The Practitioner Health Service is a confidential, free, self-referral NHS service for doctors and dentists with mental illness and addiction problems.

It is made up of the combined services of the NHS Practitioner Health Programme (PHP), NHS General Practitioner Health Service (GPHS) and Trainee Doctors and Dentists Support Service (TDDSS). Services are available England wide and we see doctors and dentists with the whole range of mental illness and are able to offer a wide range of pharmacological treatments and talking therapies.

www.php.nhs.uk  www.gphealth.nhs.uk

england.phpadmin@nhs.net  gp.health@nhs.net

Tel - 0300 030 3300

The Wounded Healer
10 Year Anniversary Conference of the Practitioner Health Service
BMJ Mental Health Team of the Year 2018
Thursday 4 - Friday 5 October 2018
30 Euston Square, London, NW1 2FB
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<td>Welcome&lt;br&gt;Dr Clare Gerada, Medical Director, NHS Practitioner Health Programme</td>
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<td>10.15</td>
<td>International Keynote Session: Why are Doctors in Distress?&lt;br&gt;Dr Abigail Zuger, Associate Clinical Professor of Medicine, Icahn School of Medicine at Mount Sinai, &amp; Senior Attending Physician, Mount Sinai Roosevelt &amp; Mount Sinai St. Luke’s Hospitals in New York City</td>
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<td>10.45</td>
<td>Question and answers</td>
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<td>11.00</td>
<td>International Keynote Session&lt;br&gt;Mr Henry Marsh, Retired Neurosurgeon and Author&lt;br&gt;Do No Harm: Stories of Life, Death and Brain Surgery&lt;br&gt;• The difficulty of finding a balance between clinical detachment and compassion.&lt;br&gt;• The over-arching benefit of having good colleagues but the need for some iron in the soul.&lt;br&gt;• The difficulty of being honest with yourself, your colleagues and patients, especially as doctors now work in an increasingly critical, unsympathetic environment.</td>
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<td>11.40</td>
<td>The Singing Healer&lt;br&gt;Iwan Roberts</td>
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<td>15.45</td>
<td>Group Discussion: Changing practice to support sick doctors: Consensus building as to what works?&lt;br&gt;Chair: Dr Clare Gerada, Medical Director, NHS Practitioner Health Programme&lt;br&gt;Dr Ide Delargy, Clinical Lead, Practitioner Health Matters Programme, Dublin&lt;br&gt;Professor Debbie Cohen OBE, Director, Student Support School of Medicine, Director, Medic Support and the Centre for Psychosocial Research, Occupational and Physician Health, Cardiff University School of Medicine&lt;br&gt;Dr Gustavo Tolchinsky, Secretary of the Board, Barcelona Medical Council</td>
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<td>16.30</td>
<td>Keynote Closing Address: This is going to hurt&lt;br&gt;Adam Kay, Writer, Comedian &amp; Former Junior Doctor&lt;br&gt;Based on his best-selling book about his experiences of being a junior doctor</td>
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<td>Dr Clare Gerada, Medical Director, NHS Practitioner Health Programme</td>
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<td>Drinks Reception</td>
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<td>08.00</td>
<td>Start the Day with the BMJ</td>
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<td></td>
<td><strong>Anne-Marie Doyle</strong> Consultant Clinical Psychologist Royal Brompton and Harefield NHS Foundation Trust</td>
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<td><strong>Lucy Warner</strong> Chief Executive NHS Practitioner Health Programme and NHS GP Health Service</td>
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<td><strong>Dr Henrietta Bowden-Jones</strong> Consultant Psychiatrist CNWL NHS Trust &amp; President Medical Women’s Federation</td>
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<td>09.00</td>
<td>Tea and coffee</td>
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<td>Chairman’s Introduction</td>
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<td>09.25</td>
<td>Keynote: The emotional impact of caring</td>
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<td>• the emotional impact of work and what we should do to address these issues</td>
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<td>Keynote</td>
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<td>Keynote: A father’s experience</td>
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<td>• Losing my son to the system</td>
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<td>• what have I learnt</td>
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<td>10.40</td>
<td>Question and answers, Followed by tea and coffee break at 10.45</td>
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<tr>
<td>11.05</td>
<td>The development of expert biographies in medical writing</td>
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<td>• contextual analysis of the emergence and changing content of physicians writing about and publishing their own illness experiences narratives over the 20th century.</td>
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<td>• over the last 100 years the number and prominence of physicians writing about their own illnesses (especially mental health conditions) has increased.</td>
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<td>• the emergence and subsequent increase of autobiographical ill doctors over the last century is contextualised with wider understandings of medical practice and illness.</td>
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<td>11.25</td>
<td>Burnout Proof LIVE Workshop: Proven tools to lower stress levels, build more life balance and a more ideal practice. Bust three burnout myths to burnout proof your career</td>
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<td>• the quadruple aim blueprint strategy for organization-wide burnout prevention</td>
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<td>• burnout proof LIVE: interactive training</td>
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<td>12.50</td>
<td>Lunch and exhibition with The Singing Healer performance in the auditorium</td>
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<td>14.10</td>
<td>CONFERENCE CONTINUES &amp; SPlITS INTO BREAKOUT STREAMS</td>
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<td>TEA &amp; COFFEE BREAK &amp; EXHIBITION</td>
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<td>15.55</td>
<td>Keynote: Toward Preventing Physician Suicide: It Takes a Village</td>
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<td>• biopsychosocial risk factors for mental illness and suicide in physicians</td>
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<td>• how stigma works against recognition of illness in physicians themselves and confounds help-seeking and adherence to life-saving treatments</td>
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<td>• systemic, institutional, intercollegial, familial and individual changes that must occur to stop physicians from killing themselves</td>
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<td>16.25</td>
<td>#AndMe - changing minds about mental health</td>
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<td>• A cross professional anti stigma campaign</td>
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<td>• Positive senior role modelling within healthcare professions to reduce the stigma of mental ill health</td>
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<td>16.30</td>
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<td>Next Steps, Consensus Statement</td>
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<td>Question and answers, then Close</td>
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Stream 1.A. Addiction

1.A.i. The Dutch system of practitioner health: addicted doctors

De Rond M.E.J., Kuppens J., Prud’homme M., Rode H.

Lead Author: Dr M. E. J. De Rond, Project Leader for ABS-doctors, The Royal Dutch Medical Association

Summary

Alcohol is part of social life in Western society. In the Netherlands the use of soft drugs is tolerated. But how does substance use relate to work? What rules exist regarding drinking before and during work? And which rules apply to doctors in particular?

Alcohol consumption at work is prohibited in the exercise of certain professions – pilots, for example. However, there are no specific laws and regulations before and during doctors’ working shifts. Field standards are also lacking. A number of employers, such as university hospitals, have introduced a so-called alcohol and drugs policy for their doctors.

According to the RDMA, it was essential to develop a policy concerning substance use before and during work. The rules of conduct were published in January 2018 and states that doctors have to carry out their work soberly, without alcohol or psychoactive substances in their blood.

In 2011, the RDMA established ABS-doctors, a programme for doctors with addiction problems. Every year the number of doctors who contact the programme has increased (from 27 doctors in 2011 to 79 in 2017). In 2017, ABS-doctors started a monitoring programme for doctors who want to keep on working after receiving treatment but so far, few doctors have applied for the monitoring program. We are expecting that the rule of conduct will have a significant impact on the numbers of physicians turning to ABS-doctors for help or monitoring. During the conference, results after a half year will be reported.

Aims

- To inform participants about the new rule of conduct for physicians in the Netherlands concerning the use of alcohol and psychoactive substances during and prior to work
- To inform participants about ABS-doctors (the Physician Health Program of the Netherlands)
- To inform participants about the effect of the new rule of conduct on the ABS-doctors programme

Objectives

- To outline the new rules of conduct
- To explain our ABS-doctors programme
- To investigate the effects of the new rules of conduct are having in the first half of 2018

Learning points

- There were no formal rules about the use of alcohol and psychoactive substances in the Netherlands
- In January 2018 the RDMA presented new rules of conduct stating that doctors must be sober when working with patients, and must not have alcohol or psychoactive substances in their blood
- In the Netherlands there is a Physician Health Program for addicted doctors called ABS-doctors
- This programme started in 2011. In 2017, ABS-doctors started a monitoring programme for doctors who had received treatment and want to reintegrate into work
- The effect of the new rules of conduct on the ABS-doctors program

1.A.ii ‘No doc left behind’

Bruguera E., Martinez M., Bule C., Braquehais D., Tolchinsky G., Mitjans A., Padrós J.

Lead Author: Dr Gustavo Tolchinsky Wiesen, Barcelona Medical Association

Summary

The Barcelona Medical Association (BMA) created the PAIMM in 1998. Since then more than 2,500 physicians have been treated for mental disorders and substance abuse. Delivering care for physicians who must keep ‘fit to practice’ is complex and redefines the conception of success in treatment goals. We understand that treatment does not work when a patient does not follow or adhere to treatment or when results do not correlate with treatment, and that a consequence of not meeting these goals are the safety of the physician themselves and that of their patients. Professionals most at risk of not meeting treatment goals are those who, whether by severity or time elapsed, trend to deterioration, or those who alter personal, family or social relationships.

From a therapeutic point of view, we have developed a programme for Severe Mental Disorder that keeps professionals at high risk because of the diagnosis, drug abuse or poor adherence to treatment on track.

When the therapist or BMA representative considers there could be a high risk associated, cases are discussed within the multidisciplinary committee for complex cases at the BMA. 139 cases have so far been analysed in this way.

A total of 292 therapeutic contracts have been signed by 117 patients. The therapeutic contract is a tool to assure specific goals during treatment and follow-up, and sets conditions for the practice in order to maintain it and guarantee best results. It involves the therapist, the patient and a BMA representative. Disciplinary measures have been adopted in 4 cases for violation of the therapeutic contract.

When the initial diagnosis is a very severe mental disorder and treatment does not restore mental health to the point of being ‘fit to practice’, physicians are guided out of the profession to permanent disability. This has happened in nearly 150 cases to date.

Aims

- To note that clinical criteria for treatment failure may have to be redefined in the setting of physician health programmes.
- There are different strategies to address treatment failure. The main objective is to keep physicians and patients safe.
- Organisations must collaborate actively in their regulatory functions with physician health programmes to give them more information.
Objectives
- To explain our view on treatment failure in physicians with mental disorders.
- To prove to the audience that multiple strategies are needed to protect all parties.
- To show our model of integrated agents that combines a caring programme with regulatory functions.

Learning points
- When treating physicians with mental disorders, a different threshold for a good response to treatment is needed, compared to other populations.
- Unmet treatment expectations must be carefully analysed.
- Disciplinary measures must be applied at the end, but they do not mean the end of the road.

1.A.iii The Practitioner Health Service (PHS)

Dr Shivanthi Sathanandan, Consultant Psychiatrist, Practitioner Health Service

Summary
Over the years, around 10.1% of doctors attending PHS (381) have had problems with addiction – mainly alcohol addiction. Others presenting with addiction have problems with drug misuse and behavioural addiction (internet pornography and gambling). The drugs include opiates, stimulants, club drugs/legal highs and prescribed or over-the-counter medications. We believe that this is the largest cohort of doctors being treated for addiction in a single treatment service and are proud of our outcomes.

We have seen a significant drop in the number of doctors presenting with addiction issues, from 36% in 2008/9 to 7% in 2017/2018. This may be that we are reaching out to doctors earlier and providing them with care before their use of alcohol or drugs becomes problematic and entrenched.

Consistently over the years men have outnumbered women presenting with addiction problems by three to one. All age ranges have doctors with addiction though it is more common in doctors aged 35-45 years old. In general, younger doctors are more likely to use drugs, and older age groups are more likely to be addicted to alcohol.

Recover rates and abstinence in practitioner-patients is much better than for the general population, where it is expected that only between 10-30% of those addicted to alcohol and/or drugs will become abstinent.

Aims
- To discuss the treatment and support that has worked within the Practitioner Health Service over the last decade.
- To explore what hasn’t worked and some of the pitfalls to avoid in treating practitioner-patients.
- To examine the difference in outcomes between inpatient and outpatient/community rehabilitation.
Objectives

- To understand the barriers to accessing timely help and that early and appropriate intervention produces excellent outcomes.
- To gain insight into the factors which contribute to late presentation as addicted doctors do not share their issues with fellow addicts, nor do they identify as addicts until their recovery starts, seeing status and occupation as differentiators or protecting factors.
- To recognise that, although depression is well recognised in addiction, the level of low mood and suicidality is striking amongst the population of addicted doctors.

Learning points

- With treatment, addicted doctors have excellent outcomes compared to non-medical addicted patients.
- There are very high rates of complete abstinence in successful treated doctors compared with much higher use of opiate substitute treatments for non-medical addicts.

Stream 1.B. Doctors’ Stories

1.B.i Post Traumatic Stress Disorder, intrusive thoughts and memory in surgeons?

Johnson C., Bolderston H., McDougall S., Thomas K., Turner K.

Lead author: Dr Helen Bolderston, Clinical Psychologist & Senior Lecturer in Psychology, Bournemouth University

Summary

This paper combines findings from a UK-based survey with those from a detailed qualitative study in order to examine why surgeons appear to be more likely to screen positively for Post-traumatic stress disorder (PTSD) than is the norm within the general population.

PTSD is the most prevalent type of psychopathology associated with experiencing traumatic events (Yehuda 2002). While surgeons as a group may not have a pre-disposition to PTSD, the risks for healthcare professionals have been increasingly recognised (Fullerton et al., 2004; Skogstad, 2013). Nevertheless, it was remarkable that 20.2% of participants within the sample screened positively for PTSD, similar levels to military veteran populations (Prins et al. 2016). Typical symptoms were recurrent themes throughout the qualitative data, including high levels of reported rumination and intrusive thoughts following adverse events, as well as the replaying of events and counterfactual thinking.

PTSD was not the only clinical concern indicated within the study’s findings. Surgeons were, on average, mildly depressed and burnout scores were high. These findings bring into question not only surgeons’ ability to cope with the stressors within their working life, but also the efficacy of support offered to surgeons to prepare them for and mitigate against the effects of adverse events.
A prevalent emerging theme within interviews, further supported by survey data, was the perceived value of support from colleagues above other available types of support. This indicates that surgeons who fall into a category of clinical concern with regards to mental health and wellbeing may be turning to colleagues rather than seeking appropriate interventions or therapy. It also raises questions regarding the efficacy or awareness of current formal support provisions in mitigating against the negative impacts of adverse events. Whether adaptations need to be made to the current training and support pathways will be discussed.

Aims
- To discuss findings relating to possible psychopathologies experienced by surgeons following adverse events.
- To evaluate the role and efficacy of support provisions available to surgeons following adverse events and discuss ways in which training and intervention approaches may need to adapt to better support surgeons in the future.

Objectives
- To gain insight into past and current research investigating the impact of adverse events on surgeons’ wellbeing and provide insight into how these findings relate/differ to previous findings in this area.
- To examine the high proportion of positive PTSD screens within the online survey and explore this finding in conjunction with qualitative interview data relating to intrusive thoughts and rumination.
- To evaluate the extent to which formal and informal support may ameliorate impacts following adverse events.
- To evaluate how training and other interventions may be devised to provide appropriate support for when adverse events occur.

Learning points
- Surgeons within the United Kingdom are negatively impacted following adverse events.
- More exploration is needed into the prevalence of PTSD among surgeons who have experienced traumatic adverse events.
- The most often used types of support are informal, with surgeons leaning most heavily on colleagues within their own hospital.
- Current training and support provisions for surgeons are not effective in mitigating against negative impacts
- Specific training is needed to provide surgeons with a toolkit to allow them to work more effectively within their chosen profession without compromising their mental health and wellbeing.
1.B.ii Changing the culture on night shifts – making power naps the norm

Dr Nancy Redfern, Consultant Anaesthetist and Immediate Past Honorary Membership Secretary, Association of Anaesthetists of Great Britain and Ireland (AAGBI)

Summary

Busy nights are the norm in anaesthesia and intensive care. These take their toll; people feel exhausted, motivation falls, and the chance of making clinical errors increases.

Driving home sleep deprived is dangerous, but yet many have little choice, as organisations do not provide facilities to sleep after a night shift. Worse, some doctors work in a culture where sleeping is a disciplinary offence. Unsurprisingly trainee surveys report worrying levels of burnout and low morale and highlight the effects of fatigue.

To address this, the Association of Anaesthetists of Great Britain and Ireland (AAGBI) is working to improve the culture around fatigue. We aim to inspire individuals, departments and organisations to work together to reduce fatigue and minimise its impact. We are doing this by:

- Establishing a national fatigue working group.
- Agreeing a set of standards for departments and responsibilities for individuals and providing a template to audit these.
- Providing educational resources about fatigue.
- Raising awareness of senior leaders.
- Releasing a consensus statement setting out a call for action for individuals and departments.

Aims

To increase awareness of fatigue, & review ways of mitigating its impact.

Objectives

To discuss:

- What are the risks of fatigue and why is good sleep hygiene important?
- How can we improve the culture around fatigue for ourselves and our organisations?

Learning points

- To review the evidence about the impact of fatigue on safe clinical care and personal wellbeing.
- To highlight ways of empowering individuals and teams to change organisational culture about fatigue and shift work.
1.B.iii Historical perspectives on surgeons’ emotional wellbeing

Dr Agnes Arnold-Forster, Postdoctoral Research Fellow, Surgery & Emotion, University of Roehampton

Summary

This presentation will argue that historical research has a place in policy debates about surgeons’ mental health and wellbeing. It will use surgical memoirs and oral history interviews with medical students, surgical trainees, consultants, and recently retired practitioners to suggest that failure to acknowledge the emotional complexity of surgery leaves practitioners vulnerable. There is a pervasive and persistent stereotype of the detached surgeon. This detachment is a professional standard, but also contributes to an unflattering caricature. The surgeon is often presented as someone unable or unwilling to communicate effectively, engage compassionately with their patients, or express how they feel. This stereotype has a detrimental effect on surgeons’ health – an effect that has only recently begun to be recognised. Much has been written about the gnawing threat of stress and burnout, and there are current campaigns to excise bullying from the speciality. A recent article by Dr Clare Gerada on the question of surgical mental health, published in the Bulletin of the Royal College of Surgeons, argues that the problem is a historical and cultural one. She suggests that doctors have their own ‘unwritten group norms’, that are deeply engrained and have long histories. My research looks at these long histories to account for what has changed and why, what has remained the same, and what effect these shifts have had on the doctor-patient relationship and on surgeons’ emotional wellbeing and resilience. Indeed, surgeons have not always been detached, and past practitioners found value in affective as well as technical expertise.

Aims

- To provide a longue durée account of the place of emotions in surgical practice.
- To argue for the place of historical research in contemporary policy debates about surgeons’ mental health and wellbeing.

Objectives

- To provide evidence for changing emotional regimes over time.
- To identify the political and cultural shifts responsible for those changes.
- To suggest alternative emotional models for surgical practice, derived from historical examples.

Learning points

- The recent history of surgery and its attendant emotions.
- The relationship between past and present – what we can learn.
- The surgical memoir is a new genre. Twenty years ago, you would be hard-pressed to find a single published autobiographical account. Today, and following on from path-breakers like Atul Gawande, you can read an ever-increasing array. These narrative accounts of long careers provide insight into the shifting dynamics of surgery and emotions since the establishment of the NHS.
- There is a synergy between the investigative practices of the clinician and those of the historian. Healthcare practitioners ‘take histories’ and cross-reference them with other sources of evidence. Oral history interviews allow the researcher to access otherwise untold stories by practitioners who might otherwise escape the historical record (e.g. women and people of colour).
Stream 1.C. Promoting Resilience

1.C.i Preventing the preventable: SAFEMED stress management and resilience training

Dr Margaret O’Rourke, Director of Behavioural Science and Psychological Medicine, School of Medicine, University College Cork, Ireland

Summary

Doctors’ responses to the stresses of medical practice are normally distributed. On the one side are those who drift into depression, self-medicating (with alcohol or drugs) and even suicide. On the other side are those who thrive under high stress and pressure and even actively welcome the challenge. In the middle are the majority who react with symptoms of anxiety, depression and fatigue during high-stress periods but who manifest the resilience to recover and survive. However, the traits and characteristics that underpin responses to the stress of medical practice are widely considered mutable and amenable to intervention and change. UCC medical school have innovated a programme for teaching those psychological skills that help doctors understand their own propensity to stress and to improve resilient responding.

Method and results

This paper describes the SAFEMED programme for stress inoculation and resilience building. Now in its tenth year, SAFEMED has been presented in diverse settings ranging from first and final year medical students, interns/foundation training, early career trainees, to GPs and hospital consultants in the UK NHS, Royal College of Physicians, Irish College of General Practitioners and Harvard Medical School. We have created a range of programs in which doctors can learn steps and skills for stress inoculation, psychological fitness and resilience. Over 1,500 doctors have now completed and evaluated the programme, this data is presented.

Discussion and conclusions

We conclude with observations on the advantages and pitfalls of such skills-focused training. Practical considerations for implementation and programme evaluation research in this important area are discussed.

1.C.ii What is the experience for physicians of hospital Schwartz Centre Rounds?

Meystre C., Chaplin D.

Lead Author: Dr Chantal Meystre, Palliative medicine physician and integrative psychotherapist, Heart of England Foundation NHS Trust

Summary

Patient care is physically and emotionally taxing. Under-pressure doctors develop defences that help them cope with the nature of their work, but also contribute to the withdrawal from recognising, expressing and sharing the experiences of the workplace.
This contributes to the hidden curriculum of medical training, teaching medical professionals not to show emotion or distress, and to the higher rates of substance abuse, relationship breakdown and suicide amongst practitioners.

Schwartz Center Rounds are an opportunity to share the experience of delivering care with colleagues. To care with compassion, staff need to be recognised and listened to as people in the workplace.

Schwartz Center rounds were instigated in the USA after Kenneth Schwartz noticed how compassionate care made him feel better in himself during cancer treatment. The rounds aim to give staff an opportunity to share their experience of caring, understand their own feelings, and develop insights into self-care. Any staff member is welcome to lunch and the round.

Our Schwartz Center rounds have run for 3 years, supported by Trust management, The Point of Care Foundation and Macmillan Cancer Care. Content is professional, personal and occasionally intimate. Topics include patients, staff, teams and mentors, as well as contexts of delivering care. Organisational and individual content is shared.

The Rounds are well attended (15-39). Content and formal/informal feedback from those who have supported and attended the rounds will be presented. The rounds evaluate very well, but doctors’ scoring is lower than other attendees.

Verbal consent is on the basis of sharing learning but not attributing content. This abstract conforms to that consent agreement.

Aims
  - To demonstrate the aims, content and power of Schwartz Center Rounds and their acceptability to doctors, as well as other professions.

Objectives
  - To describe how rounds are introduced to an organisation and run.
  - To describe the topics and content covered in rounds.
  - To present evaluation data.

Learning points
  - Medical staff can overcome their alexithymia and share with other professionals. The hidden curriculum may explain the discrepancy in Schwartz Center Round feedback outcomes between doctors and other professions.

1.C.iii Understanding and accepting vulnerability as a positive aspect of emotional care for wounded healers

Haaland A., Kitchen T., Hassan I.

Lead author: Anne Haaland, Lecturer, University of Oslo and University of Cardiff

Summary

Vulnerability is often perceived as a sign of weakness or embarrassment by medical professions. In the words of a trainee doctor, ‘there was an innate belief that vulnerability needs to be stamped out and hidden’. Many fear vulnerability, and have not learnt how to recognise, understand and handle it with care, in themselves or in
patients/colleagues. In environments with high emotional labour, emotional reactions to situations triggering vulnerability are common. If unrecognised or mishandled, these can compromise patient safety, teamwork and professional wellbeing, contributing to higher levels of mental ill health in doctors and medical students in the UK compared to the general population.

Evaluation pre and post-training included questionnaires, semi-structured interviews, reflective narratives and FGD.

Trainees learnt to recognise, understand and appreciate positive aspects of vulnerability rather than only fearing or denying it, using EI to step back from automatic emotional reactions and speak openly with colleagues. Recognising vulnerability when working with patients and colleagues, they can reach out and make connections that enable them to meet as human beings. Many describe being kinder to themselves, enjoying work more, and being more resilient. Participants have gone from being re-active when faced with these emotions, to becoming pro-active, handling emotions with EI.

Reflective learning has enabled participants to recognise, acknowledge and care for vulnerability with self-awareness, and with a focus on relationships.

Aims
- To demonstrate how understanding and accepting vulnerability as a positive aspect of emotional care for wounded healers can help build skills to heal wounds and strengthen patient care and professional wellbeing.

Objectives
- To explore the effects of unrecognised vulnerability on the medical workforce, on patient care and on self-care of medical professionals.
- To strengthen the understanding of how recognising and understanding vulnerability can positively affect patient care and self-care of medical professionals.
- To strengthen the understanding of how learning self-awareness and emotional intelligence skills over time can be used in practice to empower medical professionals to take better care of themselves and of their patients.
- To share experiences from implementing this programme in Wales.

Learning points
- To recognise the impact of unrecognised vulnerability on patients and medical professionals in clinical care.
- How we can educate medical workforce towards a balanced consideration of vulnerability.
- Perspectives from social science and practical medicine have helped shaped this model, and implementing it in 9 countries has shown that medical practitioners across cultures have common challenges related to handling emotions at work and at home. This model is a practical, well-tested training which enables participants to learn emotional intelligence and use it to strengthen their resilience.
Stream 1.D. Mistakes, Complaints and Blame Culture

1.D.i Surgeons’ responses to adverse events: self-blame, resilience and burnout following errors and complications

Johnson C., Bolderston H., McDougall S., Thomas K., Turner K.

Lead authors: Professor Siné McDougall and Mr Kevin Turner, Bournemouth University; Royal Bournemouth and Christchurch NHS Trust

Summary

This paper reports the findings of a large and detailed UK-wide survey that examined how surgeons cope with the challenge of dealing with adverse events, errors and complications that inevitably arise when carrying out surgical procedures.

When surgeons were asked to reflect on adverse events they had experienced, it was clear that the ‘blame’ that they attached to themselves depended on nature of the event. Complications were seen as an inevitable consequence of the risks associated with particular procedures. Errors, on the other hand, were viewed significantly more negatively and were primarily attributed to personal lapses in judgement (although other factors such as fatigue, lack of knowledge or resources, poor communication and procedural risk were also cited as factors). Importantly, changes in psychological wellbeing resulted from experiencing adverse events, including higher anxiety levels and poorer sleep patterns.

This research examined two opposing ‘stereotypes’ of surgeons’ ability to cope with adverse events: one suggests that surgeons as a group tend to be immune to stress (e.g. Pegrum & Pearce 2015); the other views surgeons as the ‘second victims’ of adverse events, experiencing burnout and depression as a result (e.g. Seys & Wu 2013). Standardised psychometric measures revealed that surgeons do not have higher resilience levels than the norm to help them deal with adverse events but do exhibit higher than average levels of depression. Burnout effects were specific and client-related, arising from the physical and psychological fatigue and exhaustion associated with working with patients (Kristensen et al. 2005). The ways in which surgeons can be better supported to enhance their wellbeing and resilience in response to the challenges which they face will be discussed.

Aims

- To share the findings of a large nationwide survey examining surgeons’ wellbeing and their ability to deal with adverse events.

Objectives

- To examine differences in the attributions surgeons make when reporting errors or complications and how this informs their responses to these types of adverse events.
- To examine whether or not surgeons have a reservoir of resilience that they may draw on when dealing with adverse events.
- To examine changes in surgeons’ wellbeing as a result of adverse events.
- To examine the extent to which surgeons in the UK report high levels of burnout and depression compared with studies conducted in the US and EU.
- To discuss the implications of these findings in providing support for surgeons both prior to, and after, adverse events arise.
Learning points
- Surgeons view errors more negatively than complications.
- Complications are thought to be the result of recognised risks associated with surgical procedures while errors are thought to result from lapses in judgement.
- Surgeons experience higher anxiety and poorer sleep patterns following adverse events but do not have higher resilience levels than the norm to help them deal with adverse events. Indeed, it may simply be conscientiousness which allows them to persevere.
- Surgeons show higher than average levels of depression and particularly high levels of client-related burnout.
- Further consideration needs to be given to targeted support aimed at increasing resilience and flexibility in response to the challenges which surgeons face.

1.D.ii Recognising and coping with psychic and somatic consequences of chronic stress in doctors charged with medical error
Bersani G., Rinaldi R.
Lead author: Professor Giuseppe Bersani, Associate Professor of Psychiatry, Sapienza University of Rome, Department of Medico-surgical Sciences and Biotechnologies

Summary
The presentation deals with the presently growing issue of somatic and psychic health problems among doctors undergoing legal prosecution for alleged medical error. The most relevant mechanisms connecting this chronic stress experience to somatic and brain response are presented in their relationship to emotional symptoms and impairment of cognitive profile.

Aims
- To define the clinical features of somatic and cognitive consequences of chronic stress in doctors charged with medical error; to seek both objective indexes of brain and mental consequences (such as specific patterns of cognitive dysfunction, anatomic brain changes such as hippocampal atrophy, assessment of psychoneuroendocrine and autonomic implication) and objective assessment of mental and behavioural stress-related subjective responses.
- To evaluate medico-legal implications related to the objective assessment of acute and chronic stress-related biological damage.

Objectives
- To increase awareness among doctors about the own potential mental and somatic consequences of legal prosecution for alleged medical error, as well as about behavioural and professional consequences in a medico-legal perspective.
- To provide doctors with a more complete understanding of profession-related risks and with some potential prevention and coping strategies.
Learning points
- Legal prosecution for medical error is a typical chronic stress condition.
- Psychosomatic and brain mechanisms of chronic stress and their psychoneuroendocrine and cerebral consequences.
- The symptom and cognitive dysfunction profile of chronic stress in prosecuted doctors.
- Assessment and objective measurement of damage suffered by prosecuted doctors.
- Medico-legal implications and strategies in doctors suffering for prosecution-induced chronic stress conditions.

1.D.iii Blame and bullying within the professional hierarchy – the impact on learning from complaints within the clinical workplace

Sarah Bolger, PhD Student, University of Surrey

Summary
This presentation introduces the findings of a case study completed in 2017 exploring the role of the clinical leader in supporting organisational learning from patient complaints. Twenty-five doctors and nurses were interviewed, nine complaints meetings were observed of which six meetings’ minutes were reviewed. All findings were triangulated, and four themes produced using inductive thematic analysis. One of these, ‘blame and bullying’, is presented. The professional hierarchy was found to perpetuate and support the culture of blame from within professions, but to defend its members against other professions trying to alleviate their own responsibility during a complaint.

Aims
- To discuss how professional hierarchy can perpetuate an unhealthy workplace in terms of limiting learning from patient complaints.

Objectives
- To explore the concept of a blame culture through the context of blame avoidance from those in the same profession, those in the same department or those from different professions.
- To understand workplace bullying and harassment experienced by clinicians from their professional seniors during events that led to a complaint.

Learning points
- A positive leadership style towards learning was critical for senior consultants if change is to be effective. When this was absent, blame and bullying could unfortunately thrive, perpetuated by senior doctors who had themselves been indoctrinated into this culture. Understanding the traditional structure of the professional hierarchy within the clinical workplace is vital to improve blame culture within the context of patient complaints.
Stream 1.E. Treatment Models for Mental Health Problems

1.E.i What keeps Doctors healthy? Preventive and health promotion programmes

Mitjans A., Baranda L., Calvo A., Tolchinsky G., Padrós J.

Lead author: Anna Mitjans, Preventive and Health Promotion Programmes Manager, Galatea Foundation

Summary

The Galatea Foundation manages caring programmes for sick healthcare professionals (doctors, nurses, pharmacists, vets, dentists, psychologists, social workers and physiotherapists), as well as preventive programmes to promote healthy practice.

The Galatea Foundation has an agreement with the Catalan Health System in both caring and preventive programmes.

Since 2006, a great amount of data about health, lifestyles and work conditions has been gathered and analysed. Our data confirms that healthcare professionals have a greater risk of mental disorders than the general population. The rate of mental disorders in the general population is under 10% (GHQ-12), while for doctors, psychologists and dentists it is around 20%, and for pharmacists, nurses and medical students it is over 35%. We have also carried out a prospective study among residents who joined their training program in 2013, from which we have observed that risk of mental disorders nearly doubles after their first year.

These results are very useful in designing new training initiatives (workshops, e-learning, clinic sessions) to raise awareness and promote self-caring. Health professionals should learn to care for themselves if we want high quality and excellence in our healthcare system.

In particular, in the ‘Resident Doctors Preventive Programme’ we have developed healthier exercises for resident doctors and for their tutors with our workshop programme. It is a coordinated action with the training lead of the health centre, caring programmes coordinator and Galatea Foundation training team. These training activities are an opportunity to attendants to put in common and discuss about the causes of stress in resident doctors and to learn about attitudes and skills to manage it. They also learn about how to deal with difficult situations, using the support of occupational health services and Galatea Foundation Caring Programmes. Since we started this initiative, early detection among this target group has increased and more than 350 resident doctors have been treated.

Aims

- Preventive programmes initiatives such as research and training activities help to raise awareness of the importance of taking care of oneself as an essential condition of being a good practitioner.
- These initiatives are absolutely complementary to caring programmes as they promote early detection, practitioners learn about who can help them when they have a mental health disorder, and moreover they learn about attitudes and skills to manage risk factors and practice more healthily.
Objectives
- To show the results and conclusions of research in health, lifestyles and working conditions of doctors, resident doctors, medicine students, nurses, pharmacists, dentists, psychologists and social workers.
- To compare these with the general population.
- To explain about successful training initiatives designed on the basis of this data.

Learning points
- The doctors and nurses caring programmes started in 1998 and 1999; pharmacists and vets joined GF in 2012; psychologists in 2015; dentists and social workers in 2016; and physiotherapists in 2017. We now have greater demand for doctors and nurses in our caring programmes. It is very important to raise awareness of the importance of self-care for a good practice. Preventive and health promotion programmes are helping to reach this aim. We should continue and make greater efforts in target groups such as pharmacists, dentists or other health professionals who work alone.

1.E.ii The Trainee Doctor & Dentist Support Service (TDDSS)

Simon Lyne, Nurse Specialist and Lead for TDDSS

Summary
The Trainee Doctors and Dentist Service (TDDSS) forms part of the Practitioner Health Service. It has been specifically commissioned to provide wellbeing and prevention services to trainees in London and the South East area. It is not a treatment service per se, and rather a service which is able to signpost trainees to the most appropriate services. It can offer up to four sessions of individual face-to-face support and signposting to a range of support services including online CBT, mindfulness and the other groups offered by PHS.

The majority accessing the service are junior doctors with a much smaller number of dentists and all have self-referred.

The majority of self-referrals were for anxiety, low mood and stress-related problems, often related to workplace stress and difficult working conditions such as understaffing, difficult rotas, long working hours and lack of senior support. Approximately half of these doctors when fully assessed were found to be mentally unwell to the extent of needing medication and/or behaviour treatment for conditions including depression and addictions. These doctors were signposted to the PHS main service or to their own GP and local services. Others reflected the wide variety of distress found across the service including relationship difficulties, adjustment problems and employment issues.

Aims
- To explore the range of support and interventions that can assist trainees and the impact these can have.
Learning points

- Trainees present with a wide range of issues related to training and workplace difficulties.
- The use of cognitive and behavioural techniques, give trainees the skills and strategies to understand and manage their stress and anxiety, particularly in relation to exams and work.

1.E.iii CBT for an expert group – seven years of treating GPs: themes, interventions and outcomes

Shamira Graham, Director of Clinical and Business Operations, Efficacy Ltd and Lee Grant, Clinical Director, Efficacy Ltd

Summary

Efficacy have worked in partnership with PHP/GPH for the last seven years, delivering CBT to medical professionals with mental health problems. During this time we have treated hundreds of GPs for common mental health disorders. We will share the key themes in a discussion around treating this specific population including:

- Presenting problems – these are often longstanding due to the challenges of accessing local care.
- Risk minimisation and problem minimisation – ‘I am not actively suicidal’, ‘I am experiencing burnout, I am not depressed’. No space or time for self-care.
- Consistent and high standards for patients in their care, characterised by overworking, over-checking within a system of unrealistic demands, all of which culminates in common mental health problems.
- Unrelenting high standards in the form of perfectionistic beliefs and behaviours which at times cannot be maintained due to excessive NHS demands. These lead to beliefs such as ‘I am not good enough’, ‘I have missed something’ which in turn drive self-critical thoughts, lower mood and increase anxiety.
- GPs as an expert group – Learning as patients experience thoughts of ‘I should know this’ or ‘How did I not know this?’.
- Recovery and treatment outcome data - a success story of a model that works.

Stream 1.F. Medical Students

1.F.i Undermining behaviour and bullying: are these issues encountered by medical students as well as doctors?

Warren K., Jones K.

Lead author: Dr Katherine Warren, Clinical Teaching Fellow, Great Western Hospital, Swindon
Summary

A voluntary questionnaire was distributed to all year 3, 4 and 5 medical students at the University of Bristol asking about their experiences of undermining behaviour and bullying.

71.3% of students reported being directly affected by undermining behaviour and bullying at least once during their time at medical school, with 82.4% reporting that they had witnessed such events.

55% of students who had experienced or witnessed such events did not report this to anyone. A commonly cited reason for this was a belief that no action would be taken.

Undermining behaviour and bullying can have detrimental effects on trainees’ self-esteem and mental health, as well as a negative impact on teamwork, communication and patient safety. At the time of our research, only one published study had reported this issue in medical students in the UK.

Here, we will present our research into undermining behaviour and bullying towards medical students at the University of Bristol. Descriptive statistics and results from thematic analysis will be presented and discussed.

Aims
- To present our research looking at undermining behaviour and bullying towards medical students at the University of Bristol.

Objectives
- To raise awareness of undermining behaviour and bullying towards medical students.
- To discuss the wider implications of our results.
- To open up a discussion about how this problem may be tackled going forwards.

Learning points
- Undermining behaviour and bullying towards medical students is common yet over half of events are not reported.
- A significant barrier to reporting is a belief that no action would be taken.
- Undermining behaviour and bullying can have serious effects on self-esteem, mental health, and individuals’ progression through medical training. It is therefore essential that we detect, and address, these issues at an early stage.

1.F.ii Pride or prejudice? The role of ethnicity and culture in the mental health and professional development of medical students

Diana Bass, Kings College London and the University of Exeter

Summary

Research has shown that medical students are more vulnerable to mental illness and psychological distress than other students and find it more difficult to ask for help. This research project explores some reasons for this, and also considers several high-profile research studies that delineate a significant attainment gap between BAME+ students and their white peers. In 2014 the General Medical Council stated that ‘it is now clear that ethnicity is a factor in doctors’ attainment from secondary school onward’. BAME
students are significantly over-represented in British medical schools compared to the United Kingdom average population. This mixed-method research project investigates this by considering Attainment Gap data, with a demographic description of the background of medical students in an inner-city medical school, and students attending counselling sessions in the University Counselling Service.

This quantitative information is considered alongside a qualitative thematic analysis of assessment data of both BAME and White medical students presenting for psychological help, in order to throw some light on the ways in which students’ own experiences affect both their personal wellbeing and academic performance. The emerging narratives, often very powerful and moving, emphasise the profound importance of students’ relationships with themselves and others, and how these shape, and are shaped by their family culture as well as the external socio-economic environment. These themes are examined for differences and similarities within student presentations, and illuminate the ways in which several factors, including the surrounding medical culture, can reinforce the effects for some students of a background history of traumatic events in the family including immigration, experiences of racism and inequality in power relationships.

1.F.iii Supporting students with mental health concerns

Dr Margaret Bunting, Director of Student Support, Norwich Medical School, University of East Anglia

Summary

Advisers can find themselves in a complex situation when supporting a student with mental health concerns who is struggling with the course. This presentation will explore learning-centred advising that offers an approach to proactively identifying students who may be vulnerable. The main focus of the presentation is how to frame an adviser/advisee consultation. The research-based consultation framework for meeting students that will be presented offers flexibility and can be applied to a student on any course. The consultation framework is not a checklist. Rather, it is a framework that supports advisers to get an understanding of their student in a timely manner, allowing their own expertise to focus on an advising approach that is appropriate to the given situation.

Aims

- Dr Bunting, along with Dr Katie Ellis, has developed a framework for a student/adviser consultation. This framework is research-led. Research, undertaken at the University of East Anglia by Hubble (2016), identified themes that affect resilience amongst medical students. The data from this research has been developed and translated into practice.

Objectives

- A proactive advising system can assist in identifying young adults who are developing mental health concerns but have little to no self-help strategies in place.
Learning points
- To provide academic advisers an opportunity to:
  - explore how a proactive academic advising stance for students with declared mental health conditions can support a student to gain insight and understanding of their condition;
  - consider research findings on resilience and incorporate this into an information gathering format when advising students;
  - and raise awareness on how the information gathered about an individual student’s world can influence their academic performance.

Stream 1.G. Pure Research (The Evidence Base)

1.G.i 'Care under pressure': a realist review of interventions to tackle doctors’ mental ill-health and its impacts on the clinical workforce and patient care

Carrieri D., Briscoe S., Jackson M., Mattick K., Papoutsi C., Pearson M., Wong G.

Lead author: Dr Daniele Carrieri, Research Fellow, University of Exeter Medical School

Summary
Mental ill-health is prevalent across all groups of health professionals. Although there is a large literature on interventions that offer support, advice and/or treatment to sick doctors, the evidence has not been synthesised in a way that takes account of the complexity and heterogeneity of these interventions, and the many dimensions (e.g. individual, organisational, socio-cultural) of the problem. This research aims to improve understanding of how, why and in what contexts mental health services and support interventions can be designed in order to minimise the negative impacts of providing care on doctors’ mental ill-health. The research is funded by the NIHR (HSDR 16/53/12).

We are conducting an evidence synthesis (realist review) of interventions to tackle doctors’ mental ill-health and its impacts on the clinical workforce and patient care, drawing on diverse literature sources. We are also engaging iteratively with diverse stakeholder perspectives (e.g. doctors who have experienced mental ill-health, representatives of patients and public, other healthcare professionals, policy makers, charities) in order to produce actionable theory. This will lead to recommendations that support the tailoring, implementation, monitoring and evaluation of contextually-sensitive strategies to tackle mental ill-health and its impacts.

Aims
- To share our results to date, and to incorporate feedback from the clinical and academic audience of the conference.

Objectives
- To present and discuss the literature and our theory of why doctors develop mental ill-health, and why some strategies to reduce mental ill-health are more effective than others.
Learning points
- We will raise awareness of the published literature, and of our insights gained through the review and working with stakeholders about when, how and why interventions are effective.

1.G.ii Do doctors self-medicate to cope with their professional lives?
Corazza O., Simonato P., Mooney R., Gale T., Fineberg N., Smith P., Farrington K.

Lead author: Dr Ornella Corazza, Reader in Substance Addictions and Behaviours, University of Hertfordshire

Summary
Compared with other professionals, doctors seem to experience higher occupational stress (Piko, 2006). This results in significantly higher rates of mental health problems (Brooks et al., 2011), including alcohol and drug misuse (Ghodse and Galea, 2006), a tendency to self-medicate often leading to prescription drug abuse depression (Mata et al., 2015), and emotional exhaustion (Shanafelt et al., 2012). This presentation will look at types of stressors affecting doctors, including junior doctors, and how they cope with their life and work challenges in order to handle their wellbeing.

Special attention will be given to resilience, indented as the ability to adapt positively to adverse circumstances and the less-considered aspects of a doctor’s life. These include eating behaviours, sleeping patterns, leisure time, relaxation activities and other possible coping strategies such as smoking, alcohol consumption and abuse of other substances, as well as their personal expectations about lifestyles, wellbeing and relationships.

Aims
- To present the results of a pilot study on doctors’ wellbeing among approximately 400 doctors in hospital and mental health settings in Hertfordshire.

Objectives
- To provide a correlation between work-life balance, stress and coping strategies.
- To better understand how doctors relax and engage with coping strategies, including self-medication.
- To present new insights on the predictors of doctors’ ideal lifestyles.

Learning points
- A better understanding of the underlying mechanisms to doctors’ mental health problems.
- New insights for the development of more targeted prevention strategies for doctors’ wellbeing.
1.G.iii Measuring anxiety – Do we over pathologise?

Cohen D., Rees S.

Lead author: Professor Debbie Cohen OBE, Director, Student Support, School of Medicine, Cardiff University; Director, Medic Support and the Centre for Psychological Research, Occupational and Physician Health, Cardiff University

Summary

This project aimed to investigate the suitability of the self-report Hospital Anxiety and Depression Scale (HADS) as a screening tool for medical students.

Students are said to be ‘anxiety driven’. Research suggests medical students often display neurotic perfectionist tendencies. This may influence levels of self-reported and perceived anxiety, but may not necessarily indicate a clinical disorder. Labelling students as ‘ill’ when they may be anxious but clinically well can be detrimental to their wellbeing. Many studies of student anxiety are based on self-report scales. Clinical interviews can provide more accurate assessment of mental state. This study investigated the suitability of the self-report Hospital Anxiety and Depression Scale (HADS) as a screening tool for medical students. It specifically explored optimum cut-off points by making comparison to clinical interview data.

Method

Comparison of HADs to a structured clinical interview (SCAN) using ICD-10 diagnostic criteria. Students across all year groups with and without mental illness in one medical school were recruited to complete HADS and undertake a SCAN interview in one sitting. The HADS depression (D) and anxiety (A) subscales were recorded and compared to clinical interview findings. ‘Caseness’ is reported as a HADS score of 8 for both subscales.

Findings

50 students completed the study. Data suggests revised subscale cut-offs ≥7 for HADS (D) and ≥12 for HADS (A) would give optimal sensitivity and specificity. Patterns in responses to specific items in the HADS scales compared to clinical interviews showed discrepancy in interpretation of items. The importance of interpretation and caution with using general population data for specific population cohorts will be discussed.

This project is the first to compare medical students’ self-report results with their results from clinical interviews. It concluded that revised HADS sub-scale cut-off scores may be appropriate for medical students and provide a more effective screening tool.

Aims

- To highlight how supporting students appropriately in managing normal and abnormal emotions, and understanding how personal anxiety levels impact on performance is important.

Objectives

- To discuss that a revised HADS subscale cut-off scores may be appropriate for medical students and provide a more effective screening tool.
- To acknowledge that supporting students appropriately in managing normal and abnormal emotions and understanding how personal anxiety levels impact on performance is important.
To understand that early identification and appropriate guidance about managing emotions are important to allow students to develop as doctors but also be ‘human’.

**Learning points**
- Individual medical student HADS scores will be compared to diagnosis using clinical interview data.
- Optimum cut-off points for HADS will be explored by reviewing sensitivity and specificity calculations using the clinical interview data.
- Responses to different HADS items will be reviewed to understand how these may be interpreted by medical students.

**Stream 1.H. Reflective Practice**

**1.H.i Contemplative group dynamics for attention to self and others**

Cilasun J., Ladden L.

Lead author: Dr Jale Cilasun, Consultant Psychiatrist and Medical Psychotherapist, South West London and St George’s Mental Health NHS Trust

**Summary**

Mindfulness is a popular practice with various forms emerging as therapies and others showing staff benefits. It is thus important for health care providers to know what mindfulness is, and how it may benefit or not, a given audience. Mindfulness cultivates attention both to oneself and to others, and relates to empathetic responsiveness.

**Aims**
- This presentation will give brief theoretical and practical information so that one can make informed judgments. Two relevant aspects of mindfulness for the clinician will be presented: self-care and clinical application. Self-care will be approached through guided individual practice sessions as well as group practice sessions using speech (Contemplative Group Dynamics).

**Objectives**
- To describe the challenges and potential benefits of mindfulness practice.
- To describe how mindfulness cultivates attention both to self and others.
- To describe how mindfulness relates to empathetic responsiveness.

**Learning points**
- The practice sessions will illustrate how mindfulness cultivates attention both to self and others and how such attention relates to empathetic responsiveness. The talk and discussion aspects will look at core mindfulness principles which are thought to be responsible for a given form’s therapeutic effect.
1.I. Resilience and Healthy Workplaces

1.I.i Supporting leaders and managers for organisational well-being and resilience – a case study of a workplace intervention

Vesey R., Le Lean T., Caldwell C.

Lead author: Dr Robyn Vesey, Organisational Consultant, Tavistock Consulting, Tavistock and Portman NHS Foundation Trust

Summary

This presentation will describe a particular project supporting a senior management team in a London community service through organisational restructuring in response to new commissioning targets. The nature and rationale for the intervention will be presented, and the initial outcomes shared. An outcome study conducted one year post-intervention provided an evaluation of the longer-term impact on the service and on the service leaders and managers themselves. This details the ways in which the intervention enhanced the senior team’s effectiveness and the overall organisational wellbeing of the service, demonstrated by increased staff retention and recruitment.

Three key principles of the approach will be shared to capture how leaders can take up their management roles in ways that promote organisational wellbeing and resilience. These will include a focus on the organisational, and links will be made to the resources for employers being prepared by the National Workforce Skills Development Unit, based at the Tavistock and Portman NHS Foundation Trust.

Aims

- To explore the ways management and leadership can enable organisational wellbeing and resilience.
- To demonstrate the impact of a management and leadership intervention on organisational functioning.
- To enable participants to link systems-psychodynamic principles to their own workplaces through examples of this approach in practice.

Objectives

- To share a real-life intervention project with managers and leaders going through a restructure.
- To describe the impact of the intervention at one year follow-up evaluation on a range of indicators.
- To capture lessons learned and wider applications of the approach for healthcare leaders, managers and organisations.

Learning points

- The systems-psychodynamic approach understands management and leadership as human relational activities occurring in a particular organisational and wider social context.
- Supporting leaders to take up their management roles can enable positive organisational change and contribute to sustained organisational wellbeing.
- The key principles of organisational mirroring across boundaries, mourning through change and focusing on relationships for organisational wellbeing can be invaluable to many healthcare leaders and managers.
1.I.ii A reorientation to improved system-based management as an effective support mechanism

Spurgeon P., Hussain S.

Lead author: Professor P. Spurgeon, Emeritus Professor, Medical School, University of Warwick

Summary

The paper argues for a re-orientation from individual support provision to a more cost-effective system-based approach. In a health system context, evidence of the efficacy of the concept of medical engagement in junior doctors is presented.

Aims

- Approaches to supporting the clinical professionals through the challenges of personally demanding work are typically based within the framework of individualised provision. This focus upon coping and support, whilst valuable, may give insufficient attention to factors within the working context that may be prompting or exacerbating negative pressures. This paper argues that the more effective management of system-based issues may offer improved mental health and wellbeing for a larger group of staff, and thus be more cost-effective.

Objectives

- The presentation aims to demonstrate, with empirical evidence, that improving the level of medical engagement (assessed through the Medical Engagement Scale (MES), Spurgeon et.al, 2011) has a sustained positive impact on the wellbeing of junior doctors working in the health sector. The overall level of medical engagement in junior doctors across the country is relatively low but specific organisations were identified where the level was much higher. On investigation it was clear that these organisations had made particular efforts to change and improve the work context. A series of external independent measures of wellbeing and satisfaction correlated with higher levels of medical engagement.

Learning points

- Individual support systems can clearly be effective but the demand across many sectors can be overwhelming. Many work environments create or exacerbate distress in individual staff members. The positive impact of medical engagement with junior doctors suggests that addressing the aggravating factors in the work context may well prevent individual concerns developing, and may well reduce the impact on a much wider group of staff without the need for remedial action.
- Engagement is a cultural construct and clearly more positive or negative work environments exist. The key implementation issues are: a) recognising the potential and impact of improved levels of staff engagement, and b) equipping managers and senior colleagues with the skills to promote enhanced engagement in their organisations.
The wounded healer: a successful teaching session at the University of Southampton

Colgan S., Day L., Kendall K., Lynch S.

Lead author: Dr Kathleen Kendall, Associate Professor in Sociology as Applied to Medicine, University of Southampton

Summary

This presentation critically examines a successful symposium and supporting facilitated small groups on the wounded healer with year 2 medical students at the University of Southampton. Our multi-professional team is comprised of two clinicians, a psychologist and a sociologist.

Our learning outcomes were as follows:
- Describe the concept of the wounded healer and its relevance to medical practice.
- Reflect on some of your own psychological and/or physical wounds and how they might help or hinder your future practice as a doctor.
- Consider what actions you might take to manage your own wounds.

We will first contextualise the teaching through a consideration of the conceptual model and pedagogical principles underpinning it, as well as the motivation for its introduction. We will then outline the key components of the symposium and small group work before turning to student feedback and our own reflections. The presentation will conclude with lessons learned and plans for the future.

Aims
- To share knowledge and experience gained from teaching year 2 medical students about the wounded healer.

Objectives
- To contribute practically to a community of practice around the wounded healer.

Learning points
- Medical students are receptive toward and appreciative of teaching on the wounded healer.
- An approach which integrates conceptual knowledge, lived experience and experiential learning is effective in demonstrating the relevance of the wounded healer to students’ current learning and their future clinical practice.
Stream 1.J. Getting the Balance Right

1.J.i. Wounded healer, wounded team: the forgotten, overlooked and injured

Joffe M., Wren B.

Lead author: Dr Megan Joffe, Psychologist, Health Practice Lead, Edgecumbe Consulting

Summary

While understanding the dynamics of the ‘wounded healer’ is necessary, their impact on the team receives little, if any, independent attention. Whether due to illness, capability, conduct or behaviour the wounded healer has an impact on his/her colleagues and can deeply affect and test both individual and team resilience and challenge effective management intervention. In certain situations, the wounded healer can be helped and supported by colleagues in the healing process but in others the team needs support because of the colleague in difficulty. Intervention may be necessary because of the effects of the wounded healer’s style and relationship to work, presence or absence on the workload, patient safety and team effectiveness.

All of these factors influence the interpersonal dynamics which can have a deleterious impact on performance, staff wellbeing and on patient safety. A sense of perceived inequity and fairness of allowances made by management can have a significant influence on a team’s empathy and support for a colleague, contributing to the development of toxic group processes such as scapegoating and disengagement.

This presentation will use two case examples to illustrate the impact on team functioning and effectiveness of a ‘wounded’ colleague. Relevant psychological theory and recent consulting experience will be used to highlight the risks of a doctor in difficulty to their team’s effectiveness. The concept of organisational justice will be drawn upon, and a user-friendly version of team dynamics will be presented. Interventions that could mitigate risks to both individuals and the team will also be suggested.

Aims

- To raise awareness of the impact of the wounded healer on team effectiveness and functionality.
- To explore the relationship between individual pathology and team dynamics in creating dysfunctional teamwork in medicine.
- To consider how best to intervene in the interests of the individual clinician and their team.

Objectives

- To highlight the importance of attending to the team in which the doctor works.
- To understand the concept of team resilience and team dynamics that affect the performance of both the doctor concerned and the rest of the team.
- To understand the concept of organisational justice and how it applies to the case of a doctor in difficulty.
- To share interventions that could address these issues.
Learning points
- The team, as a group and as a group of individuals, should not be ignored.
- The individuals in the team in which the wounded healer works are affected personally by illness or difficulties in a colleague.
- Team effectiveness is impacted by the presence/absence of a wounded colleague.
- Equity and fairness should guide risk management of the team in these cases.
- Intervention can mitigate risks.

1.1.ii. The psychological impact of investigations on the clinical staff members involved

Dr Jessica Whitehead, Speciality Registrar in Occupational Medicine, East Kent Hospitals University Foundation Trust

Summary
This research has worked on formulating a protocol for supporting employees under investigation of Serious Untoward Incidents, allegations or complaints. Investigations can result in anxiety, low mood, and lack of confidence in some employees, and easily accessible support is very important.

Management and peer support is important, but some NHS Foundation Trusts are lacking organised support systems. A protocol is being formalised to ensure easily-accessible avenues of support.

Aims
- To highlight the psychological impact of investigations on staff members.
- To identify support measures that can be put in place.
- To discuss the findings of an online survey, and how this will influence the formulation of Trusts’ protocols.

Objectives
- To provide an overview of existing literature, demonstrating the impact of investigations on these ‘second victims’.
- To enable discussion of the methods and results of an online survey.
- To enable discussion of support systems (through management, peers and occupational health), mentoring and counselling.

Learning points
- An invitation to participate in an online survey was sent out in a Trust-wide news bulletin. Sixty-three clinical members of staff responded.
- Twelve people had received a complaint in the last five years, seven had been the subject of an allegation and twelve had been involved in a Serious Untoward Incident.
- Fourteen respondents felt the investigation process had had a psychological impact, such as low mood, anxiety and lack of confidence.
- Only four respondents reported being offered support.
- The need for clear and easily accessible formal and informal avenues of support was highlighted.
1.J.iii. *How to get Dutch doctors the care they need*

Hans Rode, Medical Director, The Royal Dutch Medical Association

**Summary**

The Royal Dutch Medical Association (RDMA) recently initiated a new rule of conduct titled ‘Zero is the norm’, stating that physicians may not use drugs or alcohol in the workplace, and started a physician health program (PHP: ABS-doctors) which has supported doctors with addiction problems since 2011.

Despite several campaigns, programs and interventions initiated by the RDMA, impaired physicians find it very difficult to reach out for help or treatment. At the same time, doctors in the Netherlands perceive a huge barrier to addressing the needs of impaired colleagues or reporting them to the appropriate licensure of medical boards. Several studies of Dutch medical culture reveal a number of significant factors that contribute to a ‘conspiracy of silence’, leading to many cases of physicians struggling in silence without the help that they need.

More than a third of physicians with an impaired colleague do not take action to help or address the doctor in supposed need. Most of them think it is not their responsibility or fear their intervention making no difference or backfiring with negative consequences for themselves or their colleagues.

Although the medical culture is not easy to change, a national road-show performed by a team of experts and actors allowed for hundreds of physicians to experience and to practice how to handle an impaired physician-colleague. Using examples, checklists and a structural approach on how to prepare for an intervention proved helpful according to the participants. In this presentation, our approach will be shared. It hopes to contribute to an international movement where physician health programmes disseminate ways to aid physicians getting the help they need. Breaking bad news for a fellow physician is not easy but is both worthwhile and necessary to keep physicians fit to practice.

**Aims**

- To show participants how the Dutch approach to medical culture contributes to a conspiracy of silence where it is difficult to reach out to an impaired colleague.
- To inform participants about a structural way for colleagues to intervene on behalf of impaired physicians, in order for them to receive help and treatment.
- To share a checklist with which physicians can prepare, practice and succeed in helping their colleagues in need and to make sure that patient safety is not being compromised.

**Objectives**

- To outline the most common factors that prevent doctors from getting help and treatment.
- To explain which barriers need to be removed in order to reach out to an impaired physician.
- To show participants how to format and utilise a checklist.
Learning points
- Various barriers make it difficult for impaired physicians to seek help or treatment.
- Impaired physician’s colleagues experience other obstacles that prevent them reaching out.
- Breaking bad news can be difficult, but it is necessary in breaking silences and enabling those in need to seek help and treatment.
- A work-flow and structural intervention using a checklist can be a helpful and effective way of addressing the uncovered needs of an impaired physician.

Stream 1.K. Mindfulness

1.K.i. Developing EQ and building resilience as you work: applied mindfulness tools and techniques

Dr Stephanie Jackson, Training Programme Director, Cornwall GP VTS Scheme and Tamara Russell, Clinical Psychologist and Mindfulness Trainer, The Mindfulness Centre of Excellence, London

Summary
Evidence continues to grow in support of mindfulness and self-compassion training to alleviate human suffering. While many patients can access mindfulness training groups, books and apps, elements of the interventions make them difficult for medical professionals to access. This includes things such as the requirement to undertake forty-five minutes of body-scan meditation daily.

While many medical professionals are keen to explore mindfulness, the time pressures on them make current offerings unappealing. This presentation reports the development of an applied mindfulness tool designed for those faced with such time pressures. The tool is designed for use in the workplace, and on journeys – it can be applied during geographical transitions (such as a daily commute), cognitive transitions or emotional transitions.

This tool has been taught to nursing and medical students, GPs, psychiatrists, health visitors and practice managers. It is also taught within a corporate setting to high performance individuals working in high-pressure and high-responsibility environments. The tool can be used on an individual basis or in a group format. The three-part exercise, taking six minutes or under to complete, provides a chance to develop emotional intelligence, to stay grounded in the present, and to move forward in a way that ensures priorities are kept in mind and vital energy is not wasted.

Aims
- To share the evidence base for the benefits of mindfulness for medical professionals.
- To share the neuroscientific underpinnings of the Transitional Pause exercise.
- To allow participants to experience the exercise, time permitting.
- To share the experience of those who have applied the Transitional Pause in the medical arena.
- To point to the benefits of continued practice with this tool, especially with regard to the work of GPs.
Objectives
- To introduce the notion of applied mindfulness for medical professionals.
- To show how this can best be done in a way that does not compromise the integrity of mindfulness, whilst balancing the real-world demands on these professionals.
- To inspire others to notice how transitions are an important space in the day useful for the healthy development of the body, mind and emotions. Practising mindfulness briefly and often is an alternative way to develop Emotional Intelligence.

Learning points
- Participants will recognise why there is such an urgent need for tools to support social and emotional learning. These techniques are essential.
- Participants will learn the rationale for the different elements of the Transitional Pause technique.
- Participants will experience one key ‘applied’ mindfulness practice which they can take-away from the presentation and apply immediately.

Stream 1.L. Wounded Medical Student

1.L.i. An evaluation of health, wellbeing and resilience in undergraduate and graduate medical students
O’Rourke M., Crowley F., Hammond S., O’Tuathaigh C., Duggan E.

Lead author: Dr Margaret O’Rourke, Director of Behavioural Science and Psychological Medicine, School of Medicine, University College Cork

Summary
This paper presents an evaluation of health, wellbeing and resilience in medical school, with a specific descriptive focus on medical student need and potential targets for intervention through stress management and resilience training strategies. It is based on research conducted among 490 medical students at a single medical school in Ireland.

Increased stress has been identified as a key aspect of poor student health in medical school. Specifically, high levels of stress interact with increased alcohol consumption, increased fatigue, and decreased exercise and socialisation to negatively impact on students’ health and wellbeing. There is evidence to suggest that such maladaptive behaviours, unless appropriate resilience skills are developed, can persist into postgraduate training, with important potential implications for medical practice and patient safety.

The paper outlines how, with a better understanding of the current health, wellbeing and resilience of medical students, medical schools work in partnership with students to develop better student supports and programmes which can develop and foster resilience-promoting skills.

Aims
- To highlight potential targets for intervention through stress management and resilience training strategies.
Objectives
- To explain the methodology of the research in question, highlighting the use of psychometric questionnaires and other methods.
- To make known the results of the study and report in its findings.

Learning Points
- Stress is a common experience among students during their academic years. Prevalence estimates for psychological distress range from 29% to 48%.
- Medical schools need to work in partnership with students to develop better student support mechanisms to foster resilience at both undergraduate and postgraduate level.

1.L.ii. Schwartz rounds: building compassion and resilience in multi-professional pre-registration healthcare students

Golding L., Kiemle G., Orton H., Gabbay M., Clarke P., Crumbleholme C., Anderson M., Joynes V.

Lead author: Dr Gundi Kiemle, Academic Director, Doctorate in Clinical Psychology, University of Liverpool

Summary
Schwartz Rounds are a multidisciplinary forum for healthcare-staff to reflect together on emotional and social challenges associated with their work. Rounds are being run in NHS Trusts in the UK but in only three universities to date. Liverpool is the first UK University to run multi-professional Schwartz Rounds. Third-year students from Medicine, Health Sciences, Clinical Psychology and Dentistry have been attending regular university-based Rounds since February 2016 as part of a research project funded by Health Education England North-West.

Evaluation data and results from ongoing quantitative (validated measures of self-reflection, insight, compassion, empathy, resilience, quality of life) and qualitative (interviews) measures will be discussed concerning students’ experience of the Rounds, and how this impacts on their developing clinical practice and professional identity. Findings will be discussed in the context of using Schwartz Rounds as an innovative way of enabling students to become compassionate and resilient healthcare practitioners.

Aims
- To provide an overview of the University of Liverpool’s ongoing inter-professional Schwartz Rounds project.
- To present findings from the ongoing qualitative and quantitative research and evaluation of the impact of the Rounds on students.
- To discuss using Schwartz Rounds as part of personal and professional development in healthcare education and training.

Objectives
- To discuss how Schwartz Rounds support the development of compassionate and resilient healthcare practitioners during pre-qualification clinical training.
Learning points

- Schwartz Rounds provide a valued space for students to reflect on the emotional impact of their work and normalise their feelings in a safe environment.
- Schwartz Rounds enhance effective inter-professional working from pre-qualification/pre-registration training onwards.
- Schwartz Rounds may assist in bridging the pre and post-qualification transition.
- Schwartz Rounds may facilitate the development of increased resilience, empathy and compassion in the NHS at a time when healthcare services are under considerable pressure.

1.L.iii. Evaluating the mental health literacy of medical students

Marrison Stranks, Medical Student, University of Buckingham

Summary

This presentation will provide an introduction to the concept of mental health literacy and discuss issues surrounding mental illness in medical students. The results of a study evaluating the mental health literacy of pre-clinical medical students at the University of Buckingham will be presented.

The concept of mental health literacy encompasses knowledge and attitudes towards mental health that aid in the recognition of, and help-seeking for, mental illness. Medical students are an important population in which mental health literacy should be evaluated, as it may impact medical students’ ability to seek help for mental health difficulties as well as care for themselves and patients.

Aims

- To understand the concept of mental health literacy and approaches to its measurement.
- To understand the issues surrounding mental illness in medical students
- To understand the initial findings regarding factors that significantly predict mental health literacy amongst medical students.
- To apply the concept of mental health literacy to medical student education and support services.

Objectives

- To introduce the concept of mental health literacy and discuss the Mental Health Literacy Scale as a measurement tool.
- To discuss the vulnerability of medical students to mental health issues, with a particular focus on the issues of stigma and avoidance of help-seeking.
- To report on the findings of a study of first and second-year medical students at the University of Buckingham Medical School, in which mental health literacy was measured alongside demographic factors and experiences with mental illness.

Learning Points

- The concept of mental health literacy encompasses knowledge and attitudes towards mental health that aid in the recognition of, and help-seeking for, mental illness.
- Medical students are an important population in which mental health literacy should be evaluated, as it may impact medical students’ ability to seek help for mental health difficulties as well as care for themselves and patients.
Stream 2.A. Burnout Workshop

2.A.i. Poor leadership causes burnout – tools to stop the madness

Dr Dike Drummond, CEO and Founder, TheHappyMD.com

Summary
There is a widely accepted saying in business, “People don't quit the company, they quit their boss.” It hints at the importance of your immediate supervisor - and their leadership skills - in your job satisfaction and burnout. There is no difference when your job is that of a practicing physician. Here is the truth ... A bad physician leader can burn out the doctors they supervise.

Aims
- To understand the impact physician leadership can have on the wellbeing of the physicians they lead.

Objectives
- To discuss the impact that poor physician leadership can have
- To explore why physician leadership can be a major source of stress and cause of burnout
- To identify ways how to manage your boss more effectively

Learning Points
- The variation in satisfaction among physicians is attributable to the leadership qualities of their supervisor.
- Leadership skills of a supervisor (or lack of them) can be a major factor in causing burnout
- High quality physician leaders will have a direct impact on the wellbeing of those they manage.

Stream 2.B. Looking After Self

2.B.i. The Importance of Mental Health Literacy in Medical Students: Results of a Study Evaluating the Mental Health Literacy of Medical Students at the University of Buckingham

Marrison Stranks, Medical Student, University of Buckingham

Summary
This presentation will provide an introduction to the concept of mental health literacy and discuss issues surrounding mental illness in medical students. The results of a study evaluating the mental health literacy of pre-clinical medical students at the University of Buckingham will be presented.

The concept of mental health literacy encompasses knowledge and attitudes towards mental health that aid in the recognition of, and help-seeking for, mental illness. Medical students are an important population in which mental health literacy should be evaluated, as it may impact medical students’ ability to seek help for mental health difficulties as well as care for themselves and patients.
**Aims**
- To understand the concept of mental health literacy and approaches to its measurement.
- To understand the issues surrounding mental illness in medical students.
- To understand the initial findings regarding factors that significantly predict mental health literacy amongst medical students.
- To apply the concept of mental health literacy to medical student education and support services.

**Objectives**
- To introduce the concept of mental health literacy and discuss the Mental Health Literacy Scale as a measurement tool.
- To discuss the vulnerability of medical students to mental health issues, with a particular focus on the issues of stigma and avoidance of help-seeking.
- To report on the findings of a study of first and second-year medical students at the University of Buckingham Medical School, in which mental health literacy was measured alongside demographic factors and experiences with mental illness.

**Learning Points**
- The concept of mental health literacy encompasses knowledge and attitudes towards mental health that aid in the recognition of, and help-seeking for, mental illness.
- Medical students are an important population in which mental health literacy should be evaluated, as it may impact medical students’ ability to seek help for mental health difficulties as well as care for themselves and patients.

**2.B.ii. Developing support structures for healthcare professionals working within prison settings**

Shepherd A., Sanders C., Shaw J.

Lead author: Dr Andrew Shepherd, Clinical Lecturer, University of Manchester

**Summary**
Prison environments are characterised by high levels of personal mental and physical distress amongst the resident prisoners. Clinical practitioners working in these environments are charged with delivering care that is ‘equivalent’ to that available in the general community. However, while time in prison can represent an opportunity for prisoners to engage with healthcare services, such institutions also present unique challenges for practitioners in terms of their own mental wellbeing.

This paper will present findings drawn from work exploring the experiences of mental health professionals working with ‘personality disordered’ individuals within prison environments. A focus-group-based methodology was employed, working towards developing a shared understanding of the nature of this clinical work. A thematic analysis of transcribed interview material was undertaken with the intention of developing a framework understanding of the area of practice.

These group discussions revealed the intensity of the process of ‘emotional labour’ with which professionals experienced themselves as engaging. While the role of the professional was conceptualised as supporting prisoners through a process of personal
‘identity work’, it was acknowledged that the work also represented a significant psychological process for clinicians themselves, forced as they were to contend with a variety of competing projections and demands from a multitude of sources. An adequate supervisory process was seen as necessary to support the needs of clinicians, but such support was often seen as being absent, or limited. The professional role of prison officers in such a process was also highlighted, together with the perceived limitations in their support network in this regard.

This paper attempts to highlight the intensity of the emotional process involved in working with individuals within a prison environment. This represents a unique challenge to healthcare professionals – demanding particular supervisory structures amongst other responses if clinicians are to be adequately supported.

**Aims**
- To provide an overview of the nature of clinical work within prison environments.
- To consider the particular challenges faces by professionals working in these institutions.
- To discuss the necessary support structures required for professionals to continue this work.

**Objectives**
- To provide audience members with a summary of the support systems required by professionals in prison environments.
- To utilise the framework provided by the concept of ‘emotional labour’ as a form of work undertaken by professionals meeting personal distress as a means of better understanding the need for this support.
- To consider the potential impact of better developed support networks in prison healthcare provision.

**Learning points**
- There is a significant need to adequate professional support networks within prison environments.
- Developing an understanding of the particular challenges faced by healthcare professionals in these environments is important.
- Considering the potential impact of support networks for prisoner health and potential for rehabilitation – together with the economic and wellbeing implications for this – is vital.

**2.B.iii. All work and no play: would establishing a collegiate culture for the University of Bristol academies improve student wellbeing?**

Sheppeard R., Davies P., Samuels A.

Lead author: Dr Rhian Sheppeard, Doctor CT-1, Gloucestershire Hospital NHS Trust

**Summary**
A significant amount of research highlights the negative impact of studying medicine on student wellbeing. These challenges are faced by local teachings bases across the UK.
Grassroots research can begin to challenge these negative impacts in medical schools, and therefore has the potential to increase student wellbeing.

This presentation will explain the background and purpose of such research, including its methodology. It will then discuss both quantitative and qualitative results, before examining conclusions.

It is vitally important to give medical students the tools to maintain their wellbeing early on in their careers.

**Aims**
- To highlight the local and national challenges of promoting student wellbeing.
- To discuss a research project which aimed to improve student wellbeing.
- To provide an opportunity to learn from the project so changes can be applied to delegates’ own places of work.

**Objectives**
- To detail research into student wellbeing.
- To explain the structure of the teaching base in question and the current strategies in effect.
- To describe the methodologies of the project.
- To display and discuss the results.
- To outline the challenges that have been faced and provide suggestions for fellow practitioners.

**Learning points**
- The evidence of the negative impact of studying medicine is well known – it is important to have a staff lead in place to help tackle this adversity at a grassroots level.
- There is no one-size-fits-all option when trying to engage students in activities which may lead to a perceived increase in wellbeing.
- The time-consuming nature of such projects requires staff commitment and student ownership to ensure their sustainability.
- Small and simple projects can, however, make a significant difference.
- It is important to give students the tools to maintain their own wellbeing early on in their careers.

**Stream 2.C. Resilience and Recovery**

**2.C.i. An RCT of Positive Mental Training and a positive factor analysis**

Alastair Dobbin, The Foundation for Positive Mental Health

**Summary**
The Positive Psychology movement has repeatedly and definitively found that access to positive emotions under stress is the key to resilience, such emotions are the mediator between resilience and positive outcomes: psychological growth and protection from depression. However what has not been established is where such emotions come from.
We have found that networks of episodic memories are the missing link, the mediator between resilience and positive emotions. By applying quantitative analysis to the expression in episodic memories of the basic and universal psychological needs spontaneously accessed under stress we have shown that such episodic memory networks have a unique and powerful effect on wellbeing and long-term mental health, beyond all personality traits and prior history. Certain key episodic memories with low levels of basic psychological needs satisfaction (self-defining negative memories SDNMs), are repeatedly accessed outwith conscious awareness, affecting long term wellbeing. Exploration of the memory networks which spontaneously associate with SDNMs has shown that such memories, in combination with their associated networks, play a key role in everyday functioning, directing repeated dysfunctional behaviour patterns, lowering long term wellbeing.

Working together with psychologists in McGill and Quebec and drawing on our own therapeutic experiences of looking at and moderating past memories in distressed patients/clients we have discovered and honed the techniques that allow people to access more self-determining memory networks around their SDNMs allowing people to integrate these distressing events into a holistic and positive self-image. This increases the level of needs satisfaction in their memory networks. We are revisiting early Freudian psychoanalytic techniques and creating a new way of harnessing and directing free association as a therapeutic tool. This is based on a sports psychology programme used in Olympic sport to improve performance so is entirely non-stigmatising, it is widely used by professionals for their own benefit as well as their patients/clients.

This is a new formulation of mental distress, in which, despite many other contributors and aggravators of emotional distress,

Alastair Dobbin, director of a mental health charity, the Foundation for Positive Mental Health, honorary fellow, lecturer and researcher at Edinburgh University medical school, will (very briefly!) run through some of the key steps in the research that has built this therapeutic model and look at the outcomes. A 3 ½ minute animation is available on https://vimeo.com/255287474. There is a document supporting the animation on https://bit.ly/2OaZBw1.

Our programme (Positive Mental Training) is contained in an app, the’ Feeling Good: Positive Mindset’ app, which is in the NHS digital app store https://apps.beta.nhs.uk/?page=3 and has been in continuous use in the NHS in Scotland for 12 years.

**Objectives**

- To describe the audio-based programme of stabilisation and self-analysis based on techniques used in sports psychology; Positive Mental Training.
- To identify that the key factor causing long term problems is episodic memories.

**Aims**

- To show that moderation of episodic memories appears also to be the key to recovery.
- To demonstrate that this therapeutic tool is ideal for use in a primary care setting and is used as supervised self-help by GP’s, Psychiatrists, OTs, CPNs, Speech Therapists, neurological rehabilitation and drug rehabilitation.


Learning points
- Memories can support a person under stress by providing them with a sense of self determination, a positive visualisation of how they will manage the situation and experience growth.

2.C.ii. Healing the wounded healer

Dr Andrew Tressider, GP Health South West Clinical Lead, GP Health

Summary
Life is a journey of learning. We are all actors on a stage, learning for our own personal benefit, evolving and maturing, and gaining wisdom. We live with others and learn co-creatively. Humans are part of a two-billion-year chain of evolution coded for success against a backdrop of co-operative nature. However, clever thinking humans often feel separate when head and heart are disconnected. Due to wobbles in the way we process our experiences, we store up psychological wounds in our software, which cause difficulties. Understanding how we process the data of experiences through our chakra system and grounding the system can help us rebalance when we wobble.

Using retuning tools both from nature and within our own mammalian bodily system can enhance our being – and resolve some psychological imbalances. However, if you ask a large sample of people how they are, they all say FINE – fearful, insecure, neurotic and emotionally imbalanced – the Denial mechanism. Ask a hundred health professionals the same question, however, and they cannot answer - they are too busy looking after their patients. Denial and displacement are powerful mechanisms to prevent focusing attention on our own psychological needs, and insight is not easy. It is simpler to spot someone else’s minor imperfections than it is to detect our own personal imbalances. If we choose to approach life proactively as a journey, recognising that we will encounter challenges, we could ask ourselves why not be proactive, and learn the rules and the tools to go well. This approach helps us each heal our own wounds – and so the wounded healer becomes master of the art of healing, as did Chiron, the Centaur in Greek mythology.

Aims
- To explain a model of human software and functioning, physiology and pathology which enables the Wounded Healer to understand how they can heal some of their own wounds.
- To discuss how this is not about mental illness, but rather about the normal person going out of balance.

Objectives
- To provide a contextual overview of the experience of human life.
- To remember the model of hardware body/software being.
- To relate the model to human experiences, and to how we process and reflect upon them.

Learning Points
- Humans have a ‘hardware body, software being’.
- Doctors have health imbalances.
- Reflection works at an affective level, underpinning cognition.
- There are ways forward ‘out of the wilderness’.
- Tools to help include grounding, breathing, acupressure and using information from nature.
2.C.iii. Improving the wellbeing and efficiency of healthcare professionals: benefits of workplace wellness programmes

Dr Lena Perez, Assistant Professor, Healthcare and Public Administration, Long Island University

Summary

Extensive scientific research has demonstrated the adverse impact of long work shifts, stress, and sleep deprivation on human performance. Many of these impacts are often experienced among those in the healthcare profession. Insufficient sleep and wellness impairs vigilance, memory, reaction time and decision-making capacity, thereby increasing the likelihood of error. The graduate medical education community, patient safety and advocacy groups, as well as regulatory bodies, have increasingly begun to recognise how a hectic lifestyle, compounded by a demanding work environment adversely affects the performance of healthcare professionals, identifying the potential for increased medical errors, thus risking patient safety.

This presentation reviews the scientific literature on the importance of body and mind awareness and overall well-being in healthcare professionals as they relate to patient safety and organisational efficiency. Individuals incorporating stress management techniques into their lifestyles have proven to minimise occurrences which may hinder their performance. Moreover, current trends acknowledge the benefits of alternative modes of intervention, such as yoga, and the utility of staff wellness programs to reduce stress and increase effectiveness in staff and direct care providers. Specifics regarding workplace satisfaction and performance levels from staff participating in the Staff Wellness – Hatha Yoga Program currently offered at New York Presbyterian – Brooklyn Methodist Hospital (NYPBMH), will be presented.

Preliminary discussion and analysis finds healthcare professionals to be more productive as a result of taking part, creating a positive atmosphere thereby increasing efficiency in the workplace and reducing patient risk of harm, while increasing patient safety and levels of satisfaction. A cost benefits analysis will be addressed, along with implications to the field of healthcare and suggestions of topics for future research.

Aims

- To identify stressors often experienced by healthcare professionals
- To identify the potential negative repercussions of these stressors
- To discuss the ways in which healthcare professionals can combat these stressors to engage in more effective provision of service
- To discuss the benefits of workplace-based programmes, addressed from both organisational and healthcare provider perspectives

Objectives

- To better understand how toll work demands in combination with everyday experiences can impact on healthcare professionals
- To recognise how stress can potentially impact the overall wellness and resiliency of the professional, thereby risking patient safety
- To learn ways in which individuals and organisations can prevent medical error, increase productivity and patient satisfaction through alternative modes of intervention, such as yoga staff programmes

Learning Points

- Stressors for healthcare providers need to be recognised
- The relevance of provider health and wellbeing with regard to effectiveness of service provision needs to be better understood
- The methods utilised by successful staff wellness programmes in New York yield benefits among healthcare professionals with regard to increased motivation and productivity, wellness and job performance
- The organisational benefits of implementing staff wellness programmes with respect to employee and patient satisfaction and reduced medical error need to be identified

2.C.iv. *Quantum light theory in our bodies – remaining whole and intuiting more*

Dr Susan Jamieson, Integrative Medical Practice, Hong Kong

**Summary**

This presentation will discuss theory, tools and methods in the field of quantum light theory, focusing on recent scientific discoveries such as DNA emitting photons of light, enzymes controlled by light signals, and the heart being at the centre of the body’s magnetic radiation.

The core premise of this research states that without connection to the light field energy of their own hearts, physicians will be pulled out of their centre and inevitably wounded. Health and consciousness have become separated in our current healthcare system. This presentation will describe how to utilise a particular state of consciousness in the healing arena. This is a process whereby the physician can not only facilitate the biomechanical healing of the body but can also create change on emotional and spiritual levels.

The area of ‘intuition’ in consultation will be focused on. Human beings are inherently attuned to a quantum process and interact with these surrounding energies unconsciously on a daily basis. However, we also need to consciously work with this science as much as we do with physiology and anatomy.

**Aims**
- To discuss the theory, tools and methods surrounding quantum light theory, in light of recent scientific discoveries.
- To discuss ways of facilitating the biomechanical healing of the body.
- To highlight the need to focus on the area of intuition in consultation.

**Objectives**
- To highlight the methodology of interpreting and interfacing with the light fields of doctor and patient.

**Learning points**
- Quantum processes and surrounding energies need to be worked with in the same way that physiology and anatomy are currently focused upon.
- Health and consciousness need to be considered in similar terms, not separated.
Stream 2.D. Looking at Self

2.D.i. Shame and wounds
Lyons B., Dolezal L., Gibson M.

Dr Barry Lyons, Consultant Anaesthetist/Lecturer in Bioethics, Our Lady’s Children’s Hospital, Dublin, Trinity College Dublin

Summary

Shame is a negative self-conscious emotion that arises when we believe ourselves to be judged as being flawed in some crucial way, of not having met standards or expectations, or feeling exposed as being inadequate, or of having failed. Although alluded to by Lazare in his seminal paper (1987), the academic literature on clinician shame is notably sparse. However, recent medical memoirs have tentatively begun to explore the subject. In What Doctors Feel, Danielle Ofri describes herself as burning with shame when having to account for a life-threatening error that she had made. That sensation of ‘standing in a growing puddle of mortification’ proved persistent, resurfacing many years later. Ofri is certainly not alone. The neurosurgeon, Henry Marsh, writes of accidentally cutting a facial nerve: ‘and when I saw the patient on the ward ... his ... face, paralysed and disfigured, I felt a deep sense of shame’. This notion of feeling shame in response to one’s errors is explicitly reiterated in Atul Gawande’s Complications and Gabriel Weston’s Direct Red.

Perhaps more characteristically, shame lingers under the surface in Adam Kay’s This is Going to Hurt. Shame remaining unsaid and underground is common, as the subject tends to make us so uncomfortable that we avoid discussing it. This is unfortunate because (mostly) shame has a corrosive effect on our wellbeing and is implicated in the development, or aggravation, of stress, burnout, and a variety of mental health problems. Unarticulated shame inflicts wounds that impact upon the person of the physician, and the care that they give. Discussing it seems particularly important in the current climate of increasing blame, ‘accountability’, and consequent public shaming rituals.

Aims
- To discuss the nature of shame and its prevalence in the clinic.
- To outline how it might arise, and be manifested in doctors.
- To describe the harmful impact shame may have on both the health of the clinician, and on their practice.

Objectives
- To open a conversation about clinician shame.

Learning points
- Patient and practitioner shame are both likely to be common in healthcare.
- There are a number of stimuli that provoke clinician shame, and these will be explored.
- Practitioners may respond to feeling, or being, shamed in ways that are neither healthy nor constructive.
- Shame may negatively impact upon practice.
2.D.ii. Time to take cognizance of spiritual health

Dr Adewale James Alegbeleye, Consultant Physician and Geriatrician, Basildon and Thurrock University Hospitals NHS Foundation Trust

Summary

The World Health Organisation has recently reported that world health is faced with the growing challenge of incurable chronic diseases, likely to reach its peak by 2050. Even though focus has been placed on exercise, diet and certain lifestyle changes (which are highly essential for preventing cardio- and cerebrovascular diseases), certain diseases are not preventable through such lifestyle changes. This may pose a challenge to the accepted knowledge of most people in a society. This gap in the knowledge of health calls for public attention and the need for public education. The current ‘Biopsychosocial Model’ of health has its limitations. Many articles have confirmed the triune concept of the human self: the spirit, soul and body. This is a mystery surrounding human nature and its existence that cannot be overlooked. As we are spiritual beings, the Six Domains (6D) of health are designed to explore not just the physical, social, family and emotional domains, but also the spiritual and mental domains of health.

At times when treatment does not work, the severity of a disease is not the only explanation. The research that informs this paper discovered that certain severe diseases are not amenable to treatment as well as those of unknown aetiology, may have epigenetic or more precisely spiritual roots. This vital spiritual element that is not taken actively into consideration during treatment but could help a lot of patients. To date, knowledge of the spiritual root of certain conditions is not something treatment options account for both for certain chronic incurable diseases and refractory mental health diseases. Personal exploration has shown observable evidence of this. This is an interesting subject that may, however, be a difficult one that calls for a form of further qualitative research exploration.

Aims

- To highlight that the Six Domains of Health is a new, important and comprehensive model of health which offers a means of understanding preventative solutions for a disease-free existence, especially where the prevalence of specific conditions is rising dramatically.

Objectives

- To demystify the concept of health as being broader than previously thought.
- To explain the interaction of the Six Domains of Health when dealing with health issues, and to discuss how they are dependent on one another.
- To understand why certain health challenges are cumbersome to cure.

Learning points

- Knowledge, skills and valuable insights can be offered through understanding of the Six Domains of health that can impact on one’s journey toward reaching a healthier life.
2.D.iii. Invisible pain – the many facets of health

Dr Catriona Herron, ST5 trainee in Child and Adolescent Psychiatry, Northern Ireland

Summary

This presentation will draw on relevant psychotherapeutic theory and research findings to discuss ‘Invisible Pain – the many facets of health’. These will include treatment of accidents and injuries, including problems with diagnosis and the challenges of getting appropriate treatment.

Other facets of research that will be discussed include the diagnosis of chronic pain; rehabilitation; getting stuck and lost in the system; financial stress brought about by absence from work, including using available support; attitudes toward sick leave and illness; resilience; the important of kindness and hope; and issues surround being ‘ready for work when work isn’t ready for you’.

The presentation will also draw on the arts to convey personal experience and demonstrate how creativity and creative thinking can help those experiencing pain. Time permitting, it will include music and song written during sick leave as an example of the research in question.

Aims

- To identify some of the many facets of health experienced by practising medical professionals.
- To present solutions to some of these problems, including accessing support that is currently available.

Objectives

- To highlight the importance of using creativity and the arts to help those in need.

Learning points

- Creativity and the arts can be an important outlet for those medical professionals experiencing issues with one or more of the aforementioned ‘many facets of health’, especially those on sick leave.

Stream 2.E. We Are All in This Together

2.E.i. Practitioner health: the isolated priest

David Miller, Mediator and Lay Minister, Rhos Mediation

Summary

The parish priest is often a sole practitioner, often finding themselves in similar situations to the single-handed general practitioner. Both work in stressful professional environments, and in each case support mechanisms are not immediately obvious. The single-handed practitioner is now fortunately a thing of the past.
This paper will discuss present levels of stress among clergy and discuss how this impacts upon their work and wellbeing. It will also discuss the ways in which these challenges are being addressed, and the resilience strategies that can be employed to help clergy in the future. The paper will use interviews undertaken among a representative sample of forty parish priests working in a Welsh diocese as a focus for its findings. The paper will also undertake discussion of how these methods are transferable to other professions.

Aims
- To identify those aspects of work as a parish priest which cause the most stress.
- To use a suitable psychological tool to measure psychological health in those interviewed.
- To identify how clergy are currently tackling issues deriving from stress, including through the use of drugs and alcohol.
- To learn how management could employ strategies to help priests deal with stress.
- To discuss how this methodology could be transferred to other professions.

Objectives
- To highlight the stressfulness of managing a parish.
- To identify resilience strategies to reduce this stress.
- To encourage management to consider alternative ways of working.

Learning Points
- High stress levels inevitably accompany single-handed practice.
- The coping mechanisms currently employed by single-handed practitioners are not necessarily healthy.
- Work on resilience can provide benefit to single-handed practitioners.

2.E.ii. Supporting staff to provide compassionate care

Professor Gail Kinman, Professor of Occupational Health Psychology, University of Bedfordshire

Summary

Compassionate care has wide-ranging benefits for patients and can be rewarding for healthcare staff. Nonetheless, the provision of such care may be particularly demanding for those with little experience in a caring role. Insight is therefore required into the factors that protect early career healthcare practitioners from the negative effects of the emotional demands they experience. This study utilises the job demands-resources model to examine links between ‘emotional labour’ and emotional exhaustion in student nurses. The protective role played by emotional support and emotion-focused coping (i.e. venting of emotions) is also explored.

An online questionnaire was completed by 351 student nurses with experience of working in healthcare settings. Nurses who reported more emotional labour tended to be more emotionally exhausted. Emotional support and the use of emotion-focused coping styles, such as venting, tended to protect student nurses from the negative effects of emotional labour. Support from peers was particularly beneficial in reducing the risk of emotional exhaustion. Organisations have a clear duty of care to protect the wellbeing of their staff, but the need for an ‘emotional curriculum’ to help individuals build emotional
resilience and provide high-quality compassionate care to patients is considered. Evidence-informed systemic interventions that could shape this curriculum will be discussed.

**Aims**
- To identify some of the factors that can protect early-career nurses from the negative effects of emotional labour on wellbeing.
- To identify systematic interventions to help organisations and healthcare practitioners manage the emotional demands of the work more effectively.

**Objectives**
- To outline the benefits and risks of providing compassionate care for healthcare staff.
- To present the findings of a study that utilised the job demands-resources model to examine links between emotional labour and emotional exhaustion in student nurses.
- To consider the protective role of emotional support and emotion-focused coping (i.e. opportunities for venting emotions) in the relationship between emotional labour and exhaustion.
- To identify multi-level interventions to help organisations healthcare staff develop the emotional resilience required to protect their wellbeing, while providing high-quality compassionate care to patients.

**Learning points**
- Providing compassionate care for healthcare staff has significant benefits.
- Evidence-informed interventions can be introduced at multiple levels to shape an ‘emotional curriculum’ to build emotional resilience and protect the wellbeing of staff and the quality of the care that they provide.

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2.E.iii. **Stress and wellbeing in the Australian pharmacy profession**

Chapman C., Wilson S., Wilson D., Dunkley K.

Lead author: Kay Dunkley, Executive Officer, Pharmacists’ Support Service, Australia

**Summary**

This presentation reports results from the National Stress and Wellbeing Survey of Pharmacists, Intern Pharmacists and Pharmacy Students conducted in Australia over the course of 2016/17. The online survey explored current levels of stress, work-related versus non-pharmacy-related stress, workplace satisfaction, barriers to seeking help, coping strategies used, the usefulness of coping strategies used and preparedness for workplace-related stress.

The presentation will discuss how members of the pharmacy workforce in Australia currently report more perceived stress than members of the general population. It will also examine the most commonly used and effective coping strategies, such as turning to colleagues or family and friends, practising mindfulness and meditation and taking exercise.

The presentation will also discuss how members of the pharmacy workforce are mostly unprepared to effectively deal with stress-related issues in their workplaces, particularly...
on entering those workplaces for the first time. This appears to be the biggest barrier to dealing with workplace related stressful situations.

**Aims**
- To describe the current level of stress and wellbeing of pharmacists in Australia.

**Objectives**
- To highlight barriers to seeking assistance for pharmacists in Australia dealing with stress in the workplace, along with coping strategies.
- To highlight how useful these coping strategies are, and how well the pharmacy workforce in Australia is prepared for the stressful situations they encounter in the workplace.
- To consider effective interventions to prevent burnout and/or impairment.

**Learning points**
- The pharmacy workforce in Australia is stressed.
- Many members of the pharmacy workforce in Australia employ ineffective coping strategies.
- More attention needs to be given to training to better prepare pharmacists to deal with stress-related issues in their workplace, particularly on entering them for the first time.

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**Stream 2.F. Early Resilience in Medical Students**

2.F.i. *Developing resilience through reflection in young clinicians: findings from the UCLH Medical Student Psychotherapy Scheme*

Majid S., Shoenberg P.

Lead Author: Dr Sarah Majid, Consultant Psychiatrist in Psychotherapy, University College London Medical School/Camden and Islington NHS Trust

**Summary**

The presentation will give an overview of the aims of the Medical Student Psychotherapy Scheme, with a particular focus on the role of Balint Groups in supporting medical students to develop their capacity to reflect on the emotional aspects of clinical encounters.

Findings will then be presented from research into the impact of the schemes on medical students, and recurrent themes emerging from the data regarding medical student anxieties and defences will be discussed.

Material will be presented from a Balint Group as an example of how this format can support medical students in processing the powerful emotions stirred up by their first encounters on the wards with illness, death and distress.

Delegates will then be provided with an opportunity to ask questions about the scheme, to encourage and support those thinking about setting up local Schemes along similar lines.
Aims
- To increase awareness of the UCLH Medical Student Psychotherapy and Balint Group Schemes and demonstrate the value of these as an opportunity to build resilience in young doctors from the start of their clinical training.

Objectives
- To share our understanding of typical anxieties and defences adopted by medical students as they encounter the challenges of clinical work.
- To show how Balint Groups can help medical students learn new skills in processing the inevitable emotional stresses of clinical encounters through reflecting on them, thus building clinical resilience.
- To provide an opportunity for clinicians interested in setting up Medical Students Psychotherapy or Balint Group Schemes to learn more about the schemes, ask questions and raise concerns.

2.F.ii. 'Backwards learning, forwards planning': building resilience in tomorrow’s doctors through reflective and anticipatory practice

Weston C., Hayward C., Horn C., Rees J.

Lead Author: Dr Clive Weston, sub-Dean for Professional Development, Swansea University Medical School

Summary
The realities of contemporary clinical practice challenge the resilience and wellbeing of medical students. Idealised conceptions of the profession are challenged by first hand observations of the realities of practice and by the discouraging effect of the ubiquitous negativity expressed by other NHS staff.

Two curricular activities have been designed to address these challenges, both characterised by close engagement with clinical teachers to prepare students for flourishing in a constrained complex health system. These include written reflections upon their past experiences, 'Reflective writings', and role play in small group contexts anticipating future problems, known as 'Preparation for Clinical Practice'.

It is proposed that this combination of ‘backwards learning’ and ‘forward planning’, involving both reflection and anticipation, encourages students to consider NHS challenges positively and improves their sense of empowerment. Graduates that have taken part in these activities report (relatively) high levels of preparedness and low levels of anxiety as they begin work.

Aims
- To consider curricular interventions which promote the wellbeing and mental health of medical students during undergraduate studies and later practice.

Objectives
- To describe our approach to reflective writing.
- To summarise themes found within an archive of 3,000 pieces – some of which directly address practitioner health.
- To describe how the students’ reflections shaped the Preparing for Clinical Practice course.
- To discuss the role of supportive clinical academic staff in encouraging positive changes in ways students view themselves and their wellbeing during their education.

Learning Points
- Uses of reflective writing in medical student education.
- The importance of anticipatory as well as reflective practice in building resilience and promoting well-being and preparedness.

2.F.iii. Scars and wounds from the NHS battlefields: the second victim

Dr Megan Joffe, Psychologist, Health Practice Lead, Edgecumbe Consulting with Barbara Wren, Chartered Psychologist and Edgecumbe Associate

Summary

The complex culture and competing challenges of the current turbulent NHS context are producing responses in doctors and medical teams. Medical training and healthcare culture can block the productive processing of this (realistic and predictable) trauma response, but its suppression is putting team and individual effectiveness and patient safety at risk.

Interventions need to take account of the interplay between defences (intrapsychic and professional) in doctors; the increasing pressure from relatives, managers and society; the threat of the press and media attention; and the erosion of organisational containment. All of this will impact on doctor’s health.
Poster Presentations

**Psychiatrists’ Support Service: the story so far**

Dr Teresa Borrell, Consultant Psychiatrist, Psychiatrists’ Support Service Adviser, Royal College of Psychiatrists

**Summary**

The Psychiatrists’ Support Service was launched by the Royal College of Psychiatrists in 2007 to assist psychiatrists experiencing difficult or challenging personal work. This relates to difficulties such as mental health problems, exclusion from work, bullying in the workplace, stress and disciplinary issues.

The service is free, confidential and easily accessible by phone or email and is available to members of the Royal College of Psychiatrists. This includes senior doctors, trainees and non-training-grade doctors.

There is no face-to-face contact and no therapy is offered. Rather, the role of the Psychiatrists’ Support Service is to support and signpost, if necessary, the member to the agencies already available. These include the British Medical Association Counselling Service, the Practitioner Health Programme, and the National Clinical Assessment Service amongst others.

A range of Information Guides have been developed and are regularly updates by Psychiatrists’ Support Service members with the aim of informing members of resources available to deal with particular problems or issues. The repertoire of Information Guides reflects common areas of concern to members, and the information contained in the guides should support and empower users to develop their own way of solving problems in a particular area.

As a result of the challenges currently faced by Psychiatrists, the support service has organised two conferences to date: ‘Building resilience through support: coping with the difficult challenges’ in 2015, and ‘Supporting Psychiatrists to sustain a healthy working life’ in 2017. Through these conferences the Psychiatrists’ Support Service provides networking opportunities, along with creating opportunities to promote further discussion about how to use the College and individual members resources to support Psychiatrists in difficulty.

The Psychiatrists’ Support Service is concerned with the health of trainees as well as that of senior clinicians. The service is currently engaged with the Royal College of Psychiatrists in developing a strategy to sustain the mental health of doctors across the career span.

**Aims**

- To present an overview of why and how the Psychiatrists’ Support Service was set up.
- To describe the type of problems practitioners discuss with the Psychiatrists’ Support Service.
- To describe the pathway the calls to the Psychiatrists’ Support Service follow within the service.
Objectives
- To inform delegates of the work done by the Psychiatrists’ Support Service.
- To share data about the work done by the Psychiatrists’ Support Service.
- To invite feedback from delegates.

Learning Points
- A support service for practitioners does not need to be costly.
- Practitioners can benefit from support from a variety of services.
- Practitioners themselves are an important source of support for their colleagues.
- A support service needs to evolve and adapt to change to continue to meet the needs of practitioners.

Health and self-Care for health professionals
Dr Andrew Tressider, GP Health South West Clinical Lead, GP Health

Summary
This presentation will highlight curriculum gaps in undergraduate and postgraduate education in relation to the field of health and self-care for health professionals. This follows research conducted in a variety of postgraduate settings across the South West of England through the provision of twenty workshops. A booklet has also been produced to summarise the learning.

Curriculum gaps in current educational provision to be discussed will include doctors psychological coping mechanisms; mind, body and spirit social wellbeing; mammalian responses to stressors; environmental and nutritional aspects to health; energy medicine; the everyday psychology of inter-personal energy flows and human interactions; humans as ‘hardware body, software being’; the physiology of the emotions and processing life’s experiences; the Drama Triangle which pervades life at a psychological level; and some software returning approaches.

Aims
- To explain a model of human software and functioning, physiology and pathology, which helps to uncover and begin to address some of the curriculum gaps.

Objectives
- To introduce Health and Self-Care as a valid topic.
- To cover some principle of health and self-care, both physical and psychological.
- To give some personal approaches to help enhance health.
- To show how feedback validates this topic.

Learning Points
- Humans have a ‘hardware body, software being’.
- Doctors have health imbalances.
- Reflection works at an affective level, underpinning cognition.
- There are ways forward ‘out of the wilderness’.
- Tools to help include grounding, breathing, acupressure and using information from nature.
Addiction in doctors
Curran L., Sayed H.

Lead author: Dr Hanaa Sayed, Consultant in Occupational Medicine, Kings College Hospital NHS Foundation Trust

Summary
This poster presentation will highlight the issue of addiction in doctors, including instances of its occurrences, methods of identification, and ways of tackling the problem.

The research is based upon a series of case studies carried out involving hospital doctors having addiction problems that lead to concerns. A summary of these case studies will be described in the presentation.

These findings are able to serve as the basis for development of programmes of support for doctors with addiction problems.

Aims
- To demonstrate cases of doctors who have addiction problems being referred to an occupational health service.
- To make delegates aware of the sorts of concerns raised by colleagues and managers in the context of addiction among healthcare professionals.

Objectives
- To determine the factors affecting these doctors’ behaviour and the effect this problem has had on their work and health.

Learning Points
- Addiction in the workplace presents serious problems.
- It is vitally important to have procedures in place to lead to the quick identification of early signs of addiction in doctors.

A survey evaluation of resilience education for doctors
Wylam J., Caddick L., Irvine C.

Lead author: Dr Jaimee Wylam, Leadership Fellow, Future Leaders Programme, Health Education England

Summary
The notion of teaching resilience is a relatively new concept in medical education. Resilience is an ‘emotional competence’ which ‘can be considered as a virtue or behaviour to be acquired and improved’. Careful consideration must be given to how we facilitate sessions which aim to develop emotional competencies. Emotional competencies are developed via personal experience; whether in real world scenarios or through reflection and self-discovery.

Healthcare professionals have skills in resilience. However, adequate time is not given to acknowledging the positive, and negative strategies, which contribute to that success or
to further development of resilience. In an increasingly complex working environment with constant challenges it is important we prioritise staff wellbeing to prevent burnout.

An educational workshop was designed for delivery to foundation doctors. This follows themes of resilience, wellbeing, challenges, mistakes, failure and thinking styles. The materials are delivered by a ‘near peer’ (a colleague three to four years senior). After the workshop, feedback is collected regarding the perceived usefulness of this session.

Resilience education delivered by a peer is deemed helpful for individual resilience and mental wellbeing in most of Foundation doctors surveyed. A similar majority would recommend a resilience education workshop to a colleague. Education can be a useful tool in understanding and developing personal resilience.

**Aims**
- To assess the perceived usefulness of education for resilience and wellbeing in foundation doctors.
- To share experiences with colleagues.

**Objectives**
- To improve local practice via discussion with colleagues.
- To stimulate consideration of local initiatives for building resilience.

**Learning Points**
- Normalisation of emotional responses and everyday stresses can be helpful.
- Resilience education is valued amongst foundation doctors surveyed.

**The Work of Pathfinder Sites implementing the Wellbeing Charter for Psychological Professionals’ Wellbeing and Resilience**

Rao A., Scior, K.

Lead Author: Amra Rao, Consultant Clinical Psychologist, Organisational Consultant; Chair, Division of Clinical Psychology Leadership & Management Faculty, British Psychological Society & East London Foundation Trust

**Summary**
The 2017 Stevenson / Farmer review *Thriving at work* concludes that the UK is facing a mental health challenge at work that is much larger than previously thought. It reminds us of the big human cost of poor mental health at work, and the costs to society, the economy and Government. Concerns about poor wellbeing among the NHS mental health workforce have been raised by recent annual staff wellbeing surveys conducted by the British Psychological Society and New Savoy Conference, as well as research on psychological practitioners’ mental health carried out at UCL. Jointly they indicate that many practitioners struggle with high levels of stress which often lead to symptoms of anxiety and depression, and in some cases impede their ability to provide high quality care to service users. Furthermore, a lack of openness and compassion within services can impede functioning or recovery in practitioners who have experienced mental health problems themselves.

These concerns led to the launch in 2016 of the *Psychological Professionals Wellbeing and Resilience Charter* which aims to promote a greater focus on staff psychological wellbeing, models of ensuring good psychological wellbeing at work, the co-creation of compassionate workplaces and sustainable services. It also seeks to encourage organisations to commit to monitor and improve the psychological wellbeing of their
staff. In this presentation, a brief overview of the Charter and Colloborative Learning Network (ClaN) will be provided, the work and outcomes of selected pathfinder sites that seek to improve wellbeing at organisational as well as individual practitioner level will be presented.

Aims

- To share examples of good practice in improving practitioner wellbeing within (mental) health services.

Objectives

- To encourage greater dialogue and shared learning at national and international level about what works in improving wellbeing and promoting openness about threats to wellbeing within (mental) health services.

Learning points

- The audience will gain a better understanding of how to set up learning networks to promote, support, and share good practice in supporting practitioner wellbeing within (mental) health services. They will gain insight into specific work aimed at creating more compassionate workplaces and professional organisations, and work targeting employers, as well as employees.
The Practitioner Health Service is a confidential, free, self-referral NHS service for doctors and dentists with mental illness and addiction problems.

It is made up of the combined services of the NHS Practitioner Health Programme (PHP), NHS General Practitioner Health Service (GPHS) and Trainee Doctors and Dentists Support Service (TDDSS).

Services are available England wide and we see doctors and dentists with the whole range of mental illness and are able to offer a wide range of pharmacological treatments and talking therapies.

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International Practitioner Health Summit 2018
The Wounded Healer
10 Year Anniversary Conference of the Practitioner Health Service
BMJ Mental Health Team of the Year 2018
Thursday 4 - Friday 5 October 2018
30 Euston Square, London, NW1 2FB

Programme and Work Stream Abstracts

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