongly agreed that the HWB lectures or small group activities changed their awareness or behaviour regarding their personal health. **Discussion:** Our experience and the student feedback suggest that a HWB curriculum adds value when integrated into a medical programme. A flexible ‘circular’ approach is suggested for a HWB curriculum, whereby multiple sources of student and staff feedback are used in an ongoing way to keep the curriculum relevant to students, as well as in line with current research in this area.

**TRANSITION THEORIES AND BEST PRACTICE**

**137 WORKSHOP**

**Best practices for preparing and assisting physicians in transitions**

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**Introduction:** The purpose of this workshop is to discuss current theories around teaching and preparing physicians for transitions in life: life-cycle change, crisis, coping, and resiliency. Many life transitions occur between entering medical school and death; the last transition. We’ve developed a list of forty life transitions, some particular to physicians and those in the health sciences. But some questions remain, how are physicians trained or prepared to face these transitions and what consistency in theory is used when coaching physicians through life’s transitions? A PubMed search reveals only one article using the search words ‘physicians’ and ‘life coaching’. If one Googles® the phrase ‘coaching physicians through transitions,’ one finds several physician career coaching venues focusing on transitioning from clinical practice to non-clinical work. Some use the change cycle, others seemingly do not emphasize any theoretical base in their description. There is paucity of literature that outlines the best theory-based educational practices for preparing students, trainees and physicians to manage and thrive through these transitions. **Goal:** The purpose of the workshop is to brainstorm current theories being used, revise the list of transitions for physicians, and to identify best practice for providing physicians assistance during life transitions. **Objectives:** Participants in the workshop will: 1. List and describe various theories around change, resiliency and coping. 2. Review, critique and refine a list of physician life transitions. 3. Discuss and document best practices for those who counsel, coach or train physicians. **Description:** This 90 minute workshop is geared toward brainstorming and developing best practices to help guide physician assistance programs, physician coaches, and healthcare educators in training and supporting physicians in transitions and life crises. **Agenda:** Introductions/welcome/topic review, Brainstorming – theories (large group), Review and refine transition list (small groups), Identifying best practices (small groups), Sharing

WOMEN IN MEDICINE

35 WORKSHOP
Professional resilience of female family doctors during lifecycle transition events

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WONCA, the Global Family Doctor organization, is the parent organization for the Working Party on Women and Family Medicine (WWPWFM). The WWPWFM is an international network of family doctors whose mission is promoting gender equity and the wellbeing of women in family medicine. Membership of the WWPWFM is open to any person who is a general practitioner or family doctor. A group of WWPWFM members are currently undertaking a global qualitative research project to determine the factors involved in maintaining the professional resilience of women primary care doctors during times of lifecycle transition, such as marriage, motherhood, and caring for aging parents. The workshop will begin with a presentation of the findings of a literature review regarding women family doctor’s professional resilience during lifecycle transitions. This will explore the importance of transition, how particular lifecycle events may affect women family doctors, how this may challenge professional resilience, and strategies that have been shown to help support women through these events. Workshop participants will then be split into small groups and asked to discuss the issues raised and consider the challenges faced by women physicians during lifecycle events. A plenary session will follow to identify the common issues and promote wider discussion. Following this further small group work will be used to start to develop strategies and solutions for maintaining professional resilience during lifecycle events, ending with a final plenary session to identify common themes. The output of the workshop will be recorded in order that it can be used to identify themes for further exploration within the qualitative interviews and focus groups in the WWPWFM research project. A report of the workshop will be publically available on the Wonca Working Party on Women and Family Medicine website.

22 ORAL
Is a career in medicine suitable for women?

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The characteristics of good doctors, such as perfectionism and altruism, can make them vulnerable to mental illness. A change in these characteristics could explain increasing presentations to a specialist mental health service for doctors - PHP, where the number of young doctors, in particular young female doctors is increasing year on year. Over the five years that PHP has been running and averaged out for all age groups, the number of men and women presenting to the service is roughly equal. However since 2008, the number of young women presenting (under 35 years old) has increased five fold, from 21 patients in 2008-2009 to over 100 between 2012-2013. Women represented 51% of all new patients between 2012-2013, over represented, even given the high numbers of women entering medicine.

43 ORAL
Gender influence on sickness presence in outpatient care

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Background: In the health care sector sickness presence is common, and especially among physicians. Sickness presence is less studied than sickness absence but might have adverse
effects for individual physicians, and for health care of patients (Wallace, et al, 2009). Previous research has shown that female physicians more often go to work while sick (Gustafsson et al., 2013). In this study, it is examined whether men and women also show different reasons for going to work while sick.

**Method and participants:** The study was conducted within outpatient care in a large Swedish city (N = 283, women 64 %). The question studied were sickness presence in a long term perspective, during the last 12 months and reasons for going to work while sick (concern for colleagues; patients; workload; economy; and perceptions of own capability). **Results:** In a long-term perspective, women stated that they went to work while sick more often than men, F (1,282) = 6.06, p = .014. Among the women, 37 % stated that they often or very often go to work while ill. For men, this figure was 23.4 %. For the last 12 month, 50% of the women and 40% of the men had gone to work while sick more than two times (mean difference = ns.). Although men and women declared similar reasons for going to work while sick, there were also interesting differences. Women indicated higher concerns for patients, and a high workload as reasons for going to work while sick. On the other hand, men indicated economic concerns to a higher degree than women and that they were capable of going to work while sick. There were no gender differences in concerns for colleagues. **Conclusions:** Sickness presence might have severe consequences, both for physicians themselves and for patients and medical care. Knowing the reasons for why physicians go to work is important in order to counter these behaviors. It is also important to notice that sex roles are of relevance in this type of behavior. HR departments and managers within medical care need to address these questions thoroughly and to implement strategies to decrease sickness presence among physicians. **References:** Gustafsson Sendén, Tevik-Lovseth, Schenck-Gustafsson, Fridner: What makes physicians go to work while sick: a comparative study of sickness presenteeism in four European countries (HOUPE). Swiss Medical Weekly. 2013 Wallace et al., Physician wellness: a missing quality indicator. Lancet. 2009; 1714–21.

**Medic and Mum, the lived experience of postgraduate medical trainees combining specialty training and motherhood**

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This qualitative study explores the lived experience of specialty trainees combining work and motherhood. What are the supporting factors and what barriers and challenges do they face? A literature review identified factors which support medical mothers as well as role identity and conflict in caring professions. Most previous research used questionnaires in quantitative studies. This study was designed to provide qualitative evidence of a lived experience, ensuring that the voices of the individual trainees were presented and heard. A psycho-social case study approach using a free association narrative interviewing method was employed. Trainees responded to a single opening question “Tell me about your experience of combining specialty training and motherhood”. The interviews were recorded, transcribed and subjected to thematic analysis. My research journal contributed data from my reflections on the trainees’ words, actions and responses, as well as my own emotional responses to their stories. Trainees were recruited to the study by a neutral e-mail outlining the study and inviting them to participate. The KSS deanery education committee gave ethical approval for the study. The main findings of the study are that women doctors report a high level of satisfaction with their training once they are mothers. Factors which assist them in their daily lives are supportive partners, family networks and friends, adjustable working patterns and visible role models. Barriers included inflexible working hours, lack of support at home and poor understanding of the demands of motherhood by colleagues and supervisors. Five of the seven participants were working part-time, declaring this enabled them to continue with their career and spend more time with their children. All participants felt motherhood had improved their skills as a doctor with increased empathy and identification with child patients and their parents. Their medical training provided the skills to deal with difficult situations at home with a degree of calm and clear decision making. All expressed surprise at the impact of motherhood on their lives and experienced stress as a result of conflicting demands between home and work. Visible role models were felt to be essential and most consultants provided support. Regrettably, all had experienced a lack of understanding from some consultants and peers and certain situations, which were clearly distressing. These trainee stories demonstrate dedication to careers and families in the face of constant tension between the two roles. This research was led to award of MA Managing Medical Careers, University of Brighton 2013.
Surgeons in Difficulty: An Exploration of Differences in Coping Behaviors among Male and Female Surgeons

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Objectives: Research supports a high level of burnout across medical specialties and continuum of medical practices. Up to 40 percent of practicing surgeons report considerable stress and subsequent burnout during their career. Burnout has been shown to have negative personal and professional consequences. Personal consequences can include substance use, sleep disturbances, and relational difficulties. Professional consequences can include poor workplace interactions, medical errors, and adverse medical events. As part of a larger study we explored differences between male and female surgeons with regard to burnout, coping and assistance seeking behaviors. This report focuses on ineffective and maladaptive coping behaviors. Methods: Surgeons in three national surgical specialty societies completed an IRB approved anonymous survey. Responses were analyzed with the general linear model employing item-specific continuous and categorical methods. We previously reported that despite similar work hours, women surgeons reported less satisfaction with work life balance. Age, gender and personal fulfilment were significantly related to clinical hours worked. Older women disproportionately provided clinical care. In this report we consider the use of alcohol as a maladaptive coping mechanism. Results: 212 surgeons (79 (37.3%) male) responded. Men and women worked similar hours (p >.05). Women worked more clinical (p <.01) in later age (F= 7.88 df 4/145, p <.01) and were less satisfied with work-life balance (F = 15.29, df 3/16, p <.01). Older physicians and female physicians were less likely to report use of alcohol to a level of personal or social discomfort (F = 4.23, df 1/201, p <.05). Alcohol use was significantly related to a poorer sense of work-life balance (F=2.5, df 5/156, p <.01). A sense of personal fulfilment, which has a direct effect on work-life balance, also has a direct effect on reported alcohol discomfort (F=2.74, df 5/159, p < .05). Sense of emotional sharing with another was significantly related to alcohol use discomfort, and both personal fulfilment and emotional partnership were disproportionate in their effect on female physicians (F=4.15, 7/159 df, p < .01). Conclusions: This study demonstrated that despite similar work hours, women surgeons report less satisfaction with work life balance. Alcohol use was related to a decrease in a sense of work-life balance. For all physicians, a sense of personal fulfilment and emotional partnership with another had positive effects on the sense of a good work-life balance. These attributes are even more effective for female physicians. Addressing workplace distress is important to maintaining a surgical labor force, but different approaches will be required for male and female surgeons.
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