My Health: A Doctors’ Wellbeing Survey

August 2016

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Acknowledgements

The My Health Survey was sponsored by Metro South Health and was developed as an innovative and timely proactive response to concerns that had been raised in recent literature, including the beyondblue survey, ‘National mental Health Survey of Doctors and Medical Students’, October 2013.

The survey was conducted by Metro South Health, being distributed by the Metro South Communications team. The analysis and reporting was undertaken by the Mater-University of Queensland Centre for Primary Health Care Innovation (MUQCPHCI) in the first instance, and subsequently by the research team using de-identified data.

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- Chris Flatley (Statistician) and Ian Hughes (Statistician), Mater Research Institute.
- The research and writing team: Dr Margaret Kay (Principal Investigator), Dr Susan O’Dwyer (Associate Researcher / Executive sponsor), Dr Georga Cooke (Associate Researcher), and Lynette Fergusson (Associate Researcher).

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Suggested citation

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1. INTRODUCTION

1.1 Preamble

This report summarises the findings of the My Health: A Doctors' Wellbeing Survey that was undertaken in Nov-Dec, 2015. This survey was developed as a research project to investigate the physical and mental health of doctors working with Metro South Health – one of the largest Hospital and Health Services in Queensland.

This research project aims to provide an understanding of the health and wellbeing of doctors working with Metro South Health. This project has been developed as an innovative and timely proactive response to the concerns that have been raised in recent literature, including the 2013 beyondblue survey (1), and recent media reports (2). While mental health issues (stress and suicidal thoughts) and workplace bullying have been the focus of recent concerns, recognition of the difficulties that doctors experience when accessing health care heightens these concerns.(3) While the current literature has focused on the mental health of doctors, little is known about the physical health of doctors in Australia.(4) The international literature has been consistent in calling for doctors to improve their ability to respond to their personal health issues and improve their ability to support their colleagues effectively when they are unwell.(5,6,7)

Currently, little is known about how health organisations can support doctors.(5) A number of health organisational researchers have identified the importance of an organisational response to address physician health and wellbeing.(8,9,10) Recent studies have highlighted the relationship between the physician’s health and the quality of care delivered, emphasising the implications for patient safety.(5)

Metro South Health is a large organisation with five hospitals and over 1800 doctors, including interns, junior doctors, doctors in training and senior doctors. As such, Metro South Health has recognised the benefits for supporting doctors in their delivery of health care services which includes enabling physicians to maintain their health.

This report presents a brief summary of the relevant literature related to physician health, recognising multiple aspects of physician wellness from the individual physician, the patient and the organisational perspectives. The report then describes the aims, method and findings of the My Health: A Doctors' Wellbeing Survey. The report concludes with a brief discussion of the issues raised in the report for further consideration by those within the organisation.

Overall, this report is designed to open a dialogue around physician health with the intention that this in itself is the beginning of an organisational intervention towards enhancing physician wellness within Metro South Health.
1. INTRODUCTION

1.2 Background

In October 2013, beyondblue released the results of their national study focused on the mental health of doctors and medical students.(1) This study was the first national Australian study to consider these issues. It documented that 3.4% of doctors recorded very high levels of distress and over 10.4% reported suicidal thoughts in the previous 12 months. In 2015, the issues of bullying experienced within the medical profession came into focus for both the medical profession and the community. A report was released by the Royal Australasian College of Surgeons which directly addressed these concerns.(11) Since then, the Australian Medical Association (WA) has also released the findings of their recent survey on sexual harassment, emphasising that “it is naive for anyone in the medical profession to think that these issues only exist in certain specialties or occur at specific locations”(p20).(12)

While these concerns are not new, these recent publications have primed the medical profession to more clearly focus on addressing these matters. Mental health issues, bullying, discrimination and harassment, the general health and wellbeing of doctors and doctors’ help-seeking behaviours are considered closely related issues. There is an increasing awareness of the need to support doctors to maintain their personal health and wellbeing, recognising the interplay between these complex issues and understanding the importance of an organisational, not just an individual response to enable these issues to be effectively addressed.(6,10)

While the mental health issues have featured strongly in the medical literature, the physical health problems experienced by doctors also need to be considered. In a 2009 national Canadian Physician Health survey, most doctors indicated that their general health was very good or excellent.(14) Doctors are health literate, they have an extensive knowledge about their preventive health and most doctors are from higher socio-economic backgrounds. Doctors therefore have a lower standard mortality rate. Because of this, the physical health of doctors has often been neglected in discussions about physician health.(4) Yet, doctors suffer the same health issues experienced by the general community, and often fail to access health care for their physical health as well as their mental health problems in a timely fashion.(3,14,15) Simple preventive health measures, such as immunisations and Papanicolaou tests are often neglected.(4,16)

Barriers to seeking health care have been well recorded. They lie deeply embedded within the medical culture and include the perceived need to be seen to be healthy, concerns about career implications when seeking care, concerns around confidentiality and the experience of stigma (perceived and real) when seeking care.(3) Stigma related to help-seeking for mental health problems was highlighted by the beyondblue study.(1,14,17)
1. INTRODUCTION

1.2 Background (cont’d)

A focus on wellness that enables physicians to identify and address their health issues proactively has benefits for the individual physician. There are also benefits for the patients. (18,19) The well physician is more likely to deliver quality care to their patients and less likely to report making medical errors. (5,20) Their patients are more likely to report being satisfied with the care they receive. (21) Recent studies have also demonstrated that physicians who personally engage with positive health behaviours are more likely to counsel their patients to do the same. (18) These health messages also carry greater authenticity and patients are more likely to respond to the health message.

Beyond the individual benefits to physician and patient, there are also benefits for the health organisation as a whole. Wellbeing and work-life balance have been linked to improved sustainability of the health workforce. Occupational stress is associated with reduced workforce participation by physicians. (5) The prevalence of physician burnout, a condition characterised by emotional exhaustion and high levels of cynicism, is increasing. (22) High levels of burnout have been reported across the broad spectrum of specialities. (23) Over one third of hospital doctors in the beyondblue study reported burnout in the emotional burnout and cynicism dimensions. (1) Interns and training doctors had even higher rates.

More recent research in physician health has considered compassion fatigue within the health workforce. (24) Figley described compassion fatigue as “secondary traumatic stress disorder in those who treat the traumatized”. (25) This is usually related to recurrent exposure to vicarious trauma, especially when there is a feeling of associated hopelessness. Compassion fatigue is often presented as a precursor to burnout in the health professional. (26) Early recognition of compassion fatigue may prevent burnout.

The 2013 “Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry” further highlighted the intimate connection between health professional health and the quality of the health care delivered by a health service. (27) In this report, Francis highlighted the link between lack of compassion (compassion fatigue) and increased morbidity and mortality. He emphasised the organisational responsibilities for leadership to enable the delivery of health care with compassion.

The health of the physician needs to be proactively supported by the organisation within which the physician works, recognising that support for physician health has benefits for the physician, for the patient and for the organisation. (5,28,29) These messages are consistent with Maslach and Leiter’s in depth assessments of the management of burnout which highlighted the benefits for both the individual and the organisation when occupational stress is proactively addressed. (30)
1. INTRODUCTION

1.2 Background (cont’d)

Studies of bullying and harassment with the workplace have identified a strong relationship between bullying and burnout and depression. (11, 31) While bullying and harassment are often stereotyped as senior doctors bullying junior doctors, it is not uncommon for senior doctors to experience bullying from their peers. (32) High rates of bullying are associated with higher rates of absenteeism and staff turnover, low levels of workplace satisfaction and reduced quality of care for patients. (10)

In 2009, Wallace et al published a seminal paper in the Lancet that turned the spotlight of physician health away from the individual physician, positioning physician health as a “missing quality indicator”. (5) From an organisational perspective, supporting physician wellness involves enabling individual physicians to identify and address their personal health needs and fostering a positive work culture that values wellness and provides support for team members experiencing health issues. (33, 34)

Some interventions have been trialled to improve the health of doctors. These have usually focused on mental health issues (e.g. mindfulness training), however some have specifically targeting physical health issues. (35, 36, 37) Such interventions demonstrate the benefits of organisational support for wellness activities and may improve the individual physician’s capacity to maintain their health. However these interventions have not been rigorously evaluated and follow-up has often been short term. While more complex interventions to enhance an organisation’s positive culture towards wellness to improve wellbeing of physicians have been strongly advocated, such approaches need to be tailored for the specific environment and evaluation remains a challenge. (6)

This report describes the results of a research project that was designed as a necessary first step to inform a comprehensive response by Metro South Health to foster a positive workplace culture that support the health of the health professionals working there. While this project focuses on physician health, from the outset it has been recognised that many different health professional groups work collaboratively to ensure the successful delivery of quality patient care within Metro South Health. It is hoped that this focused study will inform future work with other health professional groups to enable a multifaceted approach that will support workplace health within Metro South as a whole.

This research project is underpinned by a strong evidence-based foundation and designed as an initial response to the current interest in doctors’ health. The research findings will help to inform Metro South Health’s future steps towards enabling positive cultural change within the health workforce to foster a safe compassionate workplace for doctors, their colleagues and patients.
MY HEALTH SURVEY

2. Research Team

Dr Margaret Kay - Principal Investigator, Senior Medical Officer (GP), Mater UQ Centre for Primary Health Care Innovation, Mater Health Services.

Dr Susan O’Dwyer - Executive Director Medical Services, Metro South Hospital and Health Service.

Dr Georga Cooke – Director, Clinical Training, Medical Education Unit, Princess Alexandra Hospital, Metro South Hospital and Health Service.

Ms Lynette Fergusson - Director, General Practice and Junior Medical Workforce Planning & Projects, Medical Contracts and Workforce Planning Unit, Metro South Hospital and Health Service.

3. Research Objectives

The design of the My Health Survey for doctors was underpinned by a strong evidence base, recognising the need for a holistic approach to health and well-being. The survey development was informed by previous national and international studies in this field.(1,13,24,38) It considers the three issues of health - mental health, physical health and health access - as essential and inter-related aspects of doctors’ health. The health measures include a range of preventive health issues, self-reporting of health, standard survey tools and descriptions of bullying and harassment. A series of three free text questions at the end focus on understanding the current health behaviours of the individual physician, how the work environment impacts upon their health and their opinions about how Metro South Health might provide support to enhance their health.

The aim of the research project was to:

a) document the mental health, physical health, health behaviours and help seeking behaviours of the doctors working in Metro South Health hospitals;

b) identify whether there are specific associations between these issues and specific demographic factors such as age, gender, stage in career, specialty;

c) compare the findings of the survey to other national and international studies on doctors’ health;

d) identify the barriers and promoters for positive health behaviours related to the working environment.

This project was conceptualised as a necessary first step for enabling Metro South Health to promote a positive discourse around doctors’ health by drawing upon the key findings of this study to facilitate the promotion of a positive organisational culture that can support the health and wellbeing of the health workforce. This survey is designed to begin an open and continuing dialogue to promote the health and wellness of the medical staff working within Metro South Health.
4. **METHOD**

4.1 Service Level Agreement

A service level agreement was established between Metro South Health and Mater UQ Centre for Primary Health Care Innovation to enable the researchers in both organisations to work collaboratively together and to ensure the dissemination of the research findings to enable an effective response to the physician health issues that are identified, without restrictions or stipulations attached. This agreement was signed in October, 2015.

4.2 Ethical issues

Ethical Clearance and SSA Authorisation for Metro South Health were required for this project to proceed. This process has ensured careful and appropriate consideration of the management of respondent confidentiality. This was important to ensure that the distribution of the survey and analysis of the results was arranged so that individual participants could not be identified. This was arranged by ensuring that the participants were not required to provide any named data and limited demographic data. Some demographic information such as age, gender, place of work and specialty were required to provide an adequate level of richness to the data being collected. This information was collected via the electronic survey tool and the raw data were not available to members of the research team who worked at Metro South Health. The data were collected at Mater Research and the preliminary analysis removed any potentially identifying information and protected the data from inadvertent re-identification through careful collation of the data.

Ethics Approval was granted in November 2015: HREC/15/QPAH/684-685. (Appendix 4)
SSA Authorisation was provided in November 2015. (Appendix 5)

4.3 Survey development

The survey was developed from an in-depth understanding of the literature. It included measures of physical health, mental health and health access that have been used previously in other national physician health surveys. The final survey used is available in Appendix 1. It included two survey instruments – K10 and ProQOL.

Kessler Psychological Distress Scale 10 (K10) is a well-validated tool that has been used for surveys of the Australian community by the Australian Institute of Health and Welfare.(39) It was incorporated into the beyondblue survey.(1) K10 is a ten item questionnaire designed to measure the severity of symptoms of non-specific psychological distress. While it is a population screening tool for mental health problems, it is not a diagnostic tool. Participants scores range between 10-50 and those who score >=30 on the K10 have a higher incidence of mental illness diagnosis, including depression, when independently assessed by a psychiatrist.
4.3 Survey development (cont’d)

The Professional Quality of Life Scale (ProQOL) has also been well-validated in health professionals.\(^{40}\) It has not been commonly used in physician health surveys at this stage. It has three main measures. ProQOL measures compassion fatigue, compassion satisfaction, burnout and secondary traumatic stress. The ProQOL questionnaire has 30 items and has been used in other Australian hospital studies for nurses and with general practitioners.\(^{41,42}\)

Measures of lifestyle including diet, exercise, substance use and other health issues were considered. Many standard tools have not been used in medical communities and some physician health surveys that have included instruments that resulted in very long surveys. It was decided to capture this information using a series of direct questions that reduced the number of questions in the survey while providing the basic information required.

Some questions about previous health issues and management of stress were adjusted from other surveys used for this purpose. The survey questions for belittlement and harassment were adapted from Frank’s work in this field with physicians and medical students.\(^{38,43}\)

4.4 Recruitment

All medical professionals working within Metro South Health, at its five main hospital facilities were invited to participate in the survey (Appendix 2). Flyer and information about the “My Health” project were available throughout the hospitals, displayed in common areas such as lifts to encourage participation (Appendix 3).

Most doctors were contacted directly via email, although it was recognised that a number of Visiting Medical Officers may not read their official email site, so a letter was sent to VMOs as well. An email was sent to each Resident Medical Officer (including Interns, Junior Medical Officers, Senior Health Officers, Registrars, and Principal House Officers). Emails were also sent to Senior Medical Officers. A total of 1909 invitations were sent.

Each invitation included a participant information leaflet (Appendix 2). The participants were provided with a link to the web-based survey that used Survey Monkey (Gold) to gather the information. The link to the survey included a preamble to the survey and a copy of the participant information leaflet was also uploaded to ensure participants had ready access to this. The information included contact details for the Principal Investigator (independent of Metro South Health).

Second and third reminder emails were sent a fortnight apart to maximise the recruitment. The information provided with the survey included advice for participants to contact relevant organisations including the doctors’ Health Advisory Service Queensland if the participant identified concerns as they completed the survey.
4.4 Recruitment (cont’d)

The survey information did not collect any identifying information so it was not possible to re-identify any individual even if a health concern was identified. The preliminary analysis was also performed by the researchers who were independent of Metro South to ensure that no participant could be inadvertently identified through the demographic information provided. The participant needed to actively click on a link in the survey introduction to engage with the survey and this action was accepted as consent to participate in the survey. The survey took approximately 25 minutes to complete.

4.5 Data analysis

SurveyMonkey (Gold) was used to provide a spreadsheet of the raw data. The quantitative data and qualitative data from the three qualitative questions Q48, Q49 and Q50 were separated.

a) Quantitative data analysis

The downloaded results were used to calculate the scores for Body Mass Index (using height and weight), the K10 score, and the three ProQOL scores for compassion satisfaction, burnout and secondary traumatic stress. These were calculated following the relevant guidelines.

This information was then analysed to identify correlations between the descriptive demographics and the health issues identified. To date, the analysis has focused on gender, age, role (Junior, Training and Senior doctors) and specialty.

Gender was collected as a binary variable. Age was collected as six age groups. Roles were collected as seven separate roles and later grouped as Junior doctors (interns, junior house officers and senior house officers) Training Doctors (Principal house officers and Registrars) and Senior doctors (Senior Medical Officers and Visiting Medical Officers).

There were 11 options for specialty areas that the individual could select. There were also options of ‘other’ and ‘I’d prefer not to say’ to enable individuals who did not identify or were not willing to identify as having a specialty to complete this section. These options were further reduced to six specialty groups for some of the analysis – Anaesthetics/ICU; Emergency Physicians; Medical (including Medical physicians, Rehabilitation physicians; Paediatricians; Oncologists and Palliative Care); Surgical (including Surgeons and Obstetricians/Gynaecologists) Other (Psychiatrists, Radiologists, Pathologists) and Non-identified (Other and Prefer not to say).

Data have been analysed using STATA to present demographic characteristics and to identify relationships between key demographic factors and mental and physical health and health access variables.
b. Qualitative data analysis

Three qualitative free text questions ended the survey, these questions related to the barriers experienced by respondents to maintaining a healthy lifestyle, the strategies employed by respondents to maintain a healthy lifestyle and to the recommendations to Metro South Health in relation to assisting respondents to maintain their health and wellbeing.

Preliminary inductive thematic analysis was conducted with data from the three questions was supported by Excel software. Coding categories and their organisation were determined after familiarisation with the data; a sample of data was jointly coded by the principal researcher and research assistant to check for consistency in attribution to the coding categories. Illustrative quotes are provided for each theme identified in response to each question with non-identifying attributes retained.

5. RESULTS

5.1 Survey responses

The survey was sent to 1891 medical practitioners working at Metro South Health. Survey sent to:

<table>
<thead>
<tr>
<th>Medical Officers</th>
<th>Number of Emails</th>
<th>Number of Returned Letters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visiting Medical Officers</td>
<td>253 (217 emails and 36 received letters only)</td>
<td>1 letter returned</td>
</tr>
<tr>
<td>Senior Medical Officers</td>
<td>602 emails</td>
<td>17 emails bounced</td>
</tr>
<tr>
<td>Resident Medical Officers</td>
<td>1054 emails</td>
<td></td>
</tr>
</tbody>
</table>

One letter was returned and seventeen emails bounced leaving 1891 individual invitations to participate extended to the doctors at Metro South Health.

There was quite a bit of interest in the survey. A number of people contacted the research team to ensure that they did not miss out on the survey. There were a couple of late enquiries suggesting that some doctors who may have wished to complete the survey had missed their opportunity to be involved. There were no concerns raised by staff during the enquiries. The information sheet was relatively detailed, including the assurance of confidentiality of their health information, and this may have reduced the need to raise such concerns.

Three hundred and twenty-four doctors (324/1891) responded, giving a response rate of 17.13%. The response rate is lower than the beyondblue survey which was a paper-based survey. This is consistent with the lower response rates seen when other surveys have been delivered electronically.
5.2 Missing data

Although 324 responses were received, there were a number of demographic questions that the participants did not complete. Four participants did not complete gender and 68 did not record their specialty. It is acknowledged that some doctors would not have described themselves as having a specialty and they may have left this blank. While there are many possible reasons for this missing data, it is possible that some participants were concerned that this information could have identified them and so this information may have been deliberately withheld. The beyondblue study also had missing data in their specialty section.

5.3 Demographics

a) Gender, age and number of children

There was almost equal representation from men as there were women to the survey with 53% of respondents being male (n=169) and 47% female (n=151), (N=320).

Over one third of respondents were aged 31-40 years (n=112) and almost one fifth were aged 41-50 years (n=62) or 51-60 years (n=62), (N=320).

With regard to having children, 42% (n=133) responded that they had no children (N=318).

b) Citizenship

91% (n=293) of respondents were Australian citizens, 7% (n=21) were permanent residents and 2% identified as other (n=8); (N=321).
5.3 Demographics (cont’d)

c) Graduation

The number of respondents who had graduated in the last 10 years (2005-2015) was 41% (n=124), with 65% (n=199) of respondents having graduated from a university in Queensland, 14% (n=42) from an Australian another state or territory (N=307).

The gender split for Australian graduates was approximately equal (49.6% male; N=240), while 21% (N=66) graduated from an international medical school and 65% were male (n=43).

d) Current enrolment in further study

With regard to enrolment in further studies, it appears that this question was misunderstood by a number of respondents as many respondents ticked multiple categories. Responses were difficult to assess and therefore this question has not been reported on.

e) Facility

The facilities across the Metro South Health region were grouped into four to ensure anonymity for respondents working in smaller hospitals. Logan and Beaudesert Hospitals were grouped together and reported as ‘Logan’. Similarly Redland Hospital and Marie Rose Centre were grouped together and reported as ‘Redlands’. Queen Elizabeth II Hospital (QEII) and Princess Alexandra Hospital (PAH) are reported as independent facilities. Working at more than one facility was relatively common. PAH is the largest hospital in Metro South Health facility and 58% (n= 175) of respondents worked at PAH, with 56%, (n=168) working most of their hours at that facility.

* = The sum is 117% as a number of respondents worked at more than one facility.
5.3 Demographics (cont’d)

f) Stage of career

Over half of the survey’s respondents, 55% (n=168), held senior positions of Senior Medical Officer or Visiting Medical Officer, 29% (n=89) held positions of Principal House Officer or Registrar, a further 16% (n=47) held Intern, Junior House Officer or Senior House Officer positions; (N=304).

There was a slightly higher percentage of responses were from senior doctors at QEII and Redlands. Only 4% of respondents who worked most of their hours at QEII Hospital were junior doctors.
5.3 Demographics (cont’d)

g) Specialty

Respondents were asked to choose the specialty area they worked in (best fit). To help protect anonymity and mirroring some of the options in the beyondblue study, Anaesthetics and ICU were incorporated together, Oncology, Haematology and Palliative Care were incorporated together and Radiology and Pathology were incorporated together.

A large number of respondents did not report their specialty (22%; 68/304). Most of these were junior doctors (n=54) and one was a Registrar or PHO. It is likely that the junior doctors did not yet identify with a specialty. Of the 256 who responded, 5% (n=13) selected the option: ‘I prefer not to say’.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Junior</th>
<th>Reg/PHO</th>
<th>Senior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetics</td>
<td>15</td>
<td>28</td>
<td>38</td>
</tr>
<tr>
<td>Emergency Med</td>
<td>17</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>Medical - 24%</td>
<td>76</td>
<td>50</td>
<td>11</td>
</tr>
<tr>
<td>Surgical + O&amp;G 13%</td>
<td>17</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Other ++ 15%</td>
<td>11</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Non-identified*</td>
<td>34</td>
<td>3</td>
<td>11</td>
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</table>

* Non-identified = ‘prefer not to say’ (n=13) & those who did not answer the question (n=55)
+ Medical is a grouped category consisting of - medical, rehabilitation, oncology, haematology, palliative care & paediatrics
++ Other is a grouped category consisting of - radiology, pathology and psychiatry
5.4 Access to Medical Care

Doctors were asked if they had their own doctor. 
71% (n=230) of respondents stated they had a General Practitioner (GP). 
19% (n=63) did not have a GP. 
9% (n=30) had both a GP and another doctor providing their medical care while 2% (n=7) had a doctor 
who was not a GP. 
7% (n=24) did not respond to this question.

75% (n=137/183) who described their health as very good or excellent had a GP. 
77% (n=108/144) who described their health as very good or excellent had seen their doctor within the 
last 12 months.

212 doctors stated that their only relationship with their doctor was as their doctor. 
28 doctors said that they had a relationship with their doctor: as family/friend (10) or colleague (18)

Two doctors stated that they provided their own medical care - both were males aged 41-60 years. One 
of these doctors had stated that they had a GP in the previous question while the other had stated that 
they had another doctor in the previous question.

a) Timing of care

Respondents were asked when they last saw their doctor; 77% (n=182/235) of respondents reported to 
have seen a doctor within the last 12 months (84% of females / 71% of males), 6% (n=15/235) of 
respondents had not seen a doctor within the last 2 years.

b) Quality of care

Respondents were asked to rate the quality of the care provided by their doctor. 
12.3% (n= 29 /236) of respondents stated that the care they usually received was poor or fair. All but two 
of these had described themselves as having an independent GP and had seen their doctor within the 
last 24 months.

Males were more likely to rate their care as fair or poor (16% / n=18); (N=113), compared to females 
(9% / n=11); (N=122). One doctor who provided their own care described their care as fair. (The other 
stated that it was good.)

c) Income Protection Insurance

Access to income protection insurance can be an enabler to health access and 60% (n=182/306) of 
respondents reported they had this insurance. Of those with income protection insurance, 54% were 
males and 46% were female. Doctors working in anaesthesics or ICU had the highest reported rates of 
income protection insurance (84%), followed by doctors working in Emergency departments (72%). This 
compared to lower rates of income protection insurance in other specialties (60%). 26.5% (n=81) of 
respondents reported they actively chosen not to obtain insurance (51% male / 49% female).
5.5 Health status

a) Overall health status

The figure below indicates the comparison between My Health respondents (n=299) and the Canadian Physician Health Survey (13) respondents when answering the question ‘In general, would you say your health is: excellent, very good, good, fair or poor?’

61% (n=183) described their health as very good or excellent – 52.5% males and 45.7% females
Compared to Canadian Physician Health Survey – with 66%

31% (n=93) described their health as good
Compared to Canadian Physician Health Survey – with 26%

8% (n=23) described their health as poor or fair
Compared to Canadian Physician Health Survey – with 9%

22% of those describing their health as poor or fair, also stated that their physical health affected their work half of the time or most of the time over the last 4 weeks.

30% of these individuals stated that their mental health affected their work half of the time, most of the time or all of the time over the last 4 weeks.
5.5 Health status (cont’d)

When considering the health of doctors at different stages of their careers, doctors working as registrars or PHOs were more likely to describe their health as being poor.

<table>
<thead>
<tr>
<th>Health Status &amp; Stage of Career</th>
</tr>
</thead>
<tbody>
<tr>
<td>Junior</td>
</tr>
<tr>
<td>Ex/Very Good</td>
</tr>
<tr>
<td>68% (n=42)</td>
</tr>
<tr>
<td>Good</td>
</tr>
<tr>
<td>14% (n=7)</td>
</tr>
<tr>
<td>Poor/Fair</td>
</tr>
<tr>
<td>11% (n=5)</td>
</tr>
</tbody>
</table>

b) Impact of physical and mental health on work

Respondents rated how their physical or mental health impacted upon their ability to handle their workload over the previous 4 weeks.
5.5 Health status (cont’d)

b) Impact of physical and mental health on work (cont’d)

Physical health affected work in the last 4 weeks
3% (n= 9/299) of respondents reported that their work had been affected by their physical health for ‘half the time or most of the time’. This mirrored the findings of the Canadian Physician Health Survey. (13) 97% (n=290/299) of respondents reported that their work had been affected ‘Some of the time or none of the time in’ which was also similar to the Canadian Physician Health Survey (95%).

Mental health affected work in the last 4 weeks
9% (n=28/300) of respondents reported their work had been affected by their mental health for ‘half the time or most of the time or all of the time’ - compared with 5% for the Canadian Physician Health Survey. 91% (n=272/300) of respondents reported their work had been affected ‘some of the time or none of the time’ - compared with 96% in the Canadian Physician Health Survey.

Of those who stated that their mental health had significantly affected their work in the last 4 weeks (i.e. half the time or most of the time or all of the time), 25% had described their general health as poor or fair however 32% had described their general health as being very good or excellent.
5.5 Health status (cont’d)

**c) Suicidal ideation**

Suicidal ideation was recorded for respondents across a broad range of ages and career stages and specialties.

18% (n=51/286) of respondents reported contemplating suicide within the last 12 months. This compares to 10.4% respondents in the beyondblue study.

29% (n=82/287) reported contemplating suicide prior to the last 12 months, this included 40 respondents who had also contemplated suicide in the last 12 months, i.e. 11 of those who had contemplated suicide in the last 12 months had not contemplated suicide previously.

Five (N=287) respondents had attempted suicide in the past. Two of these had contemplated suicide in the last 12 months but had not contemplated suicide previously i.e. two of the eleven doctors who had not contemplated suicide previously, had acted upon their suicidal ideation and attempted suicide. Both of these respondents had high Burnout scores and one also had a high Secondary Traumatic Stress score.
5.5 Health status (cont’d)

c) Suicidal ideation (cont’d)

Percentage with Suicidal Ideation in last 12/12
By specialty (n=240)

Note: Junior doctors did not record a specialty so not included here

Suicidal ideation in last 12/12
and self-reported health

Note: Junior doctors did not record a specialty so not included here
5.5 Health status (cont’d)

d) Disability / Chronic Illness

97% (n= 285/293) of respondents described themselves as not having a disability.
20.5% (n=60/293) described themselves as having a chronic illness.

Of those who answered this question and also recorded their gender (N=279); 21% (n=59) had a chronic illness of these 59% (n=35) were male.

Of the 79% (n=220/279) who clearly stated that they did not have a chronic illness, 53% (n=116) were male. Chronic illness was reported by doctors in all stages of their careers. Although the percentage of doctors experiencing chronic illness was higher in more senior doctors (28%), over 10% of doctors early in their careers reported having a chronic illness.
5.5 Health status (cont’d)

d) Disability / Chronic Illness (cont’d)

Some respondents reported more than one chronic disease. Illnesses described included: Cardiology (10), Respiratory (8), Endocrinology (7), Psychiatry (7), Gastroenterology (5), Rheumatology/autoimmune (5), Neurology (4), Dermatology (2), Haematology (1), Renal (1), Gynaecology (1), Oncology (1).

![Chronic Illness](chart.png)

71% (n=34/48) of those reporting current or previous clinically diagnosed depression described suicide ideation at some time in the past. Current or previous clinical depression was associated with a previous suicide attempt in 8% (n=4/48). 87.5% (7/8) of those reporting current or previous eating disorders also described suicide ideation at some time in the past.

e) Other health issues

Some specific health issues were inquired about. This list of current or previous health issues has previously used in the Canadian Physician Health Study (13) is reported in the table below. A total of 114 participants reported experiencing one or more of these health issues. Some respondents indicated more than one health issue.

<table>
<thead>
<tr>
<th>Current or Previous Health Issues</th>
<th>Number (N=114)</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>alcohol abuse or dependence</td>
<td>7</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Other substance abuse or dependence</td>
<td>7</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>sexual abuse</td>
<td>16</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>domestic violence</td>
<td>12</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>clinically diagnosed depression</td>
<td>48</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td>Cancer of any type</td>
<td>15</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>obesity</td>
<td>39</td>
<td>23</td>
<td>16</td>
</tr>
<tr>
<td>anorexia nervosa or bulimia</td>
<td>8</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

71% (n=34/48) of those reporting current or previous clinically diagnosed depression described suicide ideation at some time in the past. Current or previous clinical depression was associated with a previous suicide attempt in 8% (n=4/48). 87.5% (7/8) of those reporting current or previous eating disorders also described suicide ideation at some time in the past.
5.6 Health Behaviours

Respondents were asked about recent health behaviours to help conceptualise whether doctors were participating in healthy lifestyle behaviours, recognising that many of these healthy activities were being recommended to the patients they were caring for.

a) Sleep

Respondents were asked to record how many hours they had slept on the previous night: 85.4% (n=251) had slept between 6-8 hours and 4.4% (n=13) had slept for more than 8 hours the previous night. Of the 10.2% (n=30/294) who reported sleeping for 5 hours or less, 19 were senior doctors and 9 were registrars. Of these, only 3 stated they had worked over 60 hours in the previous week while two did not report their hours. One junior doctor had slept 5 hours or less and reported not working any hours during that week.

b) Nutrition

24% (n=73/300) of respondents stated they had a meal break ‘most of the time or all of the time’ compared to 37% (n=111/300) who reported ‘none of the time’.

45% (n=131/293) of respondents reported having less than 2 serves of fruit per day, this was similar across genders.

52% (150/289) of respondents reported having less than 3 serves of vegetables per day, female respondents recorded slightly more serves than males.

34% (n=98 / 289) of respondents reported eat unhealthy food more than twice per week.
5.6 Health Behaviours (cont’d)

b) Nutrition (cont’d)

BMI was calculated for the 285 participants who provided their height and weight (self-reported). Of these, 2% (n=5) of respondents had a low BMI (<18.5kg/m²) indicating that they were underweight. This compared to 1% in the Canadian Physician Health Survey. These doctors did not report a history of anorexia nervosa.

62% (n=177) were in the normal weight range (Canadian Physician Health Survey, 54%), 26% (n=75) were in the overweight range (>25-30 kg/m²) (Canadian Physician Health Survey, 37%), and 9.5% (n=27) were in the obese range (>30 kg/m²) (Canadian Physician Health Survey, 8%). Of these, 22 reported a history of obesity.
5.6 Health Behaviours (cont’d)

c) Exercise

Over 40% (116/289) doctors reported that they completed at least 120mins mild, or 90 mins of moderate exercise in the previous week.

d) Smoking

3% (n=9/295) of respondents reported they were smokers, compared to 14% in Canadian Physician Health Survey.

e) Vaccinations

82% (n= 240/294) of respondents reported they had received an influenza vaccination in 2015 (Canadian Physician Health Survey comparison 75%), 18% (n=54 /294) stated they did not have influenza vaccination either due to choice or not being able to.

70% (n=206 /295) of respondents reported that they had been immunised against pertussis within the last 10 years whilst 30% (n=89/295) had not.

f) Alcohol

31% (n=89/287) of respondents reported drinking alcohol once a month or less (compared with 25% in Canadian Physician Health Survey).

21% (n=61/287) of respondents reported drinking alcohol more than 3 times a week (compared with 26% in Canadian Physician Health Survey).

11% (n=30/274) of respondents reported drinking 4 or more drinks on average when they drank, compared with 4.3% in Canadian Physician Health Survey.
5.6 Health Behaviours (cont’d)

**g) Stress Management**

Respondents were provided with a list of activities and asked ‘what would be your usual approach to managing stress?’ (Multiple responses could be ticked).

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do something I enjoy</td>
<td>186</td>
<td>53%</td>
<td>47%</td>
</tr>
<tr>
<td>Spend time with family</td>
<td>149</td>
<td>48%</td>
<td>52%</td>
</tr>
<tr>
<td>Exercise more</td>
<td>144</td>
<td>48%</td>
<td>52%</td>
</tr>
<tr>
<td>Spend time with friends</td>
<td>106</td>
<td>44%</td>
<td>56%</td>
</tr>
<tr>
<td>Take a holiday</td>
<td>100</td>
<td>55%</td>
<td>45%</td>
</tr>
<tr>
<td>Eat more</td>
<td>82</td>
<td>43%</td>
<td>57%</td>
</tr>
<tr>
<td>Mindfulness/relaxation</td>
<td>75</td>
<td>44%</td>
<td>56%</td>
</tr>
<tr>
<td>Avoid being with people</td>
<td>71</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>Drink more</td>
<td>55</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Discuss concerns with mentor</td>
<td>54</td>
<td>32%</td>
<td>68%</td>
</tr>
<tr>
<td>Pray</td>
<td>47</td>
<td>55%</td>
<td>45%</td>
</tr>
<tr>
<td>Take time off work</td>
<td>36</td>
<td>56%</td>
<td>44%</td>
</tr>
<tr>
<td>Formal debriefing</td>
<td>11</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Use recreational drugs</td>
<td>2</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Smoke more</td>
<td>1</td>
<td>100%</td>
<td>0%</td>
</tr>
</tbody>
</table>

20% (n=11/55) of respondents who stated they would ‘drink more’ as their usual approach to managing stress were already drinking more than would be recommended according to the Australian guidelines (regularly or as binge drinking).

35% (n=17/48) who stated they had currently or previously experienced depression stated they would drink more as their usual approach to managing stress.
5.7 Mental Health Surveys

a) Stress – K10

In analysing the results from the K10 assessment of stress, the results presented here use the same cut offs described in the beyondblue study (i.e. ≤19 = low, 20-24 = moderate, 25-29 = high and ≥30 = very high).

Higher K10 scores indicate increasing stress.

In the My Health survey 71.5% (n=206/288) of respondents recorded a low score, 16% (n=45/288) a moderate score, 8% (n=23/288) a high score and 5% (n=14 / 288) a very high score (4% beyondblue study).
5.7 Mental Health Surveys (cont’d)

a) Stress – K10 (cont’d)

There was a trend for senior doctors to have a K10 in the normal or mild range compared to those in other career stages. There was also a slight trend of lower levels of stress was observed for those over 50 years old, consistent with the findings of the beyondblue study.

![Stages of Career and K10 Scores](image)

215 doctors completed the K10 and their specialty. Of these, 11.6% (n=24) recorded very high levels of stress levels.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>High &amp; Very High (n=24)</th>
<th>Total in Specialty (N=215)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetics/ICU</td>
<td>7 (17.9%)</td>
<td>39</td>
</tr>
<tr>
<td>Emergency</td>
<td>4 (10.5%)</td>
<td>38</td>
</tr>
<tr>
<td>Medical *</td>
<td>8 (10.8%)</td>
<td>74</td>
</tr>
<tr>
<td>Surgical/Obstetrics</td>
<td>2 (5.4%)</td>
<td>37</td>
</tr>
<tr>
<td>Other **</td>
<td>3 (11.1%)</td>
<td>27</td>
</tr>
</tbody>
</table>

+ Medical is a grouped category consisting of - medical, rehabilitation, oncology, haematology, palliative care & paediatrics
++ Other is a grouped category consisting of - radiology, pathology and psychiatry
5.7 Mental Health Surveys (cont’d)

b) Burnout (using ProQOL)

Burnout is characterized by feelings of unhappiness, disconnectedness, and insensitivity to the work environment. Overall 23% (n=63/278) of respondents fell into the 75 centile for burnout of these 52% (n=33/63) were male.

44% (n=28/63) of those in the 75 centile for burnout had contemplated suicide within the last 12 months. Another 16% (n=10/63) in the 75 centile for burnout had previously contemplated suicide, prior to the past 12 months. Only 10% (n=22/215) of respondents who were not in the 75 centile for burnout reported that they had contemplated suicide within the last 12 months.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>% (N=278)</th>
<th>number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetics/ICU</td>
<td>28%</td>
<td>(n=11/39)</td>
</tr>
<tr>
<td>Emergency</td>
<td>17%</td>
<td>(n=6/36)</td>
</tr>
<tr>
<td>Medicine / Rehab</td>
<td>17%</td>
<td>(n=9/52)</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>17%</td>
<td>(n=1/6)</td>
</tr>
<tr>
<td>Oncology / Haem / Pal</td>
<td>17%</td>
<td>(n=2/12)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>15%</td>
<td>(n=1/8)</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>20%</td>
<td>(n=3/15)</td>
</tr>
<tr>
<td>Radiology / Pathology</td>
<td>40%</td>
<td>(n=4/10)</td>
</tr>
<tr>
<td>Surgery</td>
<td>21%</td>
<td>(n=6/29)</td>
</tr>
</tbody>
</table>

The beyondblue study used Maslach Burnout Inventory (MBI) which identified ‘emotional exhaustion’ in 32.4%; and ‘cynicism’ in 34.6% of its respondents. In the beyondblue study, emotional exhaustion was more common in some specialties:

Anaesthetics 24.6%, ED 30.4%, Oncology 33.4%, Paediatrics 32.5%, O+G 30.9%, Mental Health 28.9%, Radiology/Pathology 32.3%, Surgery 23.5%
5.7 Mental Health Surveys (cont’d)

c) Compassion Satisfaction (using ProQOL)

The Compassion Satisfaction (CS) scale in the ProQOL score provides an indication of low Compassion Satisfaction (i.e. Compassion Fatigue) or high levels of Compassion Satisfaction. Compassion Fatigue is associated with feelings of being less invigorated and less satisfied at work and is often associated with burnout.

13.5% (n=37/274) of respondents had Compassion Fatigue, scoring in the 25 centile for Compassion Satisfaction scores, (40.5% male / 59.5% female). 40.5% (n=15/37) of respondents with Compassion Fatigue described suicide ideation within the past 12 months.

Compassion Satisfaction is associated with being happier and feeling invigorated by work. 21% (n=57/274) of respondents had high Compassion Satisfaction scores (scoring in the 75 centile for compassion satisfaction) - 50% male / 50% female.

14% (n=34/237) with average or high Compassion Satisfaction scores described suicide ideation within the past 12 months with only 9% (n=5/57) of respondents in the 75 centile for Compassion Satisfaction describing suicide ideation within the past 12 months. None of the participants who had high Compassion Satisfaction scores had high burnout scores.

The Compassion Satisfaction (CS) scores for different specialties are reported in the table below.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>High (75 centile)</th>
<th>Low (25 centile)</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetics/ICU</td>
<td>13%</td>
<td>11%</td>
<td>38</td>
</tr>
<tr>
<td>Emergency</td>
<td>26%</td>
<td>14%</td>
<td>35</td>
</tr>
<tr>
<td>Medicine / Rehab</td>
<td>24%</td>
<td>4%</td>
<td>50</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>50%</td>
<td>17%</td>
<td>6</td>
</tr>
<tr>
<td>Oncology / Haem / Pal</td>
<td>23%</td>
<td>8%</td>
<td>13</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>29%</td>
<td>0%</td>
<td>7</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>20%</td>
<td>20%</td>
<td>15</td>
</tr>
<tr>
<td>Radiology / Pathology</td>
<td>10%</td>
<td>10%</td>
<td>10</td>
</tr>
<tr>
<td>Surgery</td>
<td>28%</td>
<td>7%</td>
<td>29</td>
</tr>
</tbody>
</table>
5.7 Mental Health Surveys (cont’d)

d) Secondary Traumatic Stress

Secondary Traumatic Stress (STS) is characterized by being preoccupied with thoughts of people one has helped, this includes; feeling trapped, on edge, exhausted and overwhelmed.

In the My Health survey, 22% (n=61/275) of respondents scored in the 75 centile for secondary traumatic stress (52.5% male /47.5% female).

The Secondary Traumatic Stress (STS) scores for different specialties are reported in the table below. 21% (n=44/206) specialists had high levels of Secondary Traumatic Stress (in the 75 centile).

<table>
<thead>
<tr>
<th>Specialty</th>
<th>High (75 centile)</th>
<th>number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetics/ICU</td>
<td>13%</td>
<td>(n=5/38)</td>
</tr>
<tr>
<td>Emergency</td>
<td>22%</td>
<td>(n=8/37)</td>
</tr>
<tr>
<td>Medicine / Rehab</td>
<td>27%</td>
<td>(n=13/48)</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>17%</td>
<td>(n=1/6)</td>
</tr>
<tr>
<td>Oncology / Haem / Pal</td>
<td>23%</td>
<td>(n=3/13)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>25%</td>
<td>(n=2/8)</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>12%</td>
<td>(n=2/17)</td>
</tr>
<tr>
<td>Radiology / Pathology</td>
<td>11%</td>
<td>(n=1/9)</td>
</tr>
<tr>
<td>Surgery</td>
<td>27%</td>
<td>(n=8/30)</td>
</tr>
</tbody>
</table>

There was a tendency for high levels of STS to be associated with higher levels of burnout - 46% (n=28/61) with high levels of STS also scored in the 75 centile for burnout. However this association was not statistically significant.

There was a tendency for high levels of STS to be associated with Compassion Fatigue with 23% (n=14) scoring in the bottom 25 centile for Compassion Satisfaction, while only 8% (n=5/61) scored in the 75 centile for Compassion Satisfaction. Once again this association was not statistically significant.

While high Burnout scores were related to Career Stage, this was not the case for Secondary Traumatic Stress, with about 30% recording a high score across all three career stages.
5.8 Belittlement, Harassment and Sexual Harassment

a) Belittlement

64% (n= 181/283) of respondents reported being belittled by a Senior Medical Officer. 11% (32/283) reported being belittled by a SMO often or regularly.

42% (n= 119/284) of respondents reported being belittled by non-medical staff and 6% (n=18) reported that this happened often or regularly.

57.5% (n=164/285) of respondents reported being belittled by patients and 5% (n=15) reported that this happened often or regularly.

b) Harassment

35% (n= 99/284) of respondents reported being harassed by a Senior Medical Officer and 6% (n=16) of these reported being harassed by a SMO often or regularly. Of those who reported being harassed by senior medical officers, 26% (n=26) reported suicidal ideation within the previous 12 months, compared to 13.6% (n=25) of those who did not report such harassment.

28% (n=79/285) of respondents reported being harassed by non-medical staff, 4% (n=12) of these reported that this happened often or regularly.

54% (n=155/286) reported being harassed by patients and 6% (n=17) of these reported that this happened often or regularly.

c) Sexual Harassment

5% (n=15/287) of respondents reported being sexually harassed by a Senior Medical Officer (1 male / 14 female) and 1 person (male) reported that this was a regular experience. Of those who reported being sexually harassed by a senior medical officer, 60% (n=9) reported suicidal ideation within the previous 12 months, compared to 15.5% (n=42) of those who did not report experiencing sexual harassment by a SMO.

4.2% (n=12/286) of respondents reported being sexually harassed by non-medical staff (4 male/8 female) and 1 person (male) reported that this was a regular experience and 2 people (female) reported that this happened often.

13% (n=37/286) of respondents reported being sexually harassed by patients. 16.2% of respondents reporting sexual harassment by patients were male (n=6). 2 respondents (1 male and 1 female) reported that they were often sexually harassed.
6. Qualitative Results

Questions 48-50 provided respondents with the opportunity to present their thoughts on three issues related to their health and wellbeing. The respondents engaged with the opportunity enthusiastically providing multiple responses and often lengthy responses. This was despite the fact that these questions were at the end of quite a long survey and required dedicated time to complete. While some responses reflected frustration, many participants were responding with the intention to enable positive change. The following three sections reflect the issues presented in response to these questions. The responses are presented thematically and illustrated with quotes from the participants.

6.1 Barriers to maintaining a healthy lifestyle

What do you see as the barriers to maintaining a healthy lifestyle?

There were 241 responses to this question with the following key themes identified:

**Workload and distribution:** Most commonly raised responses included long and intense shifts often with no breaks, the expectation to finish late, always be available and do extra work in own time without pay. The unpredictability of hours, late and inflexible rostering and the nature of shift work impacting on the ability to establish a healthy routine. The intensity and stressful nature of the work and the fatigue and stress associated with being on call or ward call on top of normal work. Additionally, understaffing impacting on work and being able to take leave.

“Longer work hours and uncertainty of finishing times with increasing pattern of being required to cover for other staff, worse since the contract issues of 2013/2014. Pattern of positions being vacant for long periods, or staff on long leave without cover being provided and the expectation that the remaining staff will cover.” (SMO / Staff Specialist, Psychiatry, 51-60 years)

“In a fortnight’s roster, usually do an extra day or two of work that I am not paid or compensated for.” (SHO, 31-40 years, male)

“Working too long hours in an inefficient and stressful system” (VMO Anesthetics / ICU, male)

“I only get my roster two weeks at a time…it makes planning life very challenging.” (SHO, 21-25 years, female)
6.1 Barriers to maintaining a healthy lifestyle (cont’d)

**Nutrition:** Frequent responses included whilst at work not having time to take any breaks to eat, the lack of health food options available within the hospital especially outside regular catering hours with unhealthy food from vending machines or in tea rooms described as being the only option. Additionally, not having anywhere to eat or store food brought from home was a concern. In relation to nutrition outside of work, a lack of time to shop, cook or eat healthily was attributed to working long hours.

“We are almost never able to take proper meal breaks – I usually eat nothing while I’m at work (and therefore eat once a day – dinner time) or I find myself eating something processed, packaged and quite unhealthy while I’m at work.” (Intern, 26-30 years, male)

“12-14 hour days often with no brea” (Intern, 31-40 years, female)

“The culture of judgement for taking lunch breaks by medical and nursing staff” (PHO, Surgery, 26-30yrs)

**Health & wellbeing:** Most notably the fatigue from working long and emotionally taxing shifts was reported to impact significantly on respondents’ ability to exercise, relax and sleep. Anxiety, low mood and depression were reported. In addition, to not having time to organise health care, there was a perception that sick leave was viewed negatively. Concern for the consequences on their personal medical record and concerns about reporting to the medical board all served as barriers to help-seeking.

“Hours of work (starting early, finishing late)-makes it hard to find time to exercise, shop, cook your own food, relax and catch up with friends / family.” (House Officer, 21-25 Year, female)

“Anxiety from work related –patient and industrial /political –issues limiting enjoyment in health activities. Fatigue from poor sleep and anxiety leading to low energy levels and eating unhealthily.” (SMO / Staff Specialist, Medical, 31-40 years, male)

“Poor resources in stress management, nil time allocated to self-care or poor role modelling of self-care within the medical community. External pressure from colleagues / senior staff to continue working when burnt out.” (Registrar / Fellow, Paediatrics, 31-40 years)
6.1 Barriers to maintaining a healthy lifestyle (cont’d)

**Culture:** Themes included the medical profession having high expectations on performance, poor role modelling by senior medical staff, a lack of understanding of the medical role by other professions and management, and concern that there was little respect for junior staff.

“The expectation by my peers that I will stay significantly longer than my rostered hours if work is busy (which it almost always is). There is a shame/stigma associated with prioritising your own wellbeing.” (PHO, Medical, 26-30 years, female)

“There are certain things as a doctor, you CAN NOT ask for help with e.g. mental health issues and alcohol dependence. I would never want this stuff on my medical record or being passed onto the Medical Board.” (SMO / Staff Specialist, 51-60 years, female)

“I work in a department in which some of the senior staff are quite dysfunctional. As a result, more work falls on a smaller number of people such as myself”. (SMO/ Specialist, Medical, 51—60 years, male)

**Work life balance:** Difficulty in establishing a healthy work-life balance was attributed to the number of hours spent at work and stress related to caring for dependents especially when partners also worked long hours. Stress related to gender role expectations and concerns were raised about career progression especially in relation to part time options and starting a family. Additionally, the difficulty maintaining a social network when working long unsociable hours was also described.

“Too many hours spent at work. Especially the unpaid overtime that we seem to be expected to do, right when we could be using the time at the gym or exercising or spending it with family. If we were able to leave work at the time we were rostered to finish we could actually get time to exercise.” (JHO, 41-50 years, male)

“The number of working hours….. means that when I am not at work, despite being quite resilient and able to manage this constant workload, I am persistently exhausted and unable to participate in activities that are important for my own health such as regular exercise and time with my family and friends. At home my relationship with my husband and child have been damaged, and at work I deliver poorer quality patient care due to burn out. Dissatisfaction both in my personal life and work life obviously then lead to overall significant unhappiness, and regret surrounding my career choice.” (Registrar / Fellow, Medical, 31-40 years, female)

“Time pressure. Making time to be with family, partner, children, and still have some time for exercise just seems impossible.” (Intern, 31-40 years, female)
6.1 Barriers to maintaining a healthy lifestyle (cont’d)

Organisational: Responses included an increase in non-clinical procedures, in particular administrative work and a lack of administrative assistance to complete administrative tasks was described as resulting in reduced clinical time with patients. This in turn impacted upon work satisfaction and efficiency. Work systems and practices that appeared bureaucratic, inflexible, and inefficient with a perceived disconnect between management and clinical staff were also described. Additionally, specific comments were made about the need for closer and safer car parking options, and facilities to promote exercise e.g. exercise space, showers and lockers.

“The system is a major barrier - lots of red tape, too many managers, poorly constructed outpatient systems, geographical issues of clinic location… I still get satisfaction in seeing and treating patients and training the registrars, but the systems here make this difficult and in some cases frankly obstructive.” (SMO / Staff Specialist, Medical, 51—60 years, male)

“The lack of professional autonomy in the public health sector where decisions that involve clinical outcomes are driven by non-medical personnel / admin or by support clinical staff such as nurses.” (Registrar / Fellow, Radiology / Pathology, 31-40 years)

“Medicine as a career involves giving all of yourself to the job both physically and mentally. You have very little time for any kind of social life or other activities. As a junior doctor in a large hospital it is often a thankless and not rewarding job. Relationships are difficult to maintain. There’s so much pressure. I would never choose this again if I could.” (Medical Registrar / Fellow aged 26-30 years, female)

“No response from supervisors or admin regarding concerns about workloads, unsympathetic system.” (Registrar / Fellow, Other location, 31-40 years, male)
6.2 Personal strategies for maintaining a healthy lifestyle

What strategies do you currently do to maintain or improve your health?

There were 237 responses to this question with the following key themes identified:

**Exercise:** Responses were many and varied including 14 different types of exercise pursuits, in addition incidental exercise such as taking the stairs, parking further away from work and wearing a pedometer to track exercise at work.

“Exercise both organised and ad hoc (using lifts, standing instead of sitting, stretching)” (SMO / Staff Specialist, Psychiatry, 51-60 years)

“Eat well, exercise, work hard, be a good person and doctor.” (VMO, Surgery, 41-50 years, male)

**Nutrition, alcohol and smoking:** Responses included healthy food choices, reducing unhealthy foods including sugar, packaged foods and eating out. Reducing caffeine and alcohol and not smoking were also described. Being organised at home to enable healthy eating including meal planning, preparing healthy lunches and having vegetables available e.g. through delivery or home grown.

“Drink alcohol.” (Intern, 31-40 years, male)

**Time out:** Having time away from work was a common theme with a wide range of actions being described. These included: using a pager rather than a mobile to protect personal time, taking a lunch break, planning and having breaks or holidays away from Brisbane. Actively planning to relax at the weekend and being determined not to take work home. Some described work changes such as reducing work hours, going part time and, for a few, considering leaving medicine.

“I speak up if overloaded with work appointments to control what can be done. I don’t take work home or work unpaid hours as overtime.” (VMO, 51-60 years, female)

“Try to have one day away from home per week so can’t write up.” (VMO, 51-60 years, female)

“Try to find a way out of medicine. Exercise. Try to cook food to eat well when I get home after 11-12 hours at work and am exhausted.” (Registrar / Fellow, Medical, 31-40 year old, male)
6.2 Personal strategies for maintaining a healthy lifestyle (cont’d)

**Relationships:** Spending time with family and friends and protecting family time was a priority for many. Having supportive partners, friends and colleagues were all noted as important strategies by respondents.

“Maintenance of my mental health by the support of my husband and family.” (SMO / Staff Specialist, female)

“Having non-medical friends as well as medical ones to help balance you.” (SMO / Staff Specialist, Medical, 31-40 years, female)

**Professional help:** Having preventative health checks, seeing health professionals including a doctors, psychologists, counsellors and coaches were also strategies used. Some respondents included taking antidepressant and anxiolytic medication in their responses.

“Have increased my visits to health professionals – to be a patient for once.” (Registrar, Medical, 31-40 years, male)

**Prioritising, pastimes, positive thinking & spirituality:** Committing time to focus on being healthy, enjoying hobbies and simply having fun were described as enabling wellbeing. Practicing mindfulness, positive thinking, cognitive re-framing and meditation in addition to more formal approaches to addressing spirituality and religious practices were described.

“Try to meditate, exercise and read book or listen to my favourite music.” (Registrar / Fellow, Medical, 31-40 years, male)

**Hoping and coping:** Lastly a number of respondents spoke of hope either as a single statement or in relation to hoping things would get better such as staffing and hoping they could cope.

“Acknowledge that I will never catch up, regardless of how many hours I put in” (SMO / Staff Specialist, Medicine & Rehab, male)
6.3 Recommendations on how Metro South Health can support doctors’ wellbeing

What recommendations would you make to MSH to assist you in maintaining your health and wellbeing?

There were 213 responses to this question. Many of the responses were offered very specific suggestions with some focusing on addressing broader overarching changes, while other suggestions focused on smaller changes that could be implemented within individual units. It was recognised that many of the changes that would improve doctors’ health would also benefit other staff. The following key themes identified:

**Workload & work routine:** The need for adequate staffing and paying for overtime as well as restrictions on overtime demands, the length of shifts, the number of days worked, being on call and especially on call without a break were often mentioned. Providing pager options rather than insisting on mobile phones being used was suggested as one way to better safeguard non work time. Improved rostering with greater flexibility and more notice as well as more flexible work options including part time were also discussed. Scheduling of meetings in work hours and not at lunch breaks was also important. Protecting junior staff, recognising and preventing burnout were also considered priorities.

“I can’t see how MSH could help me maintain my health / wellbeing apart from employing more staff, allowing less on-call / evening shifts / weekends / & allowing lunch breaks.” (SMO / Staff specialist, Emergency, 31-40 years)

“Give me less to do or get me more help to do the work I need to do.” (SMO / Staff specialist, Medical, 41-50 years, female)

“Make sure everyone in every term is being paid overtime. Working 50hrs every week and being paid for 38 is not fair. You try it.” (Intern, 31-40 years, male)

“Have ‘go home on-time’ campaign to raise awareness of overtime issue - I don’t think most of my consultants know what my rostered hours actually are. We are expected to finish the list in theatre and then do pre-meds and then go home, whatever time that is.” (Registrar / Fellow, Anaesthetics / ICU, 26-30 years)

“Monitoring of rostering so that junior staff are not rostered on illegal stretches of prolonged runs, excess overtime or inadequate time between shifts.” (Registrar / Fellow, Medical, 31-40 years, female)
6.3 Recommendations on how Metro South Health can support doctors’ wellbeing (cont’d)

Health and wellbeing: Three main sub-themes - nutrition, exercise and health & support services were identified.

Nutrition: Ensuring the availability of healthy affordable food to eat in the canteen and outside of the canteen during afterhours work was regularly mentioned. Protection of lunch breaks with no meetings scheduled at this time and providing an appropriate place to eat.

“Make affordable healthy food quickly accessible for staff.” (PHO, Medical, 26-30 years, male)

“Adequate breaks, Good coffee on site, A clean, large tea room to use with somewhere to store belongings.” (Registrar, Anaesthetics / ICU)

Exercise: Provision of affordable exercise facilities (gym, classes, pool) and associated changing facilities (shower, lockers, hairdryer, iron) that could also be used for active travel users were suggested. Ensuring the promotion of exercise within the organisation with activities such as interdepartmental or ward competitive sports was also raised.

“On-site exercise facilities for staff”. (SMO / Staff Specialist, Anaesthetics / ICU, 31-40 years)

Health & Support Services: Having access to on site confidential health services including GP, health checks, vaccinations, psychologist, counseling services and mindfulness coaching.

“Provision of a service that doctors can access in anonymity without fear of being reported. I understand that in WA they are seeing increasing number of interstate doctors coming for help as this is the only state without mandatory reporting.” (SMO / Staff Specialist, Medicine, 51-60 years)

“On-site staff medical clinic will be helpful; I don’t get time to see my own GP when I need to due to work commitments.” (SMO / Staff Specialist, Psychiatry, 41-50 years)

Culture: Responses included developing a positive culture of support using mentors (senior staff, trained counselors, psychologists, managers) and ensuring support for junior staff. Enabling staff to speak up and articulate their needs to that they have an opportunity to take care of oneself, including the opportunity to leave work on time without stigma or fear of career damage were other suggestions. Taking action against bullying recognising the need to protect those affected with the promotion respectful communication was also a priority. Others noted the need for appropriate recognition of the hard work and the expertise provided to the organisation.

“Attempting to change the culture, senior staff member’s caring about junior doctors”. (PHO, Surgery, 26-30 years)
6.3 Recommendations on how Metro South Health can support doctors’ wellbeing (cont’d)

Culture (cont’d):

“Provide a confidential feedback tool to medical directors, rather than a formal complaint system. This would allow staff to highlight issues about workplace bullying, harassment, or neglectful practices with the goal of instigating change but not punishing individuals.” (JHO, 26-30 years, male)

“Help us go home and feel that we are doing a good job.” (SMO / Staff specialist, Emergency aged 31-40 years)

“Sadly I think it is a culture of the medical profession that means that we will always put people and patients first followed by ourselves and our families. I don't think there is an easy solution. Increasing numbers is only a band aid measure as trainees need to be at work and see a lot of patients in order to build the skills require to practice as a clinician. Being a doctor is incredibly rewarding but also a massive sacrifice and I would probably discourage my children from doing medicine.” (Registrar, Surgery, 31-40 years, male)

Organisational issues: Key responses included, the need for the organisation to prioritise patient care over an increasing burden of bureaucratic procedures associated with funding and administration. Additionally, reviewing distribution of workload, optimising nursing skills and autonomy (phlebotomy, cannulation, triage out of hours), provide assistance and facilities to complete administrative tasks (more admin staff, faster computers, office space). Other responses of significance including provide support with medico legal issues, provide a rest area / staff lounge and improve car parking (closer, safer and a more frequent bus).

“Provide greater support to take on administrative duties that clinicians should not have to do. Change culture to one of what can we do to support the clinicians and not just create barriers.” (SMO / Staff Specialist, Medicine, 41-50 years, male)

“Please cut down the burgeoning paperwork (now electronic work). Try not to change things for the sake of change (please practice evidence-based administration).” (SMO / Staff Specialist, 51-60 years, male)

“Decrease stress from ward call using a number of methods. Have an Iv cannulation and phlebotomy service on in the evenings and overnight, or ensure each ward has at least one nurse who can put in an Iv and take blood. Have a protocol for difficult cannulations and escalation of this. Have a nurse in charge who triages the ward call pages so you don’t get the pages which can wait until the morning or which can be sorted out by a senior nurse. Or just have two residents on ward call in the evening. It is too busy. Night ward call is ok.” (JHO, 26-30 years, male)
6.3 Recommendations on how Metro South Health can support doctors’ wellbeing (cont’d)

Organisational issues (cont’d):

“There is a wide discrepancy in workload in our Department. I understand there are different expectations and clinical obligations within different disciplines, however within our Department I think our Director could be aware of workloads: Patient bed days, patient admissions, and Clinic numbers over the course of a year, dictation, laboratory investigations, days on call. This would give an idea on workload that could be combined with hours work to see if redistribution of workload is required.” (SMO / Staff Specialist, Medicine, 51-60 years, male)

“Actually support staff in practice. Being a doctor can be very demanding but the vast majority of us try our best every day we work. We don't always have control of what happens with a patient and many of the system issues are beyond our control. When patients or families make complaints it is demoralising, especially when the complaint is unfounded or unjustified.” (SMO / Staff Specialist, Medicine & Rehab, 41-50 years)

Time out: A number of respondents highlighted a need to reduce restrictions on taking leave (recreational, sick, unpaid leave) and allowing time to be scheduled for professional development (study, training, research).

“Be more flexible with annual leave - it would be nice to take holidays for once when I want to take it, not when it suits the hospital administration.” (Registrar / Fellow, Medical, 31-40 years, male)

“Establishing relieving doctor pools within various specialties that work across metro south - a bit like relief teachers in schools or the nursing pool/agency nursing…Some specialties may require this service more than others e.g. general medicine. This would take the stress off colleagues constantly having to cover each other in order for anyone to be able to take leave (including ARL)!“ (SMO / Staff Specialist, Medical, 51-60 years, female)

Alternative response: Whilst many respondents spoke of deficits with the current situation, a small number of respondents stated that they felt that health and wellbeing and managing their workload were their responsibilities, not their employer’s. Additionally a small number spoke of feeling supported in their current positions.

“I don't think Metro Health can help. Health is a personal issue.”(VMO, Obstetrics, male)

‘I have a fantastic ASO, who really helps me manage my work-load. We have a culture in our department where it is recognized that regular holidays and study leave are supported, which allows time to rejuvenate.’ (SMO / Staff specialist, Medical, 51-60 years, female)
7. DISCUSSION

The response to My Health Survey has demonstrated high staff engagement around the issues of health and wellbeing. The response rate was similar to previous electronic surveys distributed within Metro South Health. In particular, the in-depth responses to many of the qualitative questions which were at the very end of the relatively long survey would suggest that doctors in Metro South Health are very interested and are likely to be keen to be engaged with and to support positive interventions to further enhance the health and wellbeing of staff.

The My Health Survey provides some useful insights into the health issues experienced by the doctors working within Metro South Health. It offers a holistic consideration of physical health, mental health and health access issues. It documents a basic understanding of the doctors’ health behaviours as well as their experiences of bullying and harassment. The qualitative responses to the three final questions are consistent with the quantitative findings. The survey was designed to cover a broad range of topics that would enable an overarching visualisation of the issues around doctors’ health. It provides a strong foundation of evidence to begin to address some of the issues that are raised by the findings of the survey, while recognising that further research would be necessary to adequately address other issues.

Many of the results are consistent with the findings of other surveys of doctors’ health. In particular, the study highlights that the majority of the findings in the 2013 beyondblue national study of the mental health of doctors are relevant to the Metro South Health medical community.(1) The beyondblue survey, however, did not include measures of the physical health issues.

The mental and physical health findings also resonate strongly with previous findings of international studies, in particular the Canadian Physician Health Survey.(13)

There was a reasonable response from a broad range of ages and from both genders. This generally consistent with the demographics of the doctors across Metro South Health, with a lower number of women in the older age group and a higher number of women in the junior doctor and training doctor categories. There were more participants from Princess Alexandra Hospital where more doctors are employed.

Some doctors did not complete their full demographic profile. This was permitted in the survey to ensure that participants could engage with the survey while still feeling comfortable with the level of information they were providing.

A broad range of specialties were covered. Specialties were grouped to ensure the participants would be comfortable identifying their specialty while maintaining their anonymity. Failure to assure anonymity would have reduced the detailed information that doctors would be likely to disclose about their health concerns.
7. DISCUSSION (cont’d)

It was encouraging to find that over 70% of doctors stated that they had a general practitioner (GP) and usually one who was able to provide independent care. These findings are similar to a previous Australian survey of junior doctors in which 66% reported having their own GP and to the Canadian Physician survey in which 70% of doctors reported attending a physician for a check-up within the previous 3 years. (13,24) Many doctors at Metro South had a GP despite reporting that they had very good or excellent health. It was concerning that 12% of doctors felt that the care that they received from their doctor was either fair or poor, indicating that there is room for improvement in the quality of care being delivered to doctors, although this is a complex construct.

While income protection is often recommended for doctors, many doctors do not have this. In Canada, 85% of respondents had disability insurance. (13) It would appear that doctors who regularly work with the more catastrophic presentations in patients (Emergency and Anaesthetics/ICU) were more likely to ensure that they had income protection.

Most doctors described their health as being very good or excellent. Junior doctors and especially registrars and PHOs were more likely to say that their health was poor or fair, even though more senior doctors were likely to report chronic health issues. Similarly, the senior doctors were less likely to report that their work was being affected by their mental health issues. Many doctors who stated that their mental health had impacted upon their work, still described their general health as being very good or excellent.

The high prevalence of suicide ideation, especially suicide ideation within the last 12 months is especially concerning. Suicide ideation was present across all specialties and rates were higher in junior doctors. Hem et al has previously determined the prevalence of serious suicidal ideation in Norwegian physicians to be 10% and Shanafelt reported a prevalence of suicide ideation within the previous twelve months of 6.9% in US physicians which was similar to the general population. (44,45) Suicide ideation was present in half of those who described their health as poor or fair and in nearly one third of those with a chronic illness. Of those who had experienced suicide ideation in the last 12 months, but not previously, nearly one fifth attempted suicide. The rate of attempted suicide – 1.7% (5/287) – was similar to the rate of attempted suicide previously reported in US women physicians. (46) In a longitudinal cohort study in Norway, Tyssen et al reported that 8.2% of medical students who described suicidal thoughts progressed to suicide planning in their early postgraduate years. (47) Progression was associated with depression and negative life events.

Chronic illness was present in doctors in all stages of their career though higher rates were found in more senior doctors, as would be expected. The survey identified a wide range of chronic health issues and clearly identifies that the health issues that doctors experience extend well beyond the mental health issues that often dominate the discussions about doctors’ health. A previous review of the literature indicated that doctors experienced a similar prevalence of chronic illness compared to the general population except for lower smoking related health issues. (4) Physical illness may co-exist with
mental health issues adding complexity to the care required. A study reporting on the health issues experienced by physicians presenting to the London Practitioner Health Programme reported that 11.5% had significant physical health issues. It is appropriate for doctors to be mindful that their peers may require time off to seek medical care for appropriate follow up of their health conditions. Given the stigma that doctors may experience seeking health care, it is important for doctors to reflect upon their personal, and their work unit’s, attitude to doctors requiring time off for these reasons.

In this survey, doctors were also asked to identify specific health issues that they had experienced or were currently experiencing. This list included domestic violence and sexual abuse. It is recognised that these questions are not the ideal method for identifying experiences of domestic violence or sexual abuse. Despite the fact that many people may not have disclosed these issues with this form of questioning, of the 114 who did complete this section, over 10% disclosed domestic violence and over 14% disclosed sexual abuse (31% male). This study is one of the few studies to document the experience of sexual abuse in doctors across both genders. If the total number of respondents (324) is used as the denominator (providing a very conservative estimate) then the prevalence of domestic abuse is 3.7% (12/324) and the prevalence of sexual abuse is 4.9% (16/324). A previous study of US women physicians revealed a prevalence of 3.7% for domestic violence and of 4.7% for sexual abuse. It is important to recognise that doctors who are currently, or have previously experienced such abuse, may need extra support if they are exposed to a history of current or previous domestic violence or sexual abuse disclosed by their patients.

A number of doctors disclosed a history of eating disorders giving a conservative prevalence of 2.7% (8/324) which is slightly higher than the prevalence of 2% estimated for the general population in Australia. Brooks et al indicated that serious eating disorders were the reasons for some physicians presenting to the London Practitioner Health Programme.

Others disclosed a history of clinically diagnosed depression giving a conservative prevalence of 14.8% (48/324) which is a little higher than the prevalence reported by Centre et al in their consensus paper on depression and suicide in physicians. Importantly, a high percentage of those with clinically diagnosed depression reported previous suicide ideation.

Most doctors engaged in relatively healthy health behaviours. Many doctors provided detailed information in their qualitative responses describing how Metro South Health could enable better compliance with the positive health behaviours for doctors. A number of very pragmatic suggestions such as facilitating access to healthy foods and exercise options were provided. While the doctors were keen to engage with positive health behaviours, it was clear that with the long hours and interruptions during the day, that they valued support from their workplace. There are benefits for patients when their doctor actively maintains their personal wellbeing including the perception that the health messages delivered by that doctor are more authentic. Most doctors reported having adequate
sleep. Few doctors smoked and more were vaccinated, however it would be worth promoting whooping cough vaccination for doctors.

Strategies reported for stress management were quite varied. While many were positive, some were worrying. At least 18% described drinking more alcohol, 27% described eating more and 23% described avoiding being with people. These behaviours are not positive stress management activities and the choices were higher than recorded in the beyondblue study, although this study focused on techniques used by doctors who had ever felt anxious or depressed. In particular, in the Metro South survey, 20% of those who stated they would drink more were already drinking more than recommended and 35% had a history of diagnosed depression which is concerning. A larger proportion of doctors reported using prayer, mindfulness or doing something enjoyable compared to the beyondblue study. Despite their health literacy, some doctors may need to be supported to identify more positive ways to manage their stress to maximise their wellbeing and these may be integrated into the workplace.

Stress levels experienced by doctors across the Metro South Health facilities were similar to those reported in the national beyondblue survey. Stress levels were relatively higher in the junior doctors and this has been reported in other international studies. Anaesthetic/ICU doctors had higher levels of stress. This group also had higher burnout scores. Shanafelt et al recently documented an increase in burnout across the specialties between 2011 and 2014. Clearly there is a need to address burnout and this requires an organisational response. Enhancing compassion satisfaction for health workers requires a positive working environment and failure to do so has serious consequences for health organisations. Surgeons reported higher levels of secondary traumatic stress (STS), though the numbers in each specialty category were low so the significance of these differences is difficult to determine. Since the prevalence of STS does not seem to match that of burnout, this form of stress would appear to be quite different to that of burnout. It is likely that a focus on developing a positive focus on wellbeing at work will help address all of these mental health issues and improve wellbeing for doctors and other health professionals.

Belittlement, harassment and sexual harassment are not uncommonly experienced by doctors in Metro South Health. The Senior Medical Officer was often identified as the perpetrator and over 10% experienced being regularly belittled and 6% regularly harassed by an SMO. Suicidal ideation was more commonly reported by those who were harassed and especially by those who were sexually harassed. There are legal and ethical responsibilities for physicians and for employers to ensure a safe workplace. It is worrying that some surveys have indicated that doctors who have experienced bullying and harassment find it difficult to report these behaviours.

Belittlement, harassment and sexual harassment were also reported from patients and non-medical staff, but this was not as frequent. Sexual harassment was experienced by both male and female doctors.
7. DISCUSSION (cont’d)

Previous studies have demonstrated that bullying is more likely to prevail if the work environment is stressful. (10, 55) The AMA(WA) study clearly demonstrates that bullying and harassment issues are prevalent across the specialties so physicians cannot assume that this is a problem isolated to one specific group. (12) Recently the Royal Australian College of Surgeons released their action plan to address these issues for their college. (56) Embracing similar approaches across the specialties so that there is a consistent push to improve the culture in medicine that has enabled the persistence of these issues will be a challenge for all health organisations. Recognising how the hidden curriculum has contributed to the establishment of the medical culture is essential if change is to be enabled. (57) Overtly fostering a positive culture requires positive leadership and it is likely that this will be an ideal time to enable that change given the current discourse within the profession as a whole.

This report aims to initiate an important and informed conversation around physician health setting a foundation for a healthy workplace. Some comparisons with previous studies are provided to provide some perspective in the interpretation of the findings. This is a unique study in the Australian landscape which will open opportunities for future research. It provides some specific recommendations for the future including educational interventions, support for doctors’ self-management of their health, improved pathways for health access, as well as targeted responses to address specific concerns raised in this report.

Dissemination of these findings to the doctors within Metro South Health will assist future engagement with a positive organisational response that promotes a healthy workplace. A plan for dissemination to a broader audience is an important next step. Future interventions will demonstrate Metro South Health’s continuing leadership in this field. A healthy medical workforce and a healthy workplace will benefit all staff, not just physicians. Ultimately a positive organisational response that enhances the health and wellbeing of physicians will benefit patients, their care and their satisfaction with the care they receive.
7. DISCUSSION (cont’d)

7.1 Limitations

There are a number of limitations to consider when reading this report. While the response rate was reasonable for this online survey, and comparable to other electronic surveys at Metro South, it was still a low response rate. It is not possible to know how the health of the responders compared to that of the non-responders. It could be speculated that those who had health issues may have had more concerns about presenting their health issues in this survey, even though confidentiality in this survey was prioritised. Similarly, it could be speculated that those who had health issues may have been more inclined to engage with the survey with the intention of enabling change through the documentation of their health issues.

Most of the results are reported together, rather than separated into the four different health settings that were captured. The relatively small numbers of participants from the smaller health settings made it difficult to determine whether the findings specific to these services were significantly different to those of the larger services. Comments about the specific health services were further limited as a number of doctors worked in different settings. Although the survey captured the main service that doctors worked in, it is possible that working in more than one setting could alter the expectations of the doctor related to their work environment and could therefore alter the experience (positively or negatively) that they reported. Similarly, it was not possible to determine the impact of private work on the health and experiences of Senior Medical Officers, and especially Visiting Medical Officers. The lower levels of stress recorded by senior doctors may reflect the senior doctor’s experience at handling such stress issues, the fact that those who were very stressed by the public health setting were less likely to continue there, or reduced stress related to working more hours in a private setting where they may feel they have more autonomy.

A number of participants did not record some of the specific demographics requested. In particular, only 79% provided their specialty. While junior doctors are likely to have left this blank as they would not have had a specific specialty, it is very possible that at least some respondents decided not to provide these specific details to help ensure their anonymity.

The survey itself required self-report of the health issues that were recorded. While doctors are likely to be very capable of reporting their health issues accurately, it is possible that doctors may specifically decide not to disclose some health issues, specifically any that they felt could be considered to impact upon their career.

The recording of the physical health issues proved somewhat problematic as the survey tool had been adapted from an international tool and the questions, especially those related to diet and exercise, require further development to provide a deeper understanding of these issues for doctors. The qualitative data demonstrate how important these issues are and future research should aim to capture this information with more clarity.
7. DISCUSSION (cont’d)

7.1 Limitations (cont’d)

It is encouraging to see that most doctors had an independent GP. Previous Australian studies have not demonstrated such good engagement with personal health care support. It is possible that this finding reflects a change over time with better education about the need for a GP. It is also possible that most doctors are now aware of the general expectation that they should have a GP and are documenting this awareness.

These findings reflect a single point in time. The study was undertaken at the end of the year and it is possible that this could be a time of increased stress, especially for junior doctors applying for new positions. It is also possible that this time of year may be a time of lower stress for interns who would have had more time to settle into their new role as doctors.

8. RECOMMENDATIONS

This final report presents the findings of the My Health: A Doctors’ Wellbeing Survey, which has been designed as an initial response to develop an integrated approach to support the health of doctors working within Metro South Health, recognising that leadership within the organisation can substantially improve the health of individual doctors. This project has been developed as an innovative and timely proactive response that acknowledges the concerns that have been raised about physician health and the importance of enhancing the health of the doctor with positive benefits for the doctor, for the patients they care for and for the organisation as a whole.

Given the breadth of issues, no one response supporting the health and wellbeing of doctors within Metro South Health will have benefits for the individual doctors, their patients, the health teams they work with and the organisation as a whole. An effective intervention to support the health and wellbeing of doctors requires an understanding of the complexity of the issues that have been highlighted in this report which contributes to a deeper understanding of the specific issues related to the health and wellbeing of doctors working with Metro South Health.

As such, this report provides an opportunity for consideration of a number of approaches designed to improve the health of doctors within the organisation.

Previous studies have confirmed the importance of the health organisation’s approach to the wellbeing of their staff. Maslach has emphasised the importance of this issue in her work on burnout. While the Maslach Burnout Inventory is regularly used to document the prevalence of burnout, she has consistently called for a systemic response from organisations when burnout rates are high. It is not
8. RECOMMENDATIONS (cont’d)

uncommon for current interventions to focus on the individual instead. While enhancing the resilience of the individual is appropriate, it cannot be an isolated intervention. Instead, interventions to create healthy workplaces require a multifactorial response.

This study demonstrates high staff engagement around the issues of health and wellbeing. Physician health issues are considered to be very relevant and this indicates that Metro South Health’s investment in this issue will be valued.

A comprehensive response requires a broad range of actions initiated within the organisation. This responsiveness does not replace the individual’s responsibility to maintain their personal health and wellbeing. The qualitative sections of the survey, clearly demonstrate that the doctors within Metro South Health appreciate this responsibility. A comprehensive response from Metro South Health would acknowledge, support and enabling this process. Broad systemic initiatives and targeted local initiatives would complement the individual’s engagement.

Systemic responses:

- Provide staff with an opportunity to provide anonymous feedback about workplace issues that have a negative impact upon health,

- Provide regular positive messages from the Executive Team relevant to health
  - Positive messages that overtime worked should be paid (i.e. it is valued),
  - “Go Home On Time Today” – enabling prioritising of work,
  - Enhance time management skills,
  - Increase knowledge about services available for support (e.g. EAS, HR, WEHOs)

- Provide opportunities to educate physicians about their health
  - Grand rounds – to provide results of the My Health Survey and open the dialogue with the staff,
  - Development of an “App” that regularly delivers positive physician health messages,
  - Inclusion of relevant positive physician health messages in other news bulletins

- Gather complementary data to further inform the meaning of specific elements of this survey:
  - Determine if data could be gathered from the current EAS scheme to identify how often medical staff are using this resource compared to other clinical (nursing and allied health professionals) staff.
  - Obtain baseline data about doctors accessing WEHOs

- Ensure that health and wellbeing programs currently available for other staff are available to medical staff and – importantly – known to be available to enable engagement.
8. RECOMMENDATIONS (cont’d)

Systemic responses (cont’d):

- Proactively enhance the physical health of doctors
  - Facilitate access to local gyms for fitness, whether on-site or nearby
  - Ensure healthy food options are available at all hours
    - All vendors should be able to demonstrate that they provide health food choices through negotiations initially and in future potentially through contractual obligations,
    - Placement of vending machines with healthy food options,
  - Signage reminding healthy behaviours e.g. promoting the use of stairs.

- Encourage cultural change around the issues of physician health
  - Actively mentor junior doctors to enable positive change,
  - Identify and counter negative messages within the hidden curriculum,
  - Encourage colleagues to seek health care
    - For their physical and mental health care,
    - For their preventive health needs,
  - Ensure adequate cover for doctors who are unwell to reduce “presenteeism”,

Targeted responses:

- Delivery of resilience programs to enhance the relevant skills
  - Target – junior doctors
  - Aim
    - to support junior doctors in their ability to identify their personal health issues, identify and their personal supports
  - Evaluate
    - Survey to assess perceived learning and value of intervention
    - Focus groups with participants
      - To inform future interventions of this nature
      - To reinforce positive learning from the intervention
      - To identify barriers for implementation of strategies to enhance wellbeing.
8. RECOMMENDATIONS (cont’d)

Targeted responses (cont’d):

- Training to enhance management skills relevant to personal health and wellbeing for the manager and for those they are managing. It would be appropriate for such education to be integrated with other management skills learning, however it is important that it is recognised that this training requires expertise.
  - Target – mid-career and senior doctors
  - Aim
    - to support doctors to maintain their health and wellbeing as they traverse new career milestones,
    - to enable doctors in management positions to identify health issues in their colleagues, especially when health issues may be impacting upon their performance,
    - to ensure that doctors in management positions are aware of pathways to care for themselves and their colleagues.
  - Evaluate
    - Survey to assess perceived learning and value of intervention
    - Focus groups with participants
      - To inform future interventions of this nature,
      - To reinforce positive learning from the intervention,
      - To identify barriers for implementation of strategies to enhance wellbeing.

- Training to improve the capacity of doctors to provide care for their doctor-patients
  - Target – senior doctors
  - Aim
    - To educate doctors about how to manage the “corridor consultation”,
    - To ensure doctors are aware of the health access barriers experienced by doctors,
    - To ensure doctors are best able to adapt their usual patient-centred skills to address this particular occupational group by:
      - Normalising help-seeking behaviour,
      - Dispelling common myths related to physician health,
      - Promoting skills for enabling and maintaining engagement with care,
      - Assisting doctors to establish a relationship with their GP,
    - To enable doctors better mentor junior doctors about positive health behaviours,
    - To recognise the key role that the hidden curriculum plays,
    - To identify champions for changes within the organisation,
    - To capture qualitative feedback on the survey findings,
    - To capture qualitative feedback to inform other strategies.
9. CONCLUSION

This report summarises the findings of the My Health: A Doctors' Wellbeing Survey that was conducted with the doctors employed with Metro South Health Services in Nov-Dec, 2015.

The survey has documented a range of physical and mental health issues that medical personnel face while they engage with delivering care to their patients. This is the first Australian survey to focus on both of these issues.

The survey confirms that a significant percentage of doctors have physical and/or mental health issues. The prevalence of health issues are similar to those described in other national and international studies. For example, the level of burnout and stress documented using this survey tool reflects the findings in studies of other health organisations. Physical health issues including chronic disease are commonly experienced by physicians. Any response that only focuses on mental health issues will fail to address the breadth of health issues that have been identified here.

A number of recommendations have been made in this report. These are designed to enable Metro South Health to continue to demonstrate its leadership in this field. It is worth highlighting, again, the engagement of the doctors who completed this survey offering valuable opportunities for fostering future engagement will be valuable. These recommendations recognise that the promotion of a healthy workplace has the broader benefits for other staff members and for the patients themselves.
## APPENDICES

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
</tr>
</thead>
<tbody>
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<td>Appendix 1</td>
<td>My Health Survey - Survey tool</td>
</tr>
<tr>
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<td>My Health Survey – Participant Information Leaflet</td>
</tr>
<tr>
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<td>My Health Survey – Promotional Flyer</td>
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<tr>
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</tr>
<tr>
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<tr>
<td>Appendix 6</td>
<td>Abbreviations</td>
</tr>
<tr>
<td>Appendix 7</td>
<td>References</td>
</tr>
</tbody>
</table>
Introduction

Thank you for deciding to begin the survey.

You will have already seen the participant information sheet that was attached to the email.

This is available here.

Before you begin though, we would like to remind you of a couple of points:

We estimate this survey will take you about 25 minutes to complete. You cannot save this survey in draft form. So if you don’t have enough time now, we suggest you bookmark the page and return later when you have the time.

If you would like any further information about his project or a pdf copy of the survey to preview, you can contact the principle researcher:

Dr Margaret Kay on 0402 299 744 or m.kay1@uq.edu.au

If you have any concerns or would like to seek independent advice about his project, the ethics officer details are:

EthicsResearch,PAH@health.qld.gov.au or phone (07) 3343 8049.

We appreciate your participation in this survey.

By clicking the ‘next’ button below that links to the survey, you will be consenting to participate in this survey.

Demographics

Please remember no questions require an answer to progress through the survey. If you would prefer not to answer a question, leave it blank and move on to the next question.

1. Your age (years):
   O  22 to 25
   O  26 to 30
   O  31 to 40
   O  41 to 50
   O  51 to 60
   O  61+

2. Your sex:
   O  Male
   O  Female

3. Your residency status is:
   O  Australian citizen
   O  Permanent resident
   O  Other (please specify)
4. How many children do you have in each of these age groups?

<table>
<thead>
<tr>
<th></th>
<th>0 children</th>
<th>1 child</th>
<th>2 children</th>
<th>3 children</th>
<th>4+ children</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5 years</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>5-11 years</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>12-17 years</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>18+ years</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

5. What year did you graduate with your medical degree?

6. Where did you graduate with your medical degree?

- O A university in Queensland
- O A university in another Australian state
- O An international medical school

7. What year did you first work as a doctor in Australia?

8. Are you currently enrolled in any other following university qualifications? (select all that are relevant)

- O I am not currently enrolled in a university qualification
- O Bachelor Degree
- O Graduate Certificate
- O Graduate/ Postgraduate Diploma
- O Master (course work)
- O Masters (research)
- O Doctor of Philosophy (PhD)

---

**Professional Characteristics**

9. Do you have your own income protection insurance in addition to that provided by QSuper?

- O Yes
- O No – I considered it but decided against it
- O No – I haven’t considered it

10. Which Metro South Facilities do you work at? (select all that are relevant)

- O Logan – Beaudesert
- O Redland – Marie Rose Centre
- O Princess Alexandra
- O Queen Elizabeth II
12. Which role do you occupy?
- Intern
- Junior House Officer
- Senior House Officer
- Principal House Officer
- Registrar/ Fellow
- Senior Medical Officer/ Staff Specialist/ Senior Staff Specialist
- Visiting Medical Officer

13. In which specialty area do you work? (choose the best fit)
- Anaesthetics/ ICU
- Emergency Medicine
- Medicine or Rehabilitation
- Surgery
- Obstetrics & Gynaecology
- Oncology/ Haematology/ Palliative Care
- Paediatrics
- Radiology/ Pathology
- Other
- I’d prefer not to say

Current Work Characteristics

14. In the last week, how many hours did you work?
- In a Metro South facility/ facilities
- At another location

15. In the last fortnight, how many days have you been on call?

Personal Health Access

16. Do you have your own doctor? (select all that apply)
- Yes – a GP
- Yes – another doctor
- No
My Health: A Doctors’ Wellbeing Survey

17. Do you have a relationship with your doctor outside of your doctor-patient relationship? (select all that apply)
   O Yes – they are a personal friend or family member
   O Yes – they are a colleague
   O Yes – they are a former colleague
   O No – I provide my own medical care
   O No – I only know this person as my doctor

18. When did you most recently see your doctor?
   O Within the last 6 months
   O Within the last 6-12 months
   O 12-24 months ago
   O More than 24 months ago

19. Is the healthcare your doctor provides usually?
   O Poor
   O Fair
   O Good
   O Excellent
   O N/A

Your Health

20. In general, would you say your health is:
   O Excellent
   O Very good
   O Good
   O Fair
   O Poor

21. In the past 4 weeks, how often did your physical health (eg. physical illness, injury) make it difficult for you to handle your workload?
   O None of the time
   O Some of the time
   O Half of the time
   O Most of the time
   O All of the time

22. In the past 4 weeks, how often did your mental health (eg. Stress, anxiety, any depression, etc) make it difficult for you to handle your workload?
   O None of the time
   O Some of the time
   O Half of the time
   O Most of the time
   O All of the time
Meal breaks

23. On the days you work in a Metro South Facility, how often do you typically manage to take a meal break of 30 minutes or more?

O None of the time
O Some of the time
O Most of the time
O All of the time

Diet, exercise and sleep

24. Please indicate your height (cm)


25. Please indicate your weight (kg)


26. On average day how many serves of the following would you eat?

Fruit (1 serve = 150g fresh fruit, 30g dried fruit, 150 mls fruit juice)

O 0   O 1   O 2   O 3   O 4   O 5+

Vegetables (1 serve = ½ cup cooked vegetables or 1 cup salad)

O 0   O 1   O 2   O 3   O 4   O 5+

27. In an average week how often would you eat fried or unhealthy food?

O 1   O 2   O 3   O 4   O 5+

28. Last night, how many hours did you sleep? (round to the closest whole number of hours)


29. In the past week, how many minutes of the following types of exercise have you performed?

Mild, minimally exertive (eg easy walking, golf, bowling)


Moderate (eg. fast walking, tennis, volleyball, dancing, easy swimming or cycling)


Strenuous (eg. jogging, soccer, aerobics, vigorous swimming or cycling)


My Health: A Doctors’ Wellbeing Survey

Immunisations

30. Did you have an influenza vaccination in 2015?
- o  Yes – in the MSH staff health program
- o  Yes – I organised this privately
- o  No – I chose not to or I am unable to have this vaccination

31. When was your most recent pertussis immunisation?
- o  Within the last 10 years
- o  More than 10 years ago
- o  I’ve never had a pertussis immunisation

Smoking and alcohol consumption

32. Have you smoked cigarettes in the last 30 days?
- o  Yes
- o  No

33. How often do you drink alcohol?
- o  Less than once a month
- o  Once a month
- o  2-3 times per month
- o  Once a week
- o  2-3 times per week
- o  4-6 times per week
- o  Everyday

34. On average, how many drinks do you consume when you drink alcohol?
- o  1 drink
- o  2 drinks
- o  3 drinks
- o  4 drinks
- o  5 drinks
- o  6 or more drinks

35. Last time you consumed alcohol, how many drinks did you consume?
- o  1 drink
- o  2 drinks
- o  3 drinks
- o  4 drinks
- o  5 drinks
- o  6 or more drinks
My Health: A Doctors’ Wellbeing Survey

Health conditions

36. Would you classify yourself as having a disability?

O Yes  
O No  
O I’d prefer not to say

If you answered ‘yes’, could you please specify


37. Do you have a chronic illness?

O Yes  
O No  
O I don’t know  
O I’d prefer not to say

If you answered ‘yes’, could you please specify


38. Check as many boxes as apply to you. Please remember this survey is confidential and all information is de-identified.

Do you currently, or have you ever, experienced any of the following:

O Alcohol abuse or dependence  
O Other substance abuse or dependence  
O Sexual abuse  
O Domestic violence  
O Clinically diagnosed depression  
O cancer of any type  
O Obesity  
O Anorexia nervosa or Bulimia

Managing stress

39. What would be your usual response to managing stress? (check as many boxes as apply)

O Drink more alcohol than usual  
O Spend time with family  
O Discuss concerns with a mentor  
O Avoid being with people  
O Smoke more cigarettes than usual  
O Spend time with friends  
O Eat more than usual  
O Take time off work  
O Use recreational drugs  
O Pray  
O Increase physical exercise  
O Do something I enjoy  
O Formal debriefing  
O Practice mindfulness or other relaxation technique  
O Take a holiday
My Health: A Doctors’ Wellbeing Survey

40. In the past 4 weeks

<table>
<thead>
<tr>
<th>Question</th>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>About how often did you feel tired for no good reason?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>About how often did you feel nervous?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>About how often did you feel so nervous that nothing could calm you down?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>About how often did you feel hopeless?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>About how often did you feel restless or fidgety?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>About how often did you feel so restless you could not sit still?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>About how often did you feel depressed?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>About how often did you feel worthless?</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

Professional Quality of Life

When you care for people you have direct contact with their lives. Below are some questions about your experiences, both positive and negative, as a doctor caring for other people. Consider each of the following questions about you and your current work situation, and select the number that honestly reflects how frequently you experience these things in the last 30 days.

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am happy</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I am preoccupied with more than one person I (help).</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I get satisfaction from being able to (help) people.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I feel connected to others.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I jump or am startled by unexpected sounds.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I feel invigorated after working with those I (help).</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I find it difficult to separate my personal life from my life as a doctor.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I am not as productive at work because I am losing sleep over traumatic experiences of a patient I care for.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I think that I might have been affected by the traumatic stress of those I look after.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I feel trapped by my job as a doctor.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Because of my profession, I have felt “on edge” about various things.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I like my work as a doctor.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I feel depressed because of the traumatic experiences of the people I look after</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I feel as though I am experiencing the trauma of someone I have looked after</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I have beliefs that sustain me.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I am pleased with how I am able to keep up with medical techniques and protocols.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I am the person I always wanted to be.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>My work makes me feel satisfied.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I feel work out because of my work as a doctor.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I have happy thoughts and feelings about those I look after and how I could help them.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I feel overwhelmed because my case load seems endless.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I believe I can make a difference through my work.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I avoid certain activities or situations because they remind me of frightening experiences of the people I have helped in the past.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I am proud of what I can do to help people.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>As a result of my helping people, I have intrusive, frightening thoughts.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I feel “bogged down” by the system.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I have thought that I am a “success” as a doctor.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I can’t recall important parts of my work with trauma victims.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I am a very caring person.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I am happy that I chose to do this work.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>
Suicidal Ideation

42. During the past 12 months, have you had thoughts of taking your own life, even if you would not really do it?
O Yes
O No

43. Prior to the previous 12 months, have you had thoughts of taking your own life, even if you would not really do it?
O Yes
O No

44. Have you ever attempted suicide?
O Yes
O No

Bullying and Harassment

45. In my work in Metro South Health, I have been belittled by:

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Regularly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interns</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Junior Medical Officers</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Senior Medical Officers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other non-medical staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

46. In my work in Metro South Health, I have been harassed by:

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Regularly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Interns</td>
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<tr>
<td>Junior Medical Officers</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Senior Medical Officers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other non-medical staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

47. In my work in Metro South Health, I have been sexually harassed by:

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Regularly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students</td>
<td></td>
<td></td>
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<tr>
<td>Interns</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Junior Medical Officers</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Senior Medical Officers</td>
<td></td>
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</tr>
<tr>
<td>Other non-medical staff</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
You are almost done. We are interested in your thoughts and suggestions about these topics.

48. What do you see as the barriers to maintaining a healthy lifestyle?


49. What strategies do you currently use to maintain or improve your health?


50. What recommendations would you make to Metro South Health to assist you in maintaining your health and wellbeing?


Thank you for taking the time to complete this survey.

The focus on health issues within this survey may have made you more aware of a health issue that you need to address. This may initially worry you, but identification of a health issue is the first step to finding a solution. All doctors should have their own general practitioner (GP) and we would recommend that you talk to your GP about this issue.

If you find that you are experiencing any significant distress related to this, then you can contact:

Lifeline, Phone: 13 11 14 for immediate support

Beyondblue, Phone: 1300 22 4636

Doctors; Health Advisory Service Qld – (07) 3833 4352 or www.dhasq.org.au This service is a confidential 24 hour telephone line for doctors and medical students.

You also have access to your Employee Assistance Scheme that provides short-term support and counseling as required, for all employees and their immediate family members. Employee Assistance Provider, OPTUM. You can contact OPTUM 24/7 on 1300 361 008.
Appendix 2
My Health Survey - Participant information leaflet

Metro South Health
Facility/hospital/clinical service name
Enquiries to: Medical Workforce Planning
Telephone: 3156 4985
Our Ref: LF:SOD_002
Date: XX November, 2015

Participant Information Leaflet

Full Project Title: My Health: A Doctors' Health Survey

Principal Researchers:
Dr Margaret Kay, Mater UQ Centre for Primary Health Care Innovation
Dr Susan O’Dwyer, Executive Director Medical Services, Metro South Health
Dr George Cooke, Director Clinical Training, Princess Alexandra Hospital
Lynette Fergusson, Director, General Practice & Junior Medical Workforce Planning & Projects

Introduction
As a Medical Practitioner working in Metro South Health, you are invited to take part in this research project. This Participant Information Leaflet explains the research project to help you decide if you want to take part in the research.

This project aims to provide an understanding of the health and wellbeing of doctors working with Metro South Health. This project has been developed as an innovative and timely response to the concerns that have been raised in recent literature, including the 2013 beyondeblue survey, and within the recent media. Mental health issues (stress and suicidal thoughts) and workplace bullying have been specific concerns that have been raised. Recognition of the difficulties that doctors experience when accessing health care heightens these concerns. The international literature has been consistent in calling for doctors to improve their ability to respond to their personal health issues and improve their ability to support their colleagues effectively when they are unwell. Little is known about how a health organisation can support doctors. Similarly, while the current literature has focused on the mental health of doctors, little is known about the physical health of doctors in Australia. Metro South Health is committed to providing leadership in this field to develop interventions, including educational interventions, which will be designed to improve the health of doctors in their organisation.

The survey will take approximately 25 minutes to complete. It is designed to gather information about physical and mental health issues, health behaviours and help-seeking behaviours. It will include some standard survey tools and some questions that have been used in other doctors’ health studies to help assess these issues. The intention is to document the health of the doctors working in Metro South Health including their perception of how work creates barriers to or facilitates your health. Furthermore, the survey seeks your views on recommendations you wish to make to Metro South Health to assist you in maintaining your health and wellbeing.

The email sent to you has a direct link to the survey. The survey is hosted by the Mater UQ Centre for Primary Health Care Innovation (MUQCPHCi). The survey will not ask you to identify yourself and you will remain anonymous. When you reach the survey you will be asked to actively click to enter the survey itself. In doing this you will be providing your consent to participate. You can, of course decide to not complete the survey. While there is no obligation for you to complete the survey, we are hoping that you will help us with this project so that we get the broad feedback from doctors at all stages in their career.
The survey will be open for six weeks from 2 November 2015 to 11 December 2015. You will not be asked for your name or to identify yourself. At the completion of the survey, the information will be collated and analysed by Dr Kay and the MUQCPHCl team. Preliminary analysis will ensure that there are no features in the results that could inadvertently identify an individual before any results are provided to the Metro South Health researchers on the team. The findings will be compared to the national and international data that is available.

Please feel free to ask questions about this project before deciding whether or not to take part. Participation in this research is voluntary and no one will know whether or not you did participate unless you tell them yourself.

You can keep this copy of this Participant Information if you wish to.

**What are the possible benefits?**
We cannot guarantee that you will receive any direct benefits from this research, completing the survey may enhance your personal awareness of your own health and wellbeing.

**What are the possible risks?**
While you complete the survey, the focus on health issues may make you more aware of a health issue that you need to address. This may initially worry you, but identification of a health issue is the first step to finding a solution. All doctors should have their own general practitioner (GP) and we would recommend that you talk to your GP about this issue. If you find that you are experiencing any significant distress related to this, then you can contact:

- Lifeline, Phone: 13 11 14 for immediate support
- Beyondblue, Phone: 1300 22 4636
- Doctors’ Health Advisory Service Qld – (07) 3833 4352 or [www.dhasq.org.au](http://www.dhasq.org.au)
  This service is a confidential 24hour telephone line for doctors and medical students.
- You also have access to your Employee Assistance Scheme that provides short-term support and counseling as required, for all employees and their immediate family members. Employee Assistance Provider, OPTUM is based on self-referral can be contacted 24/7 on 1300 361 008.

**What if I wish to withdraw from this research project?**
Once you have completed the surveys it will not be possible for the researchers to identify your survey and withdraw your information. Please be assured that the data from these surveys will be presented as collated data with no individual results released.

**How will I be informed of the results of this research project?**
A brief report will be provided to all doctors in the future. A formal report of the findings will be provided to Metro South Health. Results will also be disseminated locally through Grand Rounds and in the future it is intended to draft a manuscript for publication. The research team will develop conference presentations and draft a manuscript for publication. It is intended that these findings will help doctors to engage with their personal health proactively and will also inform future interventions, including educational interventions, which will be designed to improve the health of doctors.

**Project contact for further information:**
If you want any further information concerning this project you can contact the principal researcher Dr Margaret Kay on 0402 299 744 or [m.kay1@uq.edu.au](mailto:m.kay1@uq.edu.au)

**Ethics Office Contact for independent advice or to report concerns:**
Ethics officer details are: [EthicsResearch.PAH@health.qld.gov.au](mailto:EthicsResearch.PAH@health.qld.gov.au) or phone (07) 3443 8049.
How’s your health?

My Health: A Doctors’ Wellbeing Survey

We are conducting a research project on the health and wellbeing of medical professionals in Metro South Health.

We’re inviting you to participate in a short, anonymous survey about your physical and mental health, health behaviours and help-seeking behaviours.

The results of this survey will be used to develop a strategy to support staff in achieving optimal health and wellbeing.

Please check your e-mail for the survey link.

For more information, contact Dr Margaret Kay on m.kay1@uq.edu.au or 0402 299 744.
Dear Dr Kay

HREC Reference number: HREC/15/QPAH/684
Project Title: My Health: A Doctors' Wellbeing Survey.

Thank you for submitting the above research protocol to the Metro South Human Research Ethics Committee for ethical and scientific review, on behalf of the following Principal Investigators (see appendix). This protocol was first considered by the Human Research Ethics Committee (HREC) at the meeting held on 3 November 2015.

I am pleased to advise that the HREC has granted approval of this research protocol.

You are reminded that this letter constitutes ethical approval only. You must not commence this research protocol at a site until separate authorisation from the Metro South Chief Executive or Delegate of that site has been obtained.

A copy of this approval must be submitted to the Research Governance Office(r)/Delegate of the relevant institution with a completed Site Specific Assessment (SSA) Form for authorisation from the Chief Executive or Delegate to conduct this research at the sites listed in the Appendix below.

If this study currently receives grant funding, please remember to forward a copy of this approval letter to the relevant Grants Office of the Administering Institution(s) for the grant.

The documents reviewed and approved include:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cover letter</td>
<td></td>
<td>14 October 2015</td>
</tr>
<tr>
<td>NEAF</td>
<td></td>
<td>14 October 2015</td>
</tr>
<tr>
<td>Participant Information Leaflet</td>
<td>3</td>
<td>14 October 2015</td>
</tr>
<tr>
<td>Promotional email to doctors from Dr Richard Ashby</td>
<td>3</td>
<td>14 October 2015</td>
</tr>
<tr>
<td>Letter from Dr Ashby to VMOs to request their participation in the survey</td>
<td>3</td>
<td>14 October 2015</td>
</tr>
<tr>
<td>Poster to advertise and invite doctors to participate in study (with HREC reference)</td>
<td>n.d.</td>
<td></td>
</tr>
<tr>
<td>First email to doctors to invite their participation in the survey</td>
<td>3</td>
<td>14 October 2015</td>
</tr>
<tr>
<td>Second email to doctors – Reminder 1</td>
<td>3</td>
<td>14 October 2015</td>
</tr>
</tbody>
</table>
This HREC approval is valid from 12 November 2015 until 12 November 2018.

Please note the following conditions of approval:

1. The Coordinating Principal Investigator will immediately report any matters which might warrant review of ethical approval of the protocol in the specified format, including unforeseen events that might affect continued ethical acceptability of the protocol. Serious Adverse Events must be notified to the HREC as soon as possible. In addition the Investigator must provide a summary of the adverse events, in the specified format, including a comment as to suspected causality and whether changes are required to the Patient Information and Consent Form. In the case of Serious Adverse Events occurring at the local site, a full report is required from the Coordinating Principal Investigator, including duration of treatment and outcome of the event.

2. Amendments to the research protocol which may affect the ongoing ethical acceptability of a protocol must be submitted to the HREC for review. Amendments should be accompanied by all relevant updated documentation and a cover letter from the Coordinating Principal Investigator, providing a brief description of the changes, the rationale for the changes, and their implications for the ongoing conduct of the study. Hard copies of the cover letter and all relevant updated documents, with tracked changes, must also be submitted to the HREC office as per standard HREC SOP. (Further advice on submitting amendments is available at [http://www.health.qld.gov.au/ohmr/documents/researcher_userguide.pdf](http://www.health.qld.gov.au/ohmr/documents/researcher_userguide.pdf)

3. Amendments to the research protocol which only affect the ongoing site acceptability of the protocol are not required to be submitted to the HREC for review. These amendment requests should be submitted directly to the Research Governance Office.

4. Proposed amendments to the research protocol which may affect both the ethical acceptability and site suitability of the protocol must be submitted firstly to the HREC for review and, once HREC approval has been granted, then submitted to the Research Governance Office.

5. Amendments which do not affect either the ethical acceptability or site acceptability of the protocol (e.g. typographical errors) should be submitted electronically (track changes) and in hard copy (final clean copy) to the HREC Coordinator. These should include a cover letter from the Coordinating Principal Investigator providing a brief description of the changes and the rationale for the changes, and accompanied by all relevant updated documents with tracked changes.

6. The HREC will be notified, giving reasons, if the protocol is discontinued at a site before the expected date of completion.

7. The Coordinating Principal Investigator will provide an annual report to the HREC and at completion of the study in the specified format.

8. If you require an extension for your study, please submit a request for an extension in writing outlining the reasons. Note: One of the criteria for granting an extension is the compliance with the approval's conditions including submission of progress reports.

9. Any research study that prospectively assigns human participants or groups of humans to one or more health-related interventions to evaluate the effects on health outcomes (WHO / ICMJE 2008 definition) should be registered, including early phase and late phase clinical trials (phases I-III) in patients or healthy volunteers (WHO Recommendation / ICMJE policy). If in doubt, registration is recommended. All studies must be registered prior to the study's inception, i.e. prospectively.

http://www.anzctr.org.au/

Should you have any queries about the HREC's consideration of your protocol please contact the Metro South HREC Office on 07 3443 8049

Please note that the Metro South HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Human
Second and final reminder email            3        14 October 2015
My Health: A Doctors Wellbeing Survey
Letter in response to HREC comments       11 November 2015

This HREC approval is valid from 12 November 2015 until 12 November 2018.

Please note the following conditions of approval:
1. The Coordinating Principal Investigator will immediately report anything which might warrant review of ethical approval of the protocol in the specified format, including unforeseen events that might affect continued ethical acceptability of the protocol. Serious Adverse Events must be notified to the HREC as soon as possible. In addition the Investigator must provide a summary of the adverse events, in the specified format, including a comment as to suspected causality and whether changes are required to the Patient Information and Consent Form. In the case of Serious Adverse Events occurring at the local site, a full report is required from the Coordinating Principal Investigator, including duration of treatment and outcome of the event.

2. Amendments to the research protocol which may affect the ongoing ethical acceptability of the protocol must be submitted to the HREC for review. Amendments should be accompanied by all relevant updated documentation and a cover letter from the Coordinating Principal Investigator, providing a brief description of the changes, the rationale for the changes, and their implications for the ongoing conduct of the study. Hard copies of the cover letter and all relevant updated documents, with tracked changes, must also be submitted to the HREC office as per standard HREC SOP. (Further advice on submitting amendments is available at: http://www.health.qld.gov.au/ohmr/documents/researcher_uguide.pdf

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http://www.anzctr.org.au/

Should you have any queries about the HREC’s consideration of your protocol please contact the Metro South HREC Office on 07 3443 8049

Please note that the Metro South HREC is constituted and operates in accordance with the National Health and Medical Research Council’s (NHMRC) National Statement on Ethical Conduct in Human
Research (2007), NHMRC and Universities Australia Australian Code for the Responsible Conduct of Research (2007) and the CPMP/ICH Note for Guidance on Good Clinical Practice.

The HREC Terms of Reference, Standard Operating Procedures, membership and standard forms are available from the following websites:

Once authorisation to conduct the research has been granted, please complete the Commencement Form (Attached) and return to the Metro South Human Research Ethics Committee.

The Metro South HREC wishes you every success in your research.

Yours sincerely,

[Signature]

A/Prof Richard Roylance
Chair
Metro South Hospital and Health Service
Human Research Ethics Committee (EC00167)
Centres for Health Research
Princess Alexandra Hospital

12/11/15

C.c. Ms L Ferguson

Appendix:

List of Sites Approved

<table>
<thead>
<tr>
<th>No.</th>
<th>Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Princess Alexandra Hospital</td>
</tr>
<tr>
<td>2.</td>
<td>Queen Elizabeth II Jubilee Hospital</td>
</tr>
<tr>
<td>3.</td>
<td>Logan Hospital</td>
</tr>
<tr>
<td>4.</td>
<td>Redland Hospital and Marie Rose Centre</td>
</tr>
<tr>
<td>5.</td>
<td>Beaudesert Hospital</td>
</tr>
</tbody>
</table>
SSA AUTHORIZATION
METRO SOUTH HOSPITAL AND HEALTH SERVICE

HREC Reference number: HREC/15/QPAH/684
SSA reference number: SSA/15/QPAH/685
Project title: My Health: A Doctors' Wellbeing Survey

Dear Dr Kay,

Thank you for submitting your application for authorisation of this project. On the recommendation of the Human Research Ethics Committee (HREC), I am pleased to inform you that approval is granted for your project to proceed at the Metro South Hospital and Health Service.

This approval is subject to researcher(s) compliance throughout the duration of the research with certain requirements as outlined in the National Statement on Ethical Conduct in Human Research 2007 and Australian Code for the Responsible Conduct of Research.

The duration of this study approval is up until expiration of the reviewing HREC’s approval.

The following conditions apply to this research proposal. These are additional to those conditions imposed by the approving HREC.

1. SAEs: Where serious adverse events (SAEs) are encountered, during the course of the study which may have ethical implications. Research Governance Office must be notified as soon as possible. http://www.health.qld.gov.au/pahospital/research/adverse_events.asp

2. Proposed amendments to the research protocol or conduct of the research which may affect the ongoing ethical acceptability of the project and/or the site acceptability of the project are to be submitted firstly to the HREC for review and then to the research governance office after a HREC decision is made. A copy of the HREC approval/rejection letter must be submitted to the RGO.

3. Lapsed Approval: If the study has not commenced within twelve months approval will lapse requiring resubmission of the study to the approving HREC.

4. Annual Reviews: All studies are required by the NHMRC to be reviewed annually and reported to the relevant HREC within the 12 month reviewing period. The MS HREC Annual Report template is accessed through the MS HREC website http://www.health.qld.gov.au/pahospital/research/monitoring.asp
5. Ongoing duty of care must be followed regarding confidentiality of public information and patient privacy, when research involves the recruitment of Metro South Hospital and Health Service (MSHHS) patients. You are required to comply at all times the Australian and Queensland Laws including the Health Services Act, the Privacy Act, Public Health Act (2005) and other relevant legislation, ethics obligations and guidelines which are applicable to the MSHHS including any requirement in respect of the maintenance, preservation or destruction of patient records.

We wish you every success in undertaking this research.

Yours sincerely,

[Signature]

Prof Ken Ho,
Chair, Centres for Health Research
METRO SOUTH HEALTH

18, 11, 15
BMI: Body Mass Index
BO: Burnout
CF: Compassion Fatigue
CS: Compassion Satisfaction
EAS: Employee Assistance Scheme
GP: General Practitioner
HR: Human Resources
ICU: Intensive Care Unit
JHO: Junior House Officer
Junior doctor: Intern, JHO, SHO
K10: Kessler Psychological Distress Scale 10
QEII: Queen Elizabeth II Hospital
MSH: Metro South Health Hospital and Health Services
MUQCPHCI: Mater University of Queensland Centre for Primary Health Care Innovation
PAH: Princess Alexandra Hospital
PHO: Principal House Officer
ProQOL: Professional Quality of Life Scale
Reg: Registrar
SHO: Senior House Officer
Senior Doctor: SMO and VMO
SMO: Senior Medical Officer
STS: Secondary Traumatic Stress
Training doctor: Registrar and PHO
VMO: Visiting Medical Officer
Workplace Equity and Harassment Officer: WEHO
Appendix 7
References


52. Lemaire JB, Wallace JE. Not all coping strategies are created equal: a mixed methods study exploring physicians' self reported coping strategies. BMC Health Serv Res. 2010; 10:208.


