

EAPH conference

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The Doctor, The Patient
and The Workplace
Interactions between
Quality of Care,
Professional Satisfaction
and Organisations

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ACCEPTED ABSTRACTS

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The Doctor, The Patient and The Workplace – Interactions between Quality of Care, Professional Satisfaction and Organisations

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the Medical Profession

ORAL PRESENTATIONS

1.

SafeSpaceHealth App: An anonymous and unfiltered digital safe space for healthcare and allied health providers to connect, share, support and enhance their professional fulfilment

Presenting author: Dr. **Khurram Jahangir**, Canada

Affiliation: SafeSpaceHealth

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Co-author: Nathalie Martinek, Australia

Introduction / Aim: SafeSpaceHealth App is a revolutionary innovation, providing a completely anonymous and unfiltered digital forum for health care and allied health providers, including trainees and students, to share stories, debrief, give and receive support, be coached and experience professional learning. The burnout phenomenon in healthcare has been detrimental for mental health of health professionals and patient safety globally. The aim of this App is to enhance professional fulfilment by reducing/preventing burnout, compassion fatigue, post-traumatic stress, mental illness, self-harm, etc., while helping transform healthcare culture around the world.

Method and Results: The key feature that sets SafeSpaceHealth App apart from all other support Apps and burnout prevention initiatives is the diversity of skill, expertise, quality assurance and empathic mastery of the moderation/moderators - trained to create and maintain a safe, anonymous and trusted space online, providing support 24/7. Furthermore, we have built in AI features within the App design to help make moderation a more seamless process, in the face of rapid scaling and uptake of the App worldwide. SafeSpaceHealth App also introduces a brand new framework of Health Providers' Professional Fulfillment, integrated within the App, providing for resources while learning at the same time. The App also provides ability for its participants to record their learning and reflections in written, audio and/or video formats, and enables a repository of all their learning activities/reflections. For partner organizations, the App also enables a second, more localized ecosystem within the App – MyWorkSpace – providing more contextualized qualitative and quantitative data on factors leading to increased burnout within a specific organization/institution.

Discussion and Conclusion: SafeSpaceHealth App has the potential to alleviate suffering of our medical and allied health professionals, enhance practice and professional fulfilment, improve the quality and effectiveness of doctor-patient relationships, thereby fostering and promoting patient satisfaction.

Learning objectives:

- Learn how digital innovations can provide viable solutions to tackle the burnout epidemic globally.
- Discover how SafeSpaceHealth App's revolutionary design enables medical and allied health providers to connect, share and support each other completely anonymously.
- Discover how a brand new healthcare providers' professional fulfilment model integrated within the app provides resources while promoting learning and reflection at the same time.

2.

Precision Initiatives: Empowering Learners, Increasing Ownership through Personalization of Learning, Assessments and Leadership Development Programs, Enabled Using Digital Technology

Presenting author: Dr. **Khurram Jahangir**, Canada

Affiliation: SafeSpaceHealth

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Co-author: Nathalie Martinek, Australia

Introduction / Aim: Traditional CPD Programs tend to lack opportunities for learning to be individualized – thereby failing to facilitate an individual's professional growth, foster ownership or promote wellbeing. There is, therefore, an urgent need to transform learning, education and personal development for healthcare professions, in line with 21st century pedagogy and design-thinking. Embracing concepts such as personalization, contextualization and co-creation of initiatives, designed using adaptive and enabling digital technology, promote ownership. Framework for Precision Initiatives has been co-created using

person-centred, behavioural, interaction and adaptive design – delivering boutique initiative for every individual learner, based on their personalized needs.

Method and Results: Behavioural insights, gained through individualization of needs and goals, help frame behavioural objectives towards designing personalized competency- and quality-based assessment tool for each individual. Progress review of each learner is continuous and monitored in real-time, based on field observations, documented by both the learner and preceptor(s), using personalized electronic ‘Precision Notes’ and collated on a specifically designed, adaptive digital platform. Successful completion is based on achieving proficiency in all the behavioral objectives identified as part of the competency-based individualized curriculum. As part of commitment-to-change learning contract, Precision Initiatives introduce the concept of post-program learning reinforcement activities, offering learners opportunities to undertake impact assessment, reflection and quality improvements activities. The delivery of the program is through an innovative new digital platform, designed using adaptive technology to automate Precision Framework and enable real-time progress review based on field observations, feedback and impact assessment.

Discussion and Conclusion: Precision Initiatives is a revolutionary innovation providing opportunities for healthcare professions to undertake initiatives based on their individualized needs and goals – promoting self-assessment and self-reflection, as well as fostering sense of ownership, joy and happiness in professional lives.

Learning objectives:

- Understand the concepts of person-centred, behavioural and interaction design in creating frameworks.
- Demonstrate how frameworks designed and automated using enabling technology can increase sense of ownership – reimagining true notion of personalized development portfolios.
- Understand role of value proposition design in co-creating competency- and quality-based initiatives – guiding healthcare professions in fulfilling their individualized needs.

3.

Fighting fit - national cross-sectional study on presenteeism and wellbeing in hospital doctors in Ireland

Presenting author: Dr **Lucia Prihodova**, MSc, PhD, Ireland

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Co-authors: Blanaid Hayes, Gillian Walsh, Ireland

Aims and Introduction: Presenteeism or working when ill enough to justify sick leave has previously been found to be highly prevalent in doctors. In Ireland, the financial, organisational and personnel constraints imposed by recession translated into greater work volume and a challenging training and working environment for healthcare professionals with possibly fertile ground for presenteeism. The purpose of this study was to assess the prevalence and determinants of presenteeism in hospital doctors in the Republic of Ireland.

Methods: 1749 hospital doctors (RR = 55.3%) provided their age, sex, average working hours, grade, specialty and completed questions on presenteeism, work-life balance, Workability Scale and the Effort Reward Imbalance (ERI) questionnaire. Exploratory analyses (cross-tabs, correlations, binary logistic regression) were performed.

Results: In total, 78% of doctors confirmed having worked through illness, with this being significantly more prevalent in trainees (80.8%) than consultants (75.6%). Females reported higher presenteeism than males: in consultants 81.1% vs 71.9%; and in trainees 86% vs 72.5%. When comparing specialties, psychiatrists (83.9%) and emergency medicine doctors (82.1%) reported highest rates while anaesthetists reported lowest rates (73.1%). Younger age, female sex, and junior grade were significantly associated with presenteeism as was lower workability, poorer work-life balance, greater work stress and higher overcommitment.

Conclusions: The levels of presenteeism in hospital doctors in Ireland were comparable to those reported internationally, with particularly high rates in female trainees. The association of presenteeism with greater work stress and overcommitment possibly indicates that presenteeism is more likely to occur in workplaces under strain where sick leave is not easily facilitated. Alternatively, it may be avoided by doctors themselves, not wanting to not let down their patients and colleagues. The link with poor work-life balance and workability indicate that this is not sustainable and need to be addressed in training and by the employer.

Learning objectives:

- Learn about risk factors of presenteeism along with possible impact on doctors, as well as proposed steps to improve the situation.

4.

Impact of Mantra Meditation Personal and Workplace Wellbeing of Emergency Department Staff in Ireland: Mixed methods study

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Co-authors: Julie Lynch, Pádraic J Dunne, Caoimhe O’Leary, Áine Carroll, Cathal Walsh, Geraldine McMahon, Barry White – all Ireland

Aims and Introduction: Faced with excessive working hours and an increasingly complex healthcare system, emergency department staff in Ireland are reporting high levels of burnout and stress. This mixed-methods combined RCT and

qualitative methods to evaluate the effect of a mantra meditation (MM) programme delivered in four sessions over three months on personal and workplace wellbeing of emergency department staff in Ireland.

Methods: Fifty-eight participants were enrolled in an RCT assessing the impact of the programme on burnout (Maslach Burnout Inventory; MBI), personal wellbeing (Depression, Anxiety and Stress Scale 21; DASS-21), mindfulness (Five Facet Mindfulness Questionnaire; FFMQ) and workplace safety (Safety Attitudes Questionnaire; SAQ) pre-intervention, post-intervention and at two month follow-up. Ten participants then took part in semi-structured interviews were conducted to harness ED staff's experience of the mantra meditation programme with a four-session mantra meditation programme. Paired t-test analysis and thematic analysis were used to analyse the data.

Results: The paired t-test analysis showed a reduction in emotional exhaustion (MBI), depersonalisation (MBI), depression (DASS-21), anxiety (DASS-21) and stress (DASS-21) and overall safety attitudes (SAQ), and increase in mindfulness (FFMQ), personal accomplishment (MBI). Qualitative findings identified five themes: work pressure and perceived stress; perceived benefits of meditation; conflicting attitudes to practice; barriers to meditation practice; and facilitators to practice.

Conclusions: Our findings suggest a mantra meditation programme can have positive impact personal and workplace wellbeing of emergency department staff. Additionally, we have identified adherence issues and practical considerations for wider implementation. Larger and longer trials are warranted to confirm these findings.

Learning objectives:

- Learn about impact as well as challenges in implementing a programme aimed at the wellbeing of healthcare practitioners, such as mantra meditation in a busy working environment.
- Gain an understanding of the opportunities and challenges of assessing the effects of such interventions and the benefits of combining quantitative and qualitative methods.

5.

No one wants to "rock the boat". Workplace incivility and barriers to change in radiology in Ireland – mixed methods national study of trainee and consultant radiologists

Presenting author: Dr **Lucia Prihodova**, MSc, PhD, Ireland

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Co-authors: Hadas Levy, Aileen O'Shea, Ciara O'Brien, Michael O'Reilly, Max Ryan – all Ireland

Aims and Introduction: Radiologists in Ireland face numerous challenges related to increasing demand for diagnostics, changes in health service delivery, population demographics and national strategies. Such stressful working conditions can attribute to the rise of incivility, which has a negative impact on the individual healthcare practitioner, teams, as well the patients. The purpose of this research was to assess the prevalence of specific negative behaviours and their impacts on radiologists in their workplace in the Republic of Ireland.

Methods: This study adopted a cross-sectional, mixed methods design, utilizing an anonymous online questionnaire comprised of questions on the participants' work and demographics, The Revised Negative Acts Questionnaire (NAQ-R), questions on their experience of workplace bullying and barriers to reporting. Finally, the participants invited to provide free text comments on suggestions for improvement.

Results: Out of the 177 radiologists who participated in the study (Response rate 40.5%), 41% experienced incivility at least occasionally. Other radiology/radiation oncology consultant colleagues were reported as the most frequent source of incivility. 20% have previously reported bullying and the most reported barriers for reporting included their role, fears of the situation further deteriorating and fear to be seen as a troublemaker. In relation to proposed solutions to bullying, the radiologists suggested interventions should be taken on three levels: peer to peer (local), hospital management/ human resources and national (Faculty of Radiology). The proposed interventions ranged from training, policy, confidential reporting, investigation and dismissal. Participants emphasized that underlying issues of negative workplace interactions such as the need to address inadequate staffing and high workload along with promotion of workplace environment that encourages positive interactions.

Conclusions: Our findings indicate a high prevalence of incivility in radiology in Ireland in both trainees and consultants. The findings also identify potential ways of addressing this issue on a local and national level.

Learning objectives:

- Learn about incivility and barriers in accessing help in healthcare professionals, as well as proposed steps to improve the situation.
- Learn about steps taken after the completion of the survey to tackle the situation.

7.

A decade of delivering care to doctors

Presenting author: Dr. **Clare Gerada**, MBE, FRCGP, FRCPsych, UK

Affiliation: NHS Practitioner Health Programme, Riverside Medical Center

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Aims(s) and Introduction: Over the last decade the PHP service in UK has become the largest service in Europe accessible to more than 160,000 doctors via self-referral or via their GP. This presentation will explore what we have learnt over the decade and what has changed over time.

Methods: PHP has treated more than 6000 doctors from all specialities across England. This has given a unique insight into the difference between professions, the risk factors and protective features plus the impact of organisational and external

factors on wellbeing and mental health. We have explored what treatments work and how, even the smallest intervention can have a positive impact.

Results: More than 76% of doctors not in work return to work (1000 doctors have been returned to the workplace, resulting in savings of more than £230 million). Abstinence rates exceed 89% and on all measures patients improve following treatment. Feedback is consistently positive with 93% likely to recommend the service to a friend or colleague.

Conclusions: Delivering consistently high quality care to doctors and demonstrating the impact has enabled the growth of services in UK from a 3 person team in London to a 300 strong team across the country. The conversation around doctor's health has moved from the shadows to centre stage with a move away from measuring the problem to long term meaningful solutions. Moving forward we need to focus on prevention and change in culture.

8.

Feeling well is not enough: How open minded medical students really are?

Presenting author: **Vicky Spatoula**, PhD student, Greece

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Co-author: Efharis Panagopoulou, Anthony Montgomery – Greece

Aim: Numerous studies have revealed the role of cognitive biases in clinical settings. Older patients are often viewed by health professionals as set in their ways and unable to change their behavior. Members of different racial or ethnic groups have different access to treatment options. The main objective of the current study was to compare stereotypes concerning age, sexual orientation, and gender between medical students and social science students.

Method: 300 medical students and 300 students of Social Science Studies of the Aristotle University of Thessaloniki, completed a questionnaire that included the Ambivalent Sexism Inventory scale (ASI), the Fraboni scale of ageism (FSA) and the Homophobia Scale (HS)

Results: Medical students have more biases concerning homosexuality and age compared to students of social sciences ($p=0.002$). Results also showed that the biases among medical students increased over the years.

Conclusions: Results highlight the role of education in managing issues of diversity in society and policy responses have been varied. Academic medicine can increase awareness and education regarding health disparities through several venues.

Learning objectives:

- Understand the importance of educating students about healthcare disparities.
- Evaluate the role of medical education
- Estimate the importance of introducing multi-cultural lessons in medical curriculum.

9.

Does Empathy Change During Undergraduate Medical Education? – A Meta-Analysis

Presenting author: **Vicky Spatoula**, PhD student, Greece

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Co-authors: Efharis Panagopoulou, Anthony Montgomery – Greece

Introduction / Aim: The aim of this meta-analysis was to synthesize the existing evidence examining how empathy changes during undergraduate medical education and assess whether different types of measures produce different results.

Method and Results: Three electronic bibliographic databases were last searched on 28/11/2018. Quantitative studies including a measure of empathy in medical undergraduate students and a comparison of the results among the different years of study, were included. All analyses were guided by Lipsey and Wilson and conducted using Comprehensive Meta-Analysis software. The overall sample size for the twelve studies ($n=12$) was 4906 participants. Results indicate a significant effect ($g = 0.487$, $SE = 0.113$, $95\% CI = 0.265, 0.709$), suggesting that there is moderate evidence that empathy scores changed. Studies using the Jefferson's Scale for Physician Empathy (JSPE) reported higher effect sizes ($g = 0.834$, $SE = 0.219$, $95\% CI = 0.406, 1.263$), while the effect size for studies using other scales was smaller and non-significant ($g = 0.099$, $SE = 0.052$, $95\% CI = -0.003, 0.201$).

Discussion and Conclusions: This review indicated significant evidence that self-ratings of empathy changed across the years of medical education. However, we need to be cautious because this effect was only significant when empathy was assessed using the JSPE.

Learning objectives:

- Understand the role of empathy in Medical education
- Be concerned about the instruments that we use to measure empathy in medical education.
- Evaluate the multiple factors which influence empathy in medical students.

10.

Empowering physician to improve mental work environment

Presenting author: Dr. **Sofie Hjortø**, Board member, Gynecologist, Denmark

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Co-author: **Mette Krøigaard**, Denmark

Introduction/Aim: Working as physicians can be emotionally stressful and the workload can be overwhelming. The aim of this study was to uncover the mental work environment for physicians and search for as well as select tools relevant to improve the mental health. The knowledge was build into a course aiming to enable physicians (union- and safety representatives) to uncover challenges and empowering them to improve mental health and work environment.

Method and results: Using knowledge from surveys of physician mental health and work environment, member inquiries and our business psychologists we uncovered the significant factors for physician mental health including workload, time pressure, loneliness, emotional stress, work-life balance, interruptions, resource shortages and lack of management attention. The surveys showed, that the management felt uncertain of how to deal with the mental work environment. We used the individual – group – leader – organization model (IGLO) to analyse the identified factors and find relevant tool for improvement. We designed a two-day course aiming to teach the participants how to uncover the mental work environment and practice different tools used to improve mental health at individual, group, management and organizational level. The course was developed in 2015-2016 and launched after a successful test course in 2017.

Discussion and Conclusions: Improving mental work environment increases the quality of patient treatment, the well-being of physicians whereas it reduces the risk of burn out. By attending the two-day course the union- and safety representatives are empowered to uncover and improve mental health at individual, group, leader and organizational level. The management often lack sufficient knowledge of and ability to take care of the mental work environment. Thus it is even more important, that the physicians are capable and willing to improve the mental health and work environment.

Learning objectives:

- Be inspired to improve and work with mental work environment

13.

A Danish national review of the working environment and work-life-balance for junior doctors becoming specialist in family medicine

Presenting author: Dr. **Kim Agerholm Brogaard**, Board member, Denmark

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Aims and Introductions: We experience a massive pressure on the Danish health care system. The population is aging and treatment options are numerous. The workload is increasing. However, the number of doctors in family medicine is stationary. The aim was to investigate working environment and work-life-balance for junior doctors in family medicine.

Methods: In June 2018, the Junior Doctors Association in Denmark conducted a questionnaire survey among members in specialist education in family medicine.

The aim was to map the current specialist-specific challenges and issues related to the working environment that occupies future doctors in family medicine. In total, 1,827 people received the questionnaire, of which 744 respondents responded, giving a total response rate of 40.7%.

Results: Junior doctors in family medicine experience a stressed work life. They often experience the need to shorten breaks in order to be able to honor the workload and many go to work when they are ill. It occurs to a greater extent among junior doctors in family medicine at hospitals compared to primary care. Many have a desire to work in reduced hours. It is a desire of more time to the family and an experience of a heavy workload. Many are also concerned about being involved in a patient complaint case. Finally, one third of junior doctors in family medicine feel lonely. The feeling of loneliness is significantly greater among doctors employed in hospital departments compared to doctors employed in primary care.

Conclusions: Junior doctors in family medicine do in great extent experience a stressed work life. They shorten breaks and often go to work when they are ill. Many doctors are concerned about being involved in a patient complaint case. One third of junior doctors in family medicine feel lonely. A massive effort is needed to ensure better working conditions for junior doctors in family medicine.

Learning objectives:

- Almost three out of four junior doctors in family medicine wish to work in reduced hours due to the experience of a heavy workload and a desire of more time to the family.
- Junior doctors in family medicine experience a higher level of loneliness in hospital departments compared to the doctors in primary care despite of being surrounded by many colleagues at the hospital.
- The workload is a threat to junior doctors' health and wellbeing.

14.

The future coverage and recruitment of doctors in family medicine in primary care in Denmark - seen from the junior doctors' point of view

Presenting author: Dr. **Kim Agerholm Brogaard**, Board member, Denmark

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Aims and Introductions: In Denmark, we experience a widespread and increasing shortage of doctors in family medicine and challenges to recruit doctors in primary care. It is a threat to ensure easy and equal access for patients to primary care.

The aim was to investigate, what is important to ensure recruitment and maintenance of junior doctors in family medicine to primary care. This will provide further knowledge about a number of issues that we should prioritize to ensure coverage and recruitment of family doctors.

Methods: In June 2018, the Danish Junior Doctors Association, sent a questionnaire to all its members attending specialist education in family medicine. The questionnaire contained questions about the wishes of junior doctors in family medicine for future employment opportunities. In total, 1,827 people received the questionnaire, of which 744 respondents responded, giving a total response rate of 40.7%.

Results: About one out of four Danish junior doctors in family medicine are unclear in relation to whether they want to own their own practice. However, they wish to work in general practice - either as an employee at the start of their medical career or as owner later in the career process. Solo work is not preferred. More than half of all junior doctors in family medicine can largely imagine working elsewhere like the secondary health care system, the pharmaceutical industry or research positions. Having to work in primary care is not entirely without concern for junior doctors in family medicine. More extensive documentation concerns the junior doctors. Almost three out of four respondents respond to worry about having a heavy workload.

Conclusions: Danish junior doctors in family medicine are unclear in relation to whether they want to work in primary care. Intensive and interdisciplinary efforts are needed to ensure recruitment and coverage of family doctors in primary care in Denmark in the future.

Learning objectives:

- Junior doctors doing career in family medicine are interested in working in primary care. However, working in a general practice is not given in advance. They see many opportunities when it comes to their future career path.
- Junior doctors in family medicine want colleagues. Solo work is not preferred.
- Junior doctors worries about meeting demands for more comprehensive documentation of quality in primary care. It may be a threat to ensure medical coverage in general practice in the future.

15.

Health of health professionals – ReMed: the support network for physicians Accompanying research in Switzerland

Presenting author: Dr. **Peter Christen**, Switzerland

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Co-author: Linda Hadorn, Switzerland

Aim and Introduction: Maintaining physician's health is increasingly recognised as a matter to discuss in public and research. Physician health is a critical issue, because poor physician's health can have severe impact on doctor's performance, patient safety, quality of care and may affect standards of care. To help doctors in crisis, the Swiss Medical Association (FMH) founded the support Network ReMed in 2007. An experienced team of counsellors takes care of doctors suffering from various crises. The counsellors offer targeted support in difficult situations and are "committed to promoting health, helping physicians to function effectively, and guaranteeing patient safety, in order to guarantee the general population high-quality and safe medical care provided by healthy and contented doctors". In 2015, the program leaders initiated an external evaluation on the mode of operation (effectiveness, efficiency, relevance, adequacy), awareness of the network, numbers of contacts, and statistical data.

Methods: In Switzerland, there exists only this specific helpline for physicians. Data source is limited to data available from this program. The executive committee of ReMed gathered semi-structured reasons for encounter as well as gender, age, professional activity and marital status over the last 9 years. Furthermore, 122 doctors (response rate 35%) that had contact with ReMed answered a questionnaire, and interviews with committee members were conducted.

Results: Based on the descriptive and qualitative results various actions were implemented, such as, reedition of basic documents, introducing new standards and structured feedback after each consultation, expanding monitoring and follow-up support, as well as strengthening the support of members of the network. Results may be presented during the oral speech.

Conclusion: Additionally to the existing results, ReMed plans an accompanying study to create profiles of doctors getting in contact with ReMed and evaluate the quality of consultations. The analysis helps to identify what variables might refer to a greater risk of health problems and where preventive implications might be possible. First insights are expected in spring 2019.

Learning objectives:

- Get to know more about the support Network ReMed from Switzerland
- Get an insight on an unique fundus of data
- Know more about possible preventive implications of the findings

19.

Referral of Patients with Cancer to Palliative Care: Experiences of Swedish Physicians

Presenting author: **Karin Adolfsson**, Sweden

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Co-authors: Thomas Björk-Eriksson, Ulrika Kreichberg, Margaretha Stenmarker – all Sweden

Introduction / Aim: Patients with advanced cancer benefit from receiving standard oncology care integrated with palliative care (PC) early in the course of treatment. This strategy is based on randomized controlled trials, but is not yet established as standard of care. The aim of this study was to explore attitudes, experiences and practices among Swedish physicians regarding the referral process and the integration of oncological treatment and PC.

Method: In 2016 to 2017, 130 physicians in the south-east part of Sweden participated in a cross-sectional online survey with questionnaires dealing with the referral process to PC, the physicians' personal experiences and feelings, and organizational aspects. All participants worked with cancer patients within different specialties; oncology, urology, pediatrics, gynecology, pulmonology, and hematology.

Result: The general opinion (98%) among the physicians was that PC was beneficial for the patient. The majority (82%) had a positive attitude towards early integration in PC, with the highest rating within oncology (94%). Pediatric oncologists stated that they introduced the concept of PS early in the course of progressive disease (80%), as compared to hematologists (20%). However, the action to refer patients to PC was made late in the disease trajectory (84%) or when the patient suffered from inadequate symptom control (75%). After referral, the physicians expressed an extensive need to know (71%) that the patient had been taken care of.

Conclusions: This study explored physician's experiences concerning early referral to PC of cancer patients with advanced disease. Despite the physicians' positive approach towards this strategy and the previously documented benefit for the patient with early integration of PC, referral often occurred late in the course of the disease. The reasons for these discrepancies are probably multifactorial and related to medical and organizational encounters, attitudes within specialties, and the challenge of disrupting a close patient-physician relationship.

Learning objectives:

- Swedish physicians working with severely ill cancer patients have a positive attitude towards integration of oncological treatment and palliative care. Still, the action to refer patients to PC was made late in the disease trajectory.
- The doctor's role in the transitional phase and when integrating palliative care, has impact on the professional and patient-related needs.

20.

Physician Health Programs and Malpractice Claims: Reducing Risk through Monitoring

Presenting authors: **Elizabeth Brooks**, PhD / **Sarah R. Early**, PsyD, Colorado, US

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Introduction / Aim: The Colorado Physician Health Programs (CPHP) in the United States is a peer-assistance organization designed to provide support and advocacy to doctors struggling with addiction, physical, or mental health challenges. While the services offered by CPHP is setting new standards for recovery and care, it is prudent to consider patient safety concerns for those who have participated in the programs. This study examined whether enrollment at CPHP was associated with lower medical malpractice risk.

Method and Results: Data consisted of 818 physician-clients who were insured by the largest malpractice carrier in the state. In the two-stage analytic process, a business-model analysis of malpractice risk first examined relative risk ratings between CPHP clients and a matched (non-CPHP) physician cohort. Second, Wilcoxon analysis examined differences in annual rates of pre-monitoring and post monitoring claims CPHP clients only. After monitoring, those enrolled in the program showed a 20% lower malpractice risk than the matched cohort. Further, physicians' annual rate of claims were significantly lower after program monitoring among physician health program clients ($z = -3.092, p < .01$).

Discussion and Conclusions: Physicians had a reduced risk of medical malpractice claims after participating in the program. While the underlying reason for this finding is unknown, it is possible that the program lowered malpractice risk by effectively addressing clients' presenting problem; by teaching skills in treatment and monitoring that improved practice; or by encouraging physicians to use other professional supports, such as seeking peer consultations in the workplace. These results are consistent with literature demonstrating that physicians monitored by peer-assistance programs have excellent treatment outcomes.

Learning objectives:

- Recognize the importance of linking physician health to practice outcomes.
- Recognize the importance of insurers' risk ratings on provider practice in the United States.
- Recognize the relationship between participation in a physician health program and client malpractice risk ratings.

23.

Doctors and their defences

Presenting author: Dr. **Clare Gerada**, MBE, FRCGP, FRCPsych, UK

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They met behind the curtain, emergency department doctors and nurses desperately trying to save the life of a young man with serious head trauma and crush injuries to his abdomen. He was essentially bleeding to death. They worked for 90 minutes but could not reverse what a lorry had done to him that morning. At 13.20 the patient was pronounced dead. 'I bet he regrets not taking the tube' called out Henry, one of the doctors. The others laughed.

This doctor may appear to be uncaring, but he is using a mature defence mechanism to try and cope with an intolerable situation – that of the death of a young patient.

Medicine is a hard task master. Hours are long and unpredictable. Patients do not follow the text book descriptions of illness. They become unwell at difficult times and they die. The delivery of health care is high risk and unforgiving of errors and there is the constant fear of 'getting it wrong'.

To survive doctors need to develop coping mechanisms. Humour, a mature defence mechanism, helps alter the content of a disturbing scenario, making it become more tolerable and, in so doing, allow him to continue in his work. All psychological defences help protect the individual from anxiety and guilt and allow for an important distance to develop between unpleasant thoughts, feelings and subsequent behaviours. Defences help keep a doctor's ego (that part of an individual's unconscious mind which deals with reality) held in equipoise. Under defended and it risks being overly anxious and unable to cope, over defended it becomes hardened, detached and un-empathetic clinicians.

My talk will discuss the mechanisms, conscious and unconscious, which doctors use to cope with the demands of their job.

Learning objectives:

- By coming to this talk you will hopefully reflect on what defence mechanisms you, as a clinician use and how helpful they are or not.

24.

Does burnout affect clinical reasoning? An observational study among residents in general practice

Presenting author: Dr. **Philippe Guillou**, France

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Co-authors: Thierry Pelaccia, Marie-Frédérique Bacqué, Mathieu Lorenzo – all France

Introduction / Aim: Burnout results from excessive emotional demands in the workplace. Caregivers suffering from burnout show a state of emotional exhaustion, leading them to distance themselves from their patients and to become less efficient in their work. Our theoretical hypothesis is that burnout could alter clinical reasoning. There are few publications dealing with this issue and new data is needed to better understand how burnout might affect clinical reasoning.

Method and Results: We conducted a cross-sectional observational study in a population of interns in general practice during their last semester. Clinical reasoning performance was assessed using script concordance tests (SCT) A burnout questionnaire (Maslach burnout inventory for human services survey) was immediately proposed after SCT examination. In September 2017, 139 students were invited to SCT examination; 128 attended and 111 were included. Among the participants, 71 didn't suffer from burnout, 19 experienced mild burnout, 19 moderate burnout and 2 severe burnout. We found no significant association between the burnout and the SCT scores ($p=0.7936$).

Discussion and Conclusions: The absence of significant SCT variation depending on burnout level could be explained by the fact that SCT mostly examines the analytical dimension of the clinical reasoning process, whereas emotions are conventionally associated with the intuitive dimension. More research is needed to understand how burnout may impact clinical reasoning in its intuitive component.

Learning objectives:

- Know more about the impact of burnout on clinical reasoning
- Discuss the limits of burnout assessment by MBI-HSS
- Discuss the methodology for exploring the intuitive component of clinical reasoning

25.

Health and Self-Care for Health Professionals

Presenting author: Dr. **Andrew Tresidder**, UK

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Introduction / Aim: Health and Self-Care for Health Professionals is a multi-author free resource available on the web: www.healthandself.care. It explores common-sense areas of physician health.

Method and Results: The presentation will introduce 'Health and Self Care'

Discussion and Conclusions: Ask a hundred people how they are – and they say 'Fine' – Fearful, Insecure, neurotic and Emotionally Imbalanced. Ask a hundred Physicians, and they can't answer – they're too busy looking after patients.

Everybody uses Denial, and Physicians use Displacement as well, and are heavily defended against their own health needs – they are too busy putting oxygen masks on everyone else.

Health is not taught at medical school, but is the other end of a continuum from illness. To be healthy, the human body needs good sleep, fresh air, sunlight, hydration, nutrition, and freedom from chemical and environmental pollution. To thrive, the human soul needs safety, social contact, and a purpose in life. To mature, we need to reflect as self-aware beings, and to care for our bodies, minds and souls. (Maslow and O'Rourke). Attending to all of these needs in balance brings health and harmony of mind body and spirit – neglecting them leads to ill-health. We need to attend to both our hardware body and our software being

The resource explores concepts such as work-life balance, Compassion in Healthcare, Health, the Doctors' D's, and Doctors as Patients. It covers physical health topics such as Mammalian responses to stress, and psychological areas including Growth and Attachments in relationships, the Drama Triangle, 'how life works' and adjustment to change. It includes solutions such as medical mindfulness, the inner Smile, caring for the whole person, and other approaches.

Learning objectives:

- The resource aims to interest, inform, encourage exploration, and to support us in thinking ‘outside of the box’ to support Physician Health.

26.**Psychotherapy in physicians with addictions: the Galatea Clinic intervention program**Presenting author: **Christo Manuel Cruz Alonso**, Spain

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Co-authors: Meritxell Heredia, T. Pujol; Enric Llavayol, Regina Santiago; Eugeni Bruguera – all Spain.

Introduction: Physicians with addictive disorders represent a specific subgroup of physicians in trouble and they have an increased risk for malpractice problems. Delay in help-seeking and easy access to some legal drugs, worsen the evolution and prognosis of their problems. Some specific programs for physicians have been developed worldwide in order to warrant access to confidential treatment among them. The Galatea Clinic in Barcelona has a long experience providing specific integral care to address this issue not only among doctors but also among other healthcare givers. Both individual and group psychotherapeutic interventions have been developed over the years following a person-centered model with influences of motivational, cognitive-behavioral and systemic approaches. The 3-step specific integral care program for physicians with addictions consists of:

1. 1-month Intensive Day-Hospital period.
2. 3-weeks consolidation stage (twice a week).
3. 2-5 years follow-up program (once a week).

Interventions during the whole process include: group psychotherapy, individual psychotherapy, psychiatric assessment, drug screening, nurse support, social worker assessment (when needed) and neuropsychological evaluation (when needed). An individual treatment plan is developed in order to provide personalized care to each patient. Return to work is adequately monitored in order to warrant safe re-entry into practice.

Learning objectives:

- Identify the main features of addictions among physicians
- Understand the main difficulties that arise during their psychotherapeutic approach
- Develop strategies to deal with resistances and promote treatment adherence among this specific subgroup of patients inspired in the Galatea intensive care program for physicians with addictive disorders

31.**Exploring the potential of peer group reflection: physicians’ experiences with guided reflection on their professional performance**Presenting author: **Elisa Bindels**, Netherlands

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Co-authors: Myra van den Goor, Albert Scherpbier, Sylvia Heeneman, Kiki Lombarts – all Netherlands

Introduction / Aim: Since peers play an important role in the wellbeing, engagement and performance of the individual physician, ongoing professional development of physicians can be characterized as both a personal and a social process. Therefore, in order to facilitate physicians’ professional development and lifelong learning, it makes sense to involve peers in reflective conversations following performance feedback. This peer group reflection approach, aiming for maximization of participation and learning from others by building on natural group processes, is gaining more acceptance in practice. In this study, we explored physicians’ experiences with reflection on their performance within a peer group setting, led by a professional facilitator.

Methods: During a professionally guided peer group session, physicians were invited to reflect on their individual performance and development, using personalized outcomes of an individual 360 degrees feedback tool. Within two weeks after the session, we conducted in-depth interviews with 26 physicians from various specialties, representing 12 physician groups in 5 Dutch hospitals. Interviews were transcribed verbatim and were analyzed iteratively following the interpretative phenomenological approach.

Results: Physicians experienced the peer group sessions as a dynamic process of self-disclosure and exchange of perspectives. They reported that this exchange often confirmed their own assessment of their performance and that it did not always lead them to identify concrete follow-up steps for individual performance improvement. Nevertheless, participants did indicate that the session added value as it offered an opportunity for increasing self-awareness and deepening relationships through sharing, listening and connecting with peers. Factors that influenced this dynamic process were identified as personal (e.g. lack of energy, disturbed balance, burnout) and group characteristics (e.g. group size and composition, organizational changes). The added value of the group session depended on group dynamics, the experience of psychological safety and the possibility to engage in an open conversation with room for improvisation.

Discussion and Conclusions: This study draws attention to the affective and interactional aspect of ongoing professional learning and development. Reflecting collectively on individual feedback can lead to an increase in self-awareness and can add a deeper meaning on the level of interpersonal relationships. Authentic, accepting, empathically supporting and explorative relationships with peers appears to be an important tool for ongoing development and learning. To allow

reflection to rise from a personal activity to a social activity, it is necessary to invest in a psychologically safe environment and to involve a facilitator for the needed stimulation and structuring of the reflective process.

Learning objectives:

- Gain insight into how physicians experience group reflection
- Learn about the added value of group reflection
- Share and discuss perceived and experienced conditions for a successful group session

32.

Stress at work raises the risk of health problems among doctors: A UK cross-sectional study

Presenting author: Dr. **Asta Medisauskaite**, UK

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Aim and introduction: Burnout of doctors are linked to poor quality care, low patients' satisfaction and patient safety incidents. It is not known if occupational distress raises the risk of health problems (such as insomnia, physical health symptoms) that might compel doctors to be absent from work and increase a risk to patient safety. This study aims to assess 1) the prevalence of health problems and 2) if occupational distress increases a risk of maladaptive health-related behaviours (e.g. substance use; binge-eating) and health issues such as sleep problems and physical symptoms (e.g. headaches) among UK doctors.

Methods: We performed a cross-sectional analysis of the baseline data of a randomised controlled trial (protocol #NCT02838290). 417 UK doctors took part in this study (48% males; 49% consultants). We measured various sleep disturbances (e.g. difficulty falling asleep), substance use and binge-eating habits, and ill health symptoms (e.g. backache). Predictor variables were occupational distress (psychiatric morbidity, burnout, job effort, work-life imbalance, coping with stress through self-blame or substances) and work factors (workplace and years practicing medicine).

Results: The results revealed that a high number of doctors were experiencing various health problems. For example, 34% of doctors used substances in order to feel better; 12-61% had some type of sleep disturbances; 69% had fatigue and 33% back pain; 8% binge-ate. 55% of doctors were emotionally exhausted and 33% had psychiatric morbidity. The results also showed that occupational distress and job factors increased the odds of doctors having health problems. For example, psychiatric morbidity increased the risk of fatigue, upset stomach, headaches and other psychical symptoms as well as various sleep problems (e.g. insomnia, difficulty staying or falling asleep).

Conclusion: The results extend previous research showing that psychological distress and work environment increase a risk of doctors developing health problems.

Learning objectives:

- Learn more about the prevalence of occupational distress and health problems among doctors.
- Learn about the link between occupational stress and health problems among doctors in the UK.

36.

Treating resident physicians with mental disorders and/or addictive behaviors: the Galatea Clinic experience (1998-2018)

Presenting author: Dr. **María Dolores Braquehais**, Spain

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Introduction / Aim: The post-graduate period as a resident physician is usually associated with high emotional distress in part because of new professional demands, to other non-professional psychosocial factors and to some organizational/educational factors. Prevalence of mental disorders and, sometimes, development of addictive behaviors start during that highly-demanding period of physicians' careers. The main aim of this oral presentation is to describe the profile of resident physicians treated at the Barcelona Integral Care Program for Sick Health Professionals from 1998-2018 and to discuss the clinical implications of those findings.

Method and Results: Data from resident physicians admitted to the Barcelona Integral Care Program for Sick Health Professionals from January 1998 until December 2018 will be presented. Diagnoses will be defined according to CIDI 2.1.criterias (WHO, 1997). Psychosocial assessment will include results from the *World Health Organization Quality of Life Scale (WHOQOL)* (Lucas-Carrasco, 1998), from the *Maslach & Jackson Inventory* (1986) and from the *Longitudinal Interval Follow-up Evaluation-Range of Impaired Functioning Tool (LIFE-RIFT)* (Leon et al., 1999).

Discussion and Conclusions: Resident physician with mental disorders and/or addictions represent a special subgroup among doctors treated at Physicians' Health Programs. Changes in the culture of Medicine and preventive interventions enhancing help-seeking for doctors in trouble have contributed to an increase in the number of residents admitted to those specific programs. There are some common stressors they have to deal with during that learning & working lifetime period. Individual responses to those difficulties vary but maladaptive behaviors emerge when healthy coping mechanisms fail. Discussing the clinical implications of our findings may help design more effective preventive and treatment interventions, both for the individuals and for the institutions they work in.

Learning objectives:

- Describe the main clinical and socio-demographic features of resident physicians with mental disorders treated at a specific Physician Health Program.
- Learn about the most common psychosocial stressors they have to endure during that learning period.
- Identify which are the individual, organizational and educational vulnerabilities that may increase the risk of presenting maladaptive responses to adversities among resident physicians.

37.

Increasing risk of poor mental health among resident doctors along residency in Catalonia, a longitudinal study 2013-2017

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Aims(s) and Introduction: The study on residents' health, lifestyles and work conditions in Catalonia has the aim to assess the psychological distress and variables related to it, such as working conditions and psychosocial risks but also lifestyles and state of health. The results of this research are used to develop interventions to prevent residents become unwell.

Methods: Longitudinal study of three cycles: baseline, 478 residents (57% response rate) where interview at the Occupational Health Services during the medical check-up before starting their residency period in May 2013; end of 1st year, 290 residents (61% response rate) and end of 4th year, 216 residents (75% response rate), both answered by an on line survey. Analysis were done with SPSS statistical package.

Results: High stress levels are reflected in the higher risk of suffering from a mental distress, according to the GHQ, based on an initial value of 15% to 29% at the end of the first year of residency, which rises to 38% in the last year of training. Also, the percent of residents who took some kind of psychoactive drug rises from 8% at the beginning of the residency to 13% by the end of the first year, and up to 16% by the end of the fourth year. During the first year, consumption of antidepressants, anxiolytics and hypnotics increases, while in the fourth year consumption of the latter two increases and of antidepressants slightly decreases.

Discussion and conclusions: The results of the longitudinal study help us to improve interventions among residents and their tutors to prevent them to become ill and raise early detection. Training courses for residents should raise awareness of taking care of oneself to fit to practice and give a good and safe attention to their patients. Tutors are trained on tools and skills improvement to better help their residents and manage with difficult cases. Also recommendations to organizations to improve leadership, team work and working conditions should be done.

Learning objectives:

- Learn about health, lifestyles and working conditions of resident doctors in Catalonia.
- Learn about the most common psychosocial stressors they have to endure during that learning period.
- Learn about preventative interventions and training courses based on this data to raise awareness of the importance of selfcaring for a good practice and help them to prevent becoming unwell.

39.

A Prototype of the Surgical Hazardous Attitudes Reflection Profile (SHARP) Instrument

Presenting authors: Dr. **Kirsten Dabekaussen**, dr. **Renée A. Scheepers**, prof. dr. **Kiki Lombarts** – all Netherlands

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Aim(s) and Introduction: There is growing recognition that surgeon's non-technical behaviours are crucial in guaranteeing optimal quality and safety of patient care. However, insight in relevant attitudes underlying these behaviours is lacking. Hazardous attitudes potentially cause risk behaviour, which can result in medical errors, adverse events and unsafe work conditions. A questionnaire offering surgeons insight in their attitudinal profile is still missing and would be instrumental in risk reduction. Therefore, the aim of this study is to develop a prototype of a questionnaire instrument to measure hazardous attitudes among surgeons.

Methods: To design the Surgical Hazardous Attitudes Reflection Profile (SHARP) tool a mixed methods approach was used, consisting of (1) two focus group discussions, (2) a modified Delphi analysis and (3) a survey followed by (4) statistically investigating the psychometric properties of the tool. The SHARP was pilot-tested by inviting 558 surgeons in 14 hospitals in the Netherlands to complete the questionnaire. Statistical strategies included exploratory factor analysis with varimax rotation, calculation of internal consistency reliability coefficients and inter-scale correlations.

Results Nineteen experts participated in the focus groups, and 19 in the modified Delphi study. In total, 302 surgeons (54,1%) completed the questionnaire. Exploratory factor analysis resulted in six subscales measuring attitude towards authority ($\alpha=0,78$), own performance ($\alpha=0,69$), performance feedback ($\alpha=0,61$), own abilities ($\alpha=0,54$), uncertainty ($\alpha=0,51$), and preparing planned procedures ($\alpha=0,48$).

Conclusions This study provides a prototype instrument on six potential hazardous attitudes in surgeons, of which attitude towards "authority" and "own performance" can now validly and reliably be measured. Further research is required to

optimise this prototype version of the questionnaire, and could usefully explore the plausible relations between hazardous attitudes and clinical outcomes.

Learning objectives:

- Gain insight in relevant potential hazardous attitudes in surgeons
- Learn how to develop a prototype of a new instrument
- Learn how attitudes are associated to risk behaviour of surgeons, as a new and crucial approach in further improving patient safety outcomes

40.

Work-Related Stress (WRS) and physician: scientific literature review and critical analysis of results

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Introduction / Aim: Work-related stress (WRS) is a complex phenomenon that develops when multiple psycho-social risk factors coexist and interact. These factors include work content, work organization, technological and environmental conditions, as well as employees' skills, resources and needs. The stress response is associated with a series of physical and psychic outcomes, and given its strong impact on the wellbeing of workers. The purpose of this study is to evaluate WRS in physicians, category significantly exposed to psycho-social risk.

Method and Results: This research was carried out with systematic review is coherent with the PRISMA statement and was based on the following keywords: work-related stress, stress-related disorders, psychosocial risk, risk assessment, occupational medicine, job stress assessment, test, questionnaire, evaluation, instrument, measurement. We only included the studies regarding physicians. Data have been collected from the studies published from 1992 to 2017. Online research indicated 11.029 references: PubMed (7.089), Scopus (3.881) e Cochrane Library (59). 8.911 articles were excluded because they were not related to WRS. Among the 1.990 studies left, 351 were excluded because they were duplicates. Subsequently, the remaining articles were read in full and, as a result, 1.161 papers were excluded because did not satisfy the inclusion criteria mentioned above. The final number of articles included was 20: 14 cross-sectional, 4 systematic reviews, 1 cohort study and 1 case control.

Discussion and Conclusions: This research showed that the WRS among physician is very widespread, as they are exposed to several risk factors (dealing with sick patients and their patients, having intense workload, numerous duties and responsibilities). To date there are few studies (20) on physician and WRS and this indicates that more attention for this category of workers is needed.

Learning objectives:

- Will know stressor who are exposed physicians
- Will know the work related stress assessment used in research for the evaluation of psychosocial risk in the workplace where doctors work

41.

Development and pilot of a well-being program for hospital-based physicians

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Co-authors: Kiki Lombarts, Nathalie Hugenholtz, Renée A. Scheepers – all Netherlands

Introduction: Physicians' well-being is under pressure, harming patients, the physician workforce and healthcare systems. Although most interventions target individual physicians, well-being related problems are primarily caused by factors in the work environment. Hospitals can use well-being programs to create positive work environments, subsequently improving physicians' well-being. Today, knowledge on the development and usage of well-being programs for physicians is scarce. We (1) report on the development and piloting of a well-being program for physicians in the Netherlands and (2) evaluate the pilot using different stakeholders' experiences.

Method: From October to August 2017, the authors developed and pilot-tested a national well-being program for hospital-based physicians to monitor, maintain or enhance their well-being. The program was developed in three consecutive steps: 1) brief literature review 2) needs assessment and 3) design. The programs' development and design was based on the theoretical background of the JD-R model. Next, the program was piloted amongst faculty and residents across the Netherlands.

Results: The well-being program consisted of assessing individual physicians' well-being, feeding back well-being levels including specific recommendations for improving well-being, facilitated group discussions and team training job crafting. In total, 375 physicians from multiple Dutch hospitals participated in the pilot. Physicians' experienced the well-being program as feasible and applicable in the medical work environment. According to project team members and physicians the JD-R model was understandable and usable to analyse well-being in relation to the work environment.

Conclusions: Based on the pilot, our program and its development method, seem to provide a flexible system to monitor, maintain and potentially enhance physicians' well-being. The program offers an approach by which the work-life of both burned-out and engaged physicians can be addressed. Dutch physicians can now use the program to monitor and work on improving physicians' well-being. Also, our findings can inform the development of well-being programs (inter)nationally.

Learning objectives:

- Obtain insight in developing and designing a well-being program for physicians in various work environments, including (some) needs assessment results.
- Obtain insight in physicians and project team members' pilot experiences?
- Discuss best practices and possibilities for broader implementation of well-being interventions/programs for physicians?

43.

In our Own Words; UK doctors talking about our own mental health

Presenting authors: Dr. **Louise Freeman**, MB, ChB, FRCM and Dr. **Angelika Luehrs**, MD, MRCPsych, UK

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Background: There is no doubt about the need for doctors to look after ourselves in order to be able to provide the best possible patient care. This can be particularly challenging in the case of mental illness. The Doctors' Support Network (DSN) - a confidential peer support network for UK based medics - aims to raise awareness and reduce the stigma of mental ill health in medics. Preserving DSN members' anonymity has been a priority due to the stigma of mental ill health:

- 1996 founding of DSN - 'I think you'll find that you're the only ones!'
- DSN Support Forum - an anonymous, confidential, online, members only forum
- 2014 DSN stigma survey - felt and enacted stigma is still a major problem

The culture has started to change and DSN members, as well as other doctors, have felt able to step forward and talk about their mental health. DSN has been active in Talking to the medical profession and the general public:

- 2017 onwards #AndMe - our innovative, cross professional, anti-stigma campaign with the Royal College of Veterinary Surgeons' Mind Matters Initiative.
- 2017 World Psychiatry Association Congress in Berlin - symposium
- 2018 DSN and general media - what we've learnt so far: BBC Victoria Derbyshire programme 'Tipping Point' film, BBC Radio Five Live - discussion about the Australian Prof. Steve Robson article and mental ill health in doctors.

We will discuss the benefits of speaking out about our own mental health including 'owning' our information by telling our own stories as well as the potential risks to doctors from speaking out.

Not the only ones! Overall, DSN believes that we can change attitudes to physician health inside and outside the medical profession by supporting each other while safely demonstrating that many medics undertake successful careers despite experiencing mental ill health.

Learning objectives:

- Increase their understanding of the effect of stigma on doctors with mental ill health
- Learn about how responsible peer support can improve doctors' well-being
- Increase their awareness about the advantages and disadvantages of openness about doctors' mental ill health

46.

Invisible pain - a doctors' journey through the many facets of health

Presenting author: Dr. **Catriona Herron**, Ireland

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Introduction:

This paper describes my personal journey after sustaining a physical injury in the on call accommodation when I was on night duty. It will outline the difficulties in getting an appropriate diagnosis and treatment; the terminal diagnosis of chronic pain; rehabilitation, and being stuck and lost in the system as the patient that nobody wanted.

Method and results: not applicable

Discussion and conclusions: I will discuss the consequences that not getting an appropriate initial diagnosis and treatment had on every aspect of my life. This included financial stress: having to confront and consider bankruptcy and the trauma and humiliation of going through the benefit system. I also document issues around sick leave, and the difficulties of trying to return to work when I was ready but the workplace wasn't ready for me due to miscommunication, systemic failure and inappropriate adjustments being in place. The difficulties of being a doctor in the system with a chronic debilitating injury, my understanding of resilience and my experience of the support I received on this journey will also be explored. The important role kindness, compassion and hope played in my journey to recovery will also be emphasised.

Learning objectives:

- Awareness of the unique challenges faced by doctors who become ill
- Defining resilience
- The importance of kindness, compassion and hope whilst protocols and procedures are developed in the area of doctors support.

47.

"A tale of doctor's empathy and waiting rooms" – Quantitative research in a Paris district

Presenting author: Dr. **Patricia Pame**, GP / **Jean-Mark Josset**, Socio-economist, France

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Aims(s) and Introduction: General medicine is characterized by the length of the relationship between the practitioner and his patients. It is common to say that a doctor ends up having patients "*in his likeness*". We wanted to question the frame of this relationship by a cross-examination between doctors and patients. Beyond the strict medical diagnosis, what do patients expect from their doctor: is it empathy? Availability? Limited waiting time in the waiting room?

Methods: In order to allow a confrontation between practitioners and patients points of views, we restricted our field to a district of Paris (XIIème arrondissement) and obtained 324 patients' surveys and 14 surveys of doctors practicing in the same district, on which we did multiple descriptive and econometric statistical analysis.

Results: We noted significant differences between the doctors surveyed and the patients on the importance given to : the experience of the practitioners, his empathy, listening skills and respect of schedules. We tested multiple explanatory factors of this difference: age, gender, state of health of the patients, but also the length of the relation and the proximity between patients and doctor. One significant results of this study is that knowledge of elements of the doctor's private life (age, children, marital status, hobbies and place of residence ...) is correlated to a lesser difference between patients and doctor points of views. We also noted a major difference between doctors' perspectives, based on the length of their professional life.

Conclusions: Due to the voluntary limited scope of this study, the results can only be seen as restricted and particular, to be confronted with other surveys or references. We founded that doctors generally values more listening and empathy while their patients favor availability and limited waiting time, and that this difference vary with the age/generation of both patients and doctors but also with the 'proximity' of the couple doctor/patient. The former confirms other studies about generational evolution of medical care and the latter goes against the common saying that in order to protect oneself, the physician must separate his professional and private sphere.

48.

Wrestling with the medical self – Highlighting key factors in medical education towards enablement in doctors health

Presenting author: Dr. **Margaret Kay**, Australia

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Co-author: Vicky Dawes, Australia

Introduction / Aim: Medical education focuses on attaining excellence in health care delivery. The delivery of quality care requires physicians to maintain their wellbeing. Current understandings in doctors' health recognise that the medical culture can contribute to the difficulties experienced by doctors seeking health care for themselves. This presentation aims to understand the acculturative process and the emergence of the medical identity to inform educational strategies that better address doctors' health training for medical students and physicians.

Method: A narrative review of over 250 peer-reviewed self-authored narratives of physicians reporting their illness experience, with a focus on how the medical self is articulated, identified key themes. These findings were used to further interrogate the doctors' health literature and map the intersect between the medical identity, doctors' health and current approaches to medical education about doctors' health.

Results: When publishing their narratives, physicians often articulate their intent to educate their medical colleagues about issues of doctors' health. These narratives describe how the medical culture influences self-care, help-seeking behaviours, the treating-doctor's response, the medical care received and the stigma of illness. Distillation of these five key themes highlighted the complexity of the medical self. While the cultural imprint on the expression of the medical identity is clearly evident, the medical self embodies much more: intelligence, curiosity, independence and empathy. This study highlights the dissonance between this reality and the current simplistic representations of the doctor-patient as the sad, mad or bad physician helplessly constrained by cultural expectations. Current doctors' health education appears strongly influenced by these simplistic representations.

Conclusions: Medical education inevitably involves cultural immersion. Understanding the formation of the medical identity, in its complexity, offers an opportunity for medical educators to empower physicians to better address their health – manage their work-life balance and proactively contribute to a positive organisational approach to physician health.

Learning objectives:

- Better understand how the formation of the 'medical self' impacts on doctors' personal help- seeking behaviours.
- Improve their capacity to educate doctors and medical students about their wellbeing and coping with work-life balance.

- Develop better strategies for educating doctors and medical students about their help-seeking behaviours, which are intimately related to the quality of care they deliver to patients.

49.

Strengthening wellbeing in medical education; What works? Consequences, intentional and unintentional

Presenting author: Dr. **Thomas Kitchen**, UK

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Co-authors: Debbie Cohen, Sarah Rees, Nitin Bhalla, John Green – all UK

Introduction and Aim: The General Medical Council (UK) has published guidance for undergraduate and postgraduate education about teaching wellbeing, but can it be taught? Internationally there is a diverse approach to wellbeing or wellness in curriculae. Some have wellness as a competency based training requirement. This brings questions about ‘tick boxes’ and a ‘pass or fail’ approach to wellbeing. In contrast at Cardiff University, School of Medicine an evidence-based approach to teaching wellbeing that supports the development of positive organisational cultures has led to a new taught programme called, *‘Being a doctor and staying a person’*. The role of emotion, personal and professional values, positivity and vulnerability are explored through facilitated workshops.

Method and Results: Interactive two-hour workshops before and after an 8-week placement explore values, positive emotions and emotional intelligence. Between the workshops students undertake individual observation and ‘Reflection-in-Action’ tasks transforming the workplace into a continual learning environment. These reflections bring high face validity, supporting emotional awareness through individual learning and its effect on self and peers. The programme has been delivered to 1500 year-3 students over 3.5 years. The programme utilizes feedback to evaluate impact. Feedback has been analysed using deductive thematic analysis. Strong themes have emerged, demonstrating how participants are using the learning to improve their understanding, recognition and normalisation of emotion within the workplace. Students noted the impact on the quality of interactions with patients and colleagues. The paper will provide details of the analysis along with the 3 most important things participants took from the workshops.

Conclusions: The training has shown that it is possible to facilitate learning about wellness, strengthen emotion and self-efficacy, bringing awareness to the complex nature of working in healthcare outside of the context of professionalism or resilience training. The programme is being rolled-out to postgraduate, foundation doctors in 2019.

Learning objectives:

- Understand how using principles of emotional intelligence can be used to build a sustainable training programme for medical students
- Explore medical students perceptions of personal values, positivity and vulnerability and how this strengthens their insight into emotions
- Understand how using in-action and on-action reflection in a group setting can aid individuals to begin to build strategies to ‘keeping safe’ whilst practising medicine

50.

Self-health promotion and prevention by general practitioner: comparisons with general population

Presenting author: Dr./Prof. **Anne-Laure Lenoir**, Belgium

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Co-author: Charlotte Legrand, France

Introduction/Aim: The aim of this research was to compare the GPs and the general population for behavior in health promotion, prevention and seeing a GP.

Method and results: All GPs from one district of French-speaking Belgium were asked to complete a 29-item questionnaire including questions about nutrition and sports habits, prevention acts and taking care of their own health. This questionnaire was based on the Health Survey of the Belgian Institute of Public Health. The first part of the analysis described the respondents’ answers. The second part compared the GPs’ results with the general population. 113 GPs participated in the study (response rate was 72.4%). Most GPs followed the recommendations about vaccination, cardiovascular and cancer screening, as well as alcohol and tobacco consumption. In contrast, most GPs did not follow the recommendations about nutrition. 51.0% of GPs had insufficient physical activity as compared to recommendations. Compared to the general population, GPs scored better concerning vaccination, cardiovascular and cancer screening, alcohol and tobacco consumption. In contrast, they had a lower score concerning intensive physical activity. No significant difference was found about nutrition (except a lower consumption of dairy products). 31.0% of GPs had their own GP, compared to 94.0% of the general population. When feeling ill, most GPs used self-care and 4.4% did not treat themselves at all. 90.3% of GPs used self-prescription. Having a GP reduced significantly self-prescription and increased GP visits.

Discussion and conclusions: This study showed that GPs care about prevention acts, but less about nutrition and sports habits. Seeing one’s own GP was unusual among GPs. This could lead to self-neglect and ignorance of early warning signs that they would otherwise address if one of their patients was concerned. Promoting GPs self-health and encouraging them to seeing their own GP could improve their health condition.

Learning objectives:

- Know that GPs pay more attention to prevention acts than nutrition and sports habits.

- Know that most GPs treated themselves and 4.4% didn't treat at all.
- Know that having a GP reduces self-prescription and increases GP visits.

52.

Complex cases shared management from therapeutic and regulatory perspective. 20 year experience of shared responsibility

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Aims(s) and Introduction: Complex cases always rise dilemmas on how to proceed. The right balance between populations' safety and rehabilitation of sick physicians is not easy to achieve. Our aim is to prove that regulatory perspective combined with clinical approach are complementary and not a burden.

Methods: We've included all cases that under clinical or Councils' perspective in Catalonia in the last 20 years which had an objective risk out of nearly 3000 sick physicians treated by the therapeutic team (lack of awareness, non-adherence to treatment, follow up or drug tests control, drug abuse in clinical settings, being referred to the council by patients or colleagues...). We analyzed the cases to assess what actions were taken, how many were able to keep on working, the need of admission at our clinic, time out of practice because of sick leaves or disciplinary measures. Informed consent was signed by all physicians that if their clinician suspects they will not be fit enough to practice they would be reported to the council.

Results: We found that less than 5% of all medical population who entered the programme were considered complex cases. 121 over 20 years had underwent Therapeutic contract, 11 went through disciplinary measures. 71 managed to continue their medical carrier with no need of any disciplinary measure despite having informed the Medical Council. Over 150 physicians, too sick to be rehabilitated were led to permanent sick leaves and not through any disciplinary measure.

Discussion and conclusions: The fact of having a Caring program based in the medical council, complex cases that were reported from clinicians were able to continue with their practice after getting the right treatment and supervision from the council. Clinical decision making behind Councils regulatory role ensure both patients safety and rehabilitations for sick doctors with excellent results.

Learning objectives:

Learn that offering a caring programme as a regulatory body can be perceived as a threat by doctors and balancing the trust of doctors with the Council's duty to self-regulate when needed through disciplinary measures is the tricky part. But once the programme has overcome this, it becomes advantageous especially when it comes to difficult and complex cases. The therapists' clinical decisions help to guide regulatory decisions in the best interest of both patients and physicians and the goal of rehabilitation, protecting doctors' dignity and as a service to society.

53.

How do clinical leaders think about leadership?

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Co-authors: Katerina Georganta, Efharis Panagopoulou – Greece

Introduction / Aim: There is an expectation that physicians will be leaders within healthcare. This belief is demonstrated by the plethora of leadership competency frameworks and the fact that medical schools are attempting to integrate such competencies into medical education curricula. However, there is relatively little research on how medical leaders conceive of and interpret leadership. The beliefs that healthcare leaders hold about their role as a leader influences their actions towards issues such as staff well-being and patient safety

Method and Results: The research involved in-depth interviews with a non-random sample of clinical leaders (n=8) from Northern Greece. The participants were prompted using open-questions and prompts to discuss their conceptions of leadership and how their role as a leader influenced their interactions with colleagues and patients. The texts of the interviews were transcribed and analysed using thematic analysis.

Discussion and Conclusions: The analyzed interviews revealed interesting contradictions between how the respondents thought about leadership and how they practiced leadership. The results of the interviews are contrasted against the prevailing theories of leadership in the literature.

Learning objectives:

- Be aware of the main factors influencing the concept of leadership in a medical setting
- Be able to contrast competency based approaches to leadership development with the main leadership theories in the management literature.
- Be able to appreciate the way that the importance of beliefs as an influence on behaviours.

55.

Autistic Doctors – Not an Oxymoron

Presenting author: Dr. **Shirley Moore** B.Eng(Hons), MSc. MBChB. MRCA, UK

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Introduction: Autistic doctors have always been an important part of the medical workforce. It is only with the changes to working practices and environments that they are now being identified as such. Many autistic traits are highly valued in medicine:

- attention to detail
- memory for facts
- honesty, integrity
- passion, endurance
- good work ethic

Highly intelligent autistic adults are often able to mask the more challenging aspects of autism spectrum conditions (ASCs). The number of doctors/students with a formal ASC diagnosis is increasing, as is the number self-identifying as “on the spectrum”.

Theory: One of the reasons behind this, we believe, is changing medical practice. Modern medicine demands far more flexibility, multitasking, communication and social interaction than ever before. Shift working and cross-specialty cover has replaced the structure and support of the traditional “firm”. Rota gaps mean changes to routines, often without warning. Open plan offices are a sensory nightmare. Combining these factors with the effort it takes for someone on the spectrum to mask their less accepted traits (social awkwardness, performance anxiety, stimming) leads to fatigue and social exhaustion. If they have other responsibilities e.g. exam preparation or family commitments, and external demands exceed their internal coping mechanisms, they may become overwhelmed. This can catastrophically end in “autistic burnout”.

What to look out for in struggling doctors that might suggest an underlying ASC: We will give some real-life examples of difficulties experienced by autistic doctors and students and what might alert you to the possibility of an underlying ASC in a “doctor in difficulty”.

Supporting doctors “on the spectrum”: We will discuss some of the advantages and disadvantages of a formal diagnosis and being “out” as autistic. We will discuss reasonable adjustments and how to support autistic doctors and students to be valued and productive members of the medical workforce.

Learning objectives:

- Learn about the presentation of autism in doctors and medical students
- Learn how to support doctors and medical students with autism spectrum conditions to be valued and productive members of the medical workforce
- Be signposted to further information on neurodiversity and support networks

56.

Organization of work and physicians’ health. Boarding methodology in a public hospital in Argentina

Presenting author: Prof. **Hector Alberto Nieto**, Argentina

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Co-authors: Jesica Paula Molinari, Silvana Mara Amadore, Verónica Laura Lahourcade, Fabiana Balladore, Argentina and Simone De Sio, Italy

Introduction / Aim: The interactions between content, organization, work management and environmental conditions on one hand, and the functions and needs of workers on the other hand, can have a harmful influence on the health of doctors and on the quality of services .

Health and safety at work services must include the approach of psychosocial risks to avoid such negative influence.

The present work proposes to describe the experience of approach of the health care of the doctors in front of the suffering derived from the organization of work through an intervention device developed and implemented by the Health and Safety at Work Department (DSyST), Hospital Piñero , Buenos Aires, Argentina

Method and results: It begins with the identification of problems arising from the organization of work in the health of physicians or from workers that attend to the DSyST.

Then, a participatory group intervention, of preventive, diagnostic and therapeutic nature, is deployed with the workshop methodology. It is applied in service and consists of six group meetings. In them common objectives and work plan are established collectively. Validated instruments for collecting objective data are used for psychosocial risks. We work collectively on the organization and content of work, representations and expectations, stimulating the empathic capacity of the participants to co-construct proposals to identify processes, contents, workload and risks and prevent damage.

The coordination of the workshop is in charge of trained specialists in Work Psychology and Occupational Medicine.

In each encounter, conclusions are obtained that are finally consolidated by the specialized team and returned to the group for analysis and implementation.

In this way, risks associated with the organization of work, its impact on the quality of working life, the health of doctors and the quality of services are identified and managed.

Discussion and conclusions: The device presented is an ideal instrument for collective approach. It is specific to intervene in problems arising from work organization, with the characteristic of being implemented in the workplace of doctors and by occupational health specialists who belong to the same institution.

Learning objectives:

- Identify the risks to the health of physicians related to the organization of work
- Recognize a device to promote and protect the physicians health
- Improve the quality of service improving the physicians health

57.

Out of hours workload among Norwegian GPs

Presenting author: **Ingrid Keilegavlen Rebnord**, Norway

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Aims(s) and Introduction: In recent years there has been an outcry of dissatisfaction among Norwegian regular general practitioners (RGPs), based on experiences of significant increased workload. Heavy workload seems to affect recruitment and retention of RGPs. A 2018 study from the Norwegian Directorate of Health showed that Norwegian RGPs work in mean 55,6 hours weekly. Based on data from the recent national wide study the present study investigates Norwegian RGPs work out-of-hours (OOH) and to which extent the OOH work affects the regular work as RGP.

Methods: In early 2018, an electronic survey was sent to all 4716 RGPs in Norway. In addition to demographic background, the RGP reported minutes per day used on various tasks in the RGP practice prospectively during one week. Working time also included additional tasks in the municipality, other professional work and on out-of-hours primary health care. Differences were analysed by independent t-tests, and regression analyses.

Results: Among 1876 RGPs (39.8%), 640 (34.1%) had registered OOH work. Male RGPs worked in average 1.5 hours more than female with regular work ($p=0.001$) and in average 2.3 hours more OOH work than female ($p=0.079$). RGPs with no OOH work had in average 1.0 hour more with regular work than RGPs also working OOH ($p=0.043$). There was a great variation in OOH working hours. A linear regression analysis showed that male GPs in rural areas work more hours OOH.

Conclusions: Every third RGP in Norway also work OOH. OOH work is performed in addition to high regular workload as RGP with small gender differences and with minimal reduction in regular work. Male RGPs and RGPs from rural areas have the highest workload of OOH work.

Learning objectives:

- By attending this session participant will learn more about Norwegian regular general practitioners working time spent on out-of-hours work.
- By attending this session participant will learn more about how demographic factors affects Norwegian regular general practitioners working time and workload.

60.

A Systematic Review of the Impact of Mindfulness-Based Interventions on Physicians' Well-being and Performance

Presenting authors: **Renée A. Scheepers**, M.Sc., PhD / prof. dr. **Kiki Lombarts**, Netherlands

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Aims & Introduction: Worldwide, stressful working conditions in modern medical practice put physician well-being at risk. Research suggests that physician well-being – in terms of stress and burnout – improved following mindfulness-based interventions (MBI). MBI are furthermore considered to facilitate physicians' performance in patient care, such as increased empathy towards patients. However, research has not yet systematically reviewed evidence on the effects of MBI on physicians' performance, or on their well-being. This systematic review investigated the impact of MBI on physicians' well-being and performance in medical practice.

Methods: The authors searched PubMed and PsycINFO from inception until 9 May 2018 and independently reviewed studies investigating effects of MBI on physician well-being or performance. The authors systematically extracted data of eligible studies and assessed study quality by the Medical Education Research Study Quality Instrument (MERSQI).

Results: The review process resulted in 23 studies, including (non-)randomized controlled trials or pre-post studies of average quality. MBI showed mostly positive effects on psychological (twelve out of fifteen studies) and occupational well-being (eleven out of sixteen studies). Physicians' performance was positively affected on interpersonal indicators (i.e. empathy and patient-centeredness) in five out of seven studies. One out of three studies showed positive effects of MBI on indicators of technical performance (i.e. hand hygiene adherence).

Conclusions: The findings of this systematic review indicate that physicians' psychological and occupational well-being could benefit from MBI. In addition, MBI might facilitate physicians in delivering empathic and patient-centered care. Hospitals could consider including MBI in organizational resources to support physician well-being and professional development.

Learning objectives:

- Learn how mindfulness-based interventions affect physician well-being
- Learn how mindfulness-based interventions affect physicians' performance
- Learn next steps in research on mindfulness-based interventions in medical practice

61.**Health care utilisation of general practitioners – a qualitative study**Presenting author: Dr. **Sven Schulz**, Germany

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Introduction/Aim: International studies revealed several barriers for health care utilisation of physicians in case of own illness. This topic is of peculiar relevance for general practitioners since they mostly work in single handed practices and the care of their patients is also at risk. Studies to the health care utilization of general practitioners in Germany are lacking. The aim of our study was to identify beneficial and obstructive factors for health care utilization in case of own illness.

Methods: After developing an interview guideline we conducted and recorded 16 open guided interviews with a convenience sample of general practitioners between December 2014 and March 2015. Interviews took 65 min on average. Main subject of the interview was the description of own illness experiences from the first symptoms to health care utilisation and the further progress. The material was literally transcribed and analysed according to a qualitative content analysis approach. We developed a code-system with an inductive-deductive method. A deeper analysis is in progress with the code-theory-model using the software MaxQDA. By means of a questionnaire sociodemographic data of the participants were compiled.

Results: We will present sociodemographic data of the sample and the developed code system. In our qualitative content analysis we found 16 thematic main categories. Focusing on the category "health care utilization" we found beneficial and obstructive factors of other categories like "professional knowledge" or "imprinting" which may have impact on health care utilization.

Conclusions: Previous results show a wide range of mostly obstructive factors for health care utilisation of general practitioners. Many of these factors were also found in our study. Additionally beneficial factors were revealed. Hypotheses for further research will be generated. In a long perspective, our findings may help to provide adequate access to the health care system for general practitioners in cases of own illness.

Learning objectives:

- Learn considerations to health care utilization of German general physicians
- Discuss beneficial and obstructive factors influencing health care utilization of physicians

63.**A Qualitative Study on the Surgeon Experience During the Treatment of Prosthetic Joint Infections**Presenting author: **Karin Svensson**, Sweden

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Introduction / Aim:

The impact of prosthetic joint infection (PJI) has been studied in patients and they report on a high emotional distress and physical suffering. Attempts have been made to aid surgeons in diagnostic algorithms and treatment guidelines but there is no consensus in the use of these. Given the uncertainties when working with PJI and its negative impact on patients the management of these cases can prove challenging. Physicians report high emotional impact when complications arise and may have an increased risk for negative mental health. The highest frequency of adverse events occur within surgical specialities and current support systems may be insufficient. The aim of this study is to investigate the emotional impact on orthopaedic surgeons and what support needs they may have.

Method and Results: This is a qualitative study based on in-depth semi-structured interviews conducted in Sweden using purposive sampling to include 18 prosthetic joint surgeons. The data has been analysed using the framework method.

All interviewees had encountered difficulties in the management of PJI. Many experienced the feeling of guilt and regarded PJI as a personal failure. Some ruminated on cases but not to the extent that it had a severe negative impact on their personal life. All participants desired the possibility to discuss cases with their colleagues or receive structured support to cope. Those who had good peer support and a well-functioning cooperation with colleagues in the infectious diseases department found it easier to manage PJI cases.

Discussion and Conclusions: Our results seem to be coherent with the experiences and needs of physicians in previous studies. The possibility of peer support is brought forward as the most important coping strategy and should perhaps, in a structured form, be offered for orthopaedic surgeons dealing with adverse events.

Learning objectives:

- Gain a better understanding for how orthopaedic surgeons experience and view the management of difficulties linked to treating patients with PJI.
- Learn about how orthopaedic surgeons cope with the difficulties in treating patients with PJI.
- Learn about organisational improvements that may facilitate the orthopaedic surgeons' every-day when managing patients with PJI.

66.

Supporting Junior Doctor Wellbeing

Presenting author: Dr. Jaimee Wylam, UK

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Introduction / Aim: Teaching resilience is a relatively new concept in medical education which is receiving growing attention amid concern regarding doctors' health and wellbeing. A definition of personal resilience is not universally agreed but it can be viewed as an emotional competence which can be acquired and improved. This project aimed to explore the current experience of foundation doctors (FDs) in Yorkshire and Humber (Y&H) and evaluate an educational intervention designed to promote personal wellbeing.

Method and Results: An educational workshop was designed incorporating themes of resilience, mistakes, challenges, wellbeing and reflection. Workshops were delivered at hospitals across Y&H by a near peer (lead author). Quantitative and qualitative data was collected using a feedback questionnaire. 100 FDs attended one of five education sessions. 83 rated the session helpful for their wellbeing, 15 were neutral and 2 did not find the session helpful. 80 rated the session helpful for their resilience, 18 were neutral and 2 did not find the session helpful. 83 stated that they would recommend the session to a colleague, 16 were unsure, and 1 would not recommend the session. Free text comments drew out positive and negative responses from respondents. When asked what was good about the session, one participant stated "interactive.... made me think regarding resilience and positive things in my life". Another said "Realising everyone is in the same boat and gets stressed by the same things.... a good mix of discussion and interaction".

Discussion and Conclusions: The results support the potential benefit of near peer delivered educational workshops focused on resilience and wellbeing. Resilience and wellbeing are important, and workshops are a simple, economically viable and replicable intervention which is valued by FDs. The Foundation School Y&H will be incorporating these workshops into the mandatory training programme.

Learning objectives:

- Consider what role well-being education could play in their local area
- Be given an insight into the exercises used in a well-being education session
- Learn about the positive work carried out in Yorkshire and Humber

67.

Politicians wish for greater patient empowerment – how physicians respond?

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Introduction and aims: Several causes seem to lead to physician dissatisfaction and physician burnout. Could the changes in the patient-physician relationship due to greater patient empowerment also be a cause of physician dissatisfaction? Especially in the current Norwegian political goal of transforming healthcare into «the patients healthcare»?

The aim of this exploratory study was to investigate attitudes of Norwegian hospital physicians towards these political goals.

Method: 10 semi-structured interviews, all with physicians working in a Norwegian hospital. They work in different somatic specialities. They had 8 to +40 yrs experience as physicians. We structured the findings into three main domains for qualitative analysis.

Results:

- 1) the physicians understanding of «the patients healthcare»,
- 2) how patient empowerment had changed during their career
- 3) their experience of being governed in general.

The study revealed that the political message meant little to nothing for the physicians. Several knew nothing of the specific political goal, and considered decisions by politicians as too remote to matter in their work. In general they wished greater patient empowerment welcome. The limit seemed to be if this empowerment in any way touched their «professional core», as indication for surgery or triage of patients. Whether «the patients healthcare» would only reach the most resourceful patients was a huge concern amongst the physicians.

Conclusion: The study indicates that the more empowered patients the physicians meet, the more positive they seem to be towards patient empowerment. Thus, to turn political goals to reality, it seems to be more efficient to change the patients' attitudes and expectations than trying to change the physicians.

The physicians own prescription for improvement was more time together with each patient.

71.

Factors associated with intention to leave medical school among Norwegian medical students

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Introduction and Aim: There is little knowledge about the relationship between factors in the curricula and study environment with medical students' consideration of leaving medical school. Intention to leave medical study can be a sign of study stress and discomfort that can reduce the learning outcome, competence and growth among future physicians. The aim of the study was to investigate the prevalence of medical students' intention to leave and factors within the study environment and medical curricula associated with this intention.

Methods: Baseline survey data among all medical students (N=1634) at two Norwegian universities; one with a traditional curriculum (N=926) and one with an integrated curriculum (N=708). The web-based questionnaire included the outcome variable intention to leave (ITL) and study model variables of Perceived Medical School Stress (PMSS), study climate, social support, perceived exam anxiety and self-reported reasons. The associations were analysed with logistic regression analysis.

Results: Total response rate was 64%. About one third of the students had considered leaving medical school. In the traditional curriculum, students in the final years were more likely to report ITL ($p < .001$). In a regression model ITL was associated with low PMSS Climate ($p < .001$), low PMSS Competence (OR= 2.4, $p < .001$), low PMSS Resources (OR= .9, $p = .034$), lack of social support from peers ($p = .002$), <21 years at admission ($p = .020$), attending the last study years ($p = .001$), and having a partner ($p = .026$).

Conclusion: The prevalence of ITL was relatively high, and most associated with study stress and lack of social support from peers. The faculties should implement study models that reduce study stress and promotes social interaction between students.

Learning objectives:

- Learn more about Norwegian medical students' intention to leave medical education.
- Reflect about how different study designs affects students' experience with medical education.
- Discuss how intention to leave medical education may affect the students future work life as a physician.

72.

Facing emotionally challenging interactions with patients: emotion transfer and its association with well-being in health-care providers

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Introduction: Caring can be rewarding. However, interacting with difficult, suffering, or dying patients may come with costs for the provider. Without adequate emotion regulation, compassionate care can result in compassion fatigue or burnout. Among health care providers, there is a high prevalence of stress-related conditions which do not only impair provider well-being but also quality of care. However, it remains largely unclear how health professionals can regulate emotions to sustain their own well-being.

Methods: We recently developed a model depicting emotion transfer and emotion regulation in provider-patient interactions and their relationship to well-being. To validate this model, we used a mixed methods design comprising qualitative interviews and quantitative questionnaires administered to 79 health care providers (45 physicians, 17 nurses, 17 psychologists).

Results: Results confirmed the validity of our model and revealed that emotion transfer (depending on the type and directedness of emotions), as well as emotion regulation abilities, efficiency, and success were linked to well-being and resilience.

Conclusions: Our model can offer a promising basis for theory-driven research in this area. Prospective studies are under preparation, which aim at informing interventions that enable health care professionals to provide compassionate care without high costs for their own health.

Learning objectives

- Learn how emotions can be transferred from the patient to the provider according to our model.
- Learn about characteristics of the provider's emotional state and emotion regulation that were associated with provider well-being.
- Learn about our new studies under preparation (in an international collaboration between Zurich, Oxford, and Oslo), which aim at informing interventions to foster provider well-being.

75.

Long-term mental health effects of mindfulness training: A 4-year follow-up of an RCT in medical and psychology students

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Aims and introduction: Both individual and organizational interventions are needed to enhance well-being, counteract burnout and ensure performance in young health professionals. Mindfulness-Based Stress Reduction (MBSR) enhances

short-term psychological health, whereas studies examining long-term effects and possible psychological mechanisms are scarce. We aim to study both direct long-term effects on psychological health and possible psychological mechanisms

Methods: In a two-site randomized controlled trial, 288 medical and psychology students were allocated to a 7-week MBSR intervention (n = 144) or a control group (n = 144). During follow-up the MBSR group was offered 90-min booster sessions semi-annually. Primary outcome measures included mental distress (GHQ-12) and subjective well-being (4 items) at baseline and 1 month, 2 years, and 4 years post-intervention. Secondary outcomes included coping (Ways of coping checklist), mindfulness (Five Facet Mindfulness Questionnaire), and meditation practice. Effects were studied by mixed-model repeated measures. Mediation effects of secondary outcomes were also studied.

Results: Drop-out rates after baseline were 3%, 19%, 32% respectively. At 4-year follow up, MBSR significantly reduced mental distress and avoidance coping, and it enhanced mindfulness and problem-focused coping (Cohen's d = 0.23-0.42). Meditation practice predicted long-term mindfulness scores. Short-term effects in mindfulness-scores and problem-focused coping mediated long-term intervention effects on mental distress. Small post-intervention effects on subjective well-being and seeking social support did not persist at follow-up.

Conclusions: MBSR fostered enduring long-term effects on mental distress, active coping and mindfulness in this non-clinical sample of medical and psychology students. The secondary outcomes coping and mindfulness may be important psychological mechanisms of mindfulness training. The intervention effect-sizes were small to almost medium in this long follow-up.

Learning objectives:

- Know about the long-term effects of mindfulness-training in medical students and young doctors
- Learn about factors that may represent possible psychological mechanisms of effects in mindfulness-training
- Describe the importance of longitudinal follow-up studies and mixed model repeated measures to measure effects in such studies

76.

Increase of mental distress among female medical students in a 20-year span: findings from two Norwegian faculties

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Aims and introduction: Reports show an increase of mental distress among young adults in Norway during the last two decades. This study investigates whether this is reflected in the increasing rate of female students admitted to Norwegian medical schools. We aim to compare first-year female students in 1993 (NORDOC study, N=94) and 2015 (STUDMED, N=126) in two medical faculties and factors associated with mental distress among female medical students of today.

Method: Medical students entering two different medical faculties (I and II) in 1993 (NORDOC data) were compared with those entering the same two faculties in 2015 (STUDMED 2015). Both included our main variable, mental distress, measured by a short version of Hopkins symptom checklist (SCL-5). Independent variables in the regression analyses included age, faculty, perceived social support, hazardous drinking, and previous mental health treatment needs.

Results: Response rates were 55-89%. The rate of female students had increased from 55% to 70% from 1993 to 2015. The mean levels of SCL-5 increased significantly among the female students: 1993: mean=8.2, SD=3.3/2015: mean=10.9, SD=3.1, p<0.001, Cohens d = 0.63. There was no significant increase among the male students who were excluded from further analyses. Among those with high scores of SCL-5 (above median) 69% reported previous mental health treatment needs. Lower age, previous mental health treatment needs, low perceived social support, low levels of hazardous drinking, and faculty I were associated with SCL-5, and remained significant when controlling for other variables.

Conclusion: There has been a significant increase in mental distress among female medical students over the past 20 years. The effect size and the independent association with mental health treatment needs validate the clinical importance of this finding. The findings about social support and hazardous drinking, which is prominent at student parties, may indicate social isolation that should be further investigated.

Learning objectives:

- Recognise the increasing number of medical students who suffer from mental distress
- Learn about factors that are linked to mental distress among female medical students today, and discuss possible challenges associated with the increased female student population
- Know how to better validate clinical importance of significant findings from self-report rating scales in mental health

78.

How do hospital doctors experience the interactions between professional fulfillment, organization and quality of care? A qualitative study

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Introduction / Aim: Physicians are a robust but increasingly strained group of professional as indicated by increasing burnout numbers. In our research project we explore how physicians experience the dynamic interactions between professional fulfillment, organizational aspects and quality of patient care.

Method and Results: Interview-based interactive research strategy with hospital doctors in Norway and USA. Interviews were transcribed verbatim and analyzed by a transdisciplinary research group.

We use a collaborative strategy to increase physicians own engagement in their local workplace. Present findings reflect physician voices from hospitals in different countries.

Five themes emerged from the qualitative analysis. The complete results will be presented using doctors own voices (quotes):

1. Quality of care crowded out by production numbers and economic data
2. Stretching oneself to deliver quality of care despite organizational shortcomings
3. The accelerating struggle against time impacting well-being and quality of care
4. Quality of care the basis for professional fulfillment
5. Management not recognizing quality of care challenges and doctor initiatives

Discussion and Conclusions: Individual doctors "stretching themselves", to deliver quality of care despite organizational shortcomings, is no longer a feasible strategy. There needs to be a renewed dynamic balance between physicians and managers, speaking with each other, more than about each other. Organisational development work, with physician participation, is required. Without this we compromise both professional fulfillment and quality of patient care.

Learning objectives:

- Understand how physicians experience the interactions between professional fulfillment, organizational factors and quality of patient care
- Be able to apply this knowledge to create change-initiatives that increase engagement and reduce physician burnout
- Be able to relate to collaborative research to better engage with clinical active employees

79.

Realistic Medicine: Reconnecting Doctors with their purpose

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Aims of the session: Realistic Medicine describes a set of principles, behaviours and values which place the patient at the centre of their care by moving away from a paternalistic, "doctor knows best" approach. Realistic Medicine promotes meaningful conversations between doctors and patients, ensuring that decisions about care and treatment are shared and that unnecessary harm from over-treatment is avoided. Since 2015, when Realistic Medicine was first proposed by Dr Catherine Calderwood, Scotland's Chief Medical Officer, the policy has been received positively and has enjoyed widespread support from the wider clinical community. Our vision is that, by 2025, all healthcare workers will demonstrate their professionalism by practising Realistic Medicine.

Method: In this session, we will introduce and describe the six key principles of Realistic Medicine:

- Personalised Approach to Care
- Changing our style to Shared Decision Making
- Reducing Harm and Waste
- Tackling Unwarranted Variation
- Innovation and Improvement
- Managing Risk Better

We will demonstrate how we are supporting the clinical implementation of Realistic Medicine across these domains in Scotland, at national, local and individual level. We will share results of a national staff survey on attitudes towards Realistic Medicine and the results of a Citizens' Jury (a public engagement exercise) on Shared Decision Making.

Discussion and Conclusions: This session will explore how enabling doctors to practise Realistic Medicine or similar approaches (e.g. Choosing Wisely/ Slow Medicine) can deliver value to the person and the population by empowering staff and patients to improve services, outcomes and workplace satisfaction.

Learning Objectives:

- Gain an understanding of Realistic Medicine and its key principles;
- Learn about Scottish Government's approach for embedding Realistic Medicine into national clinical practice;
- Explore how national policy and a shared vision can empower doctors and patients to improve care and treatment.

80.

To screen or not to screen - Norwegian doctors' recommendations to their patients

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Introduction and aims: The rationale for cancer screening is debated in the medical community, as well as among health care authorities and in the general public. Evidence of benefit-harm balance is crucial and varies between different cancer forms, but other factors also influence doctors' recommendations on screening. We studied whether and why doctors recommend their patients screening and discuss how conflicts between different doctor roles can impact these decisions.

Methods: We surveyed a representative panel of Norwegian doctors in 2014/15, using a postal questionnaire, asking whether doctors recommend their patients to be screened for six forms of cancer. We also mapped the importance of early detection, reducing anxiety, false positives, radiation dose (for mammograms), needless interventions, and waste of resources when recommending breast cancer screening and prostate cancer screening. The data was analysed with descriptive methods and binary logistic regression.

Results: 1158 of 1545 doctors responded (75%). In line with Norwegian guidelines 94 % recommended screening for breast cancer and 89 % for cervical cancers. Contrary to guidelines 41% recommended their patient prostate cancer screening. Screening recommendations from GPs were more in line with Norwegian guidelines than from hospital doctors, and physician age and gender had significant effects.

Conclusions: Not only guidelines, but also medical evidence, specialty, age, gender, experience and the relationship to the patient can affect screening recommendations. Doctors serve different roles in the clinical practice, like the patient's advocate, a gatekeeper of resources, a competent member of the medical profession, or a private individual, and which role (-s) s/he is loyal to in a particular decision, can explain variations in practice and justifications. The effectiveness of e.g. guidelines, incentives, or reporting measures can depend on which role (-s) the doctor is loyal to, and policy makers should be aware of these different roles in clinical governance.

Learning objectives

- Doctors recommend cancer screening to their patients to a varying degree
- Doctors base their decisions not only evidence
- Doctors' different roles can account for their decision to recommend screening

81.

Why don't Norwegian doctors choose general practice? A study based on cross-sectional survey in 2016/2017

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Introduction and Aim: Recruitment of GPs has repeatedly been topical in health policy, media and research in Norway. The aim of this study is to find factors associated with not choosing general practice as a career, and also to quit an established general practice career.

Methods: Data are based on a cross-sectional survey of a representative sample of Norwegian doctors in 2016/2017. The response rate was 73.1 % (604/2195). The main outcome measure was based on a 17-item inventory with several potential reasons for not entering, or abandoning general practice. General Linear modelling (GLM), controlling for gender and age, was used to estimate group differences.

Results: 44,1% of the respondents had never considered a general practice career, as opposed to 39,9% who had made such considerations, 16% had worked in general practice but quit. Among those who had considered general practice but ended up with another specialty, the following factors were decisive: administrative burden, small professional network, low cooperation with other colleagues, high costs to establish own practice, not wanting to be self-employed. The group who had quit general practice, listed these factors as important: administrative burden, weak professional environment, too many obligations, small professional network.

Conclusion: Many doctors had considered general practice, most of whom did not choose this career. Administrative burden and a weak professional environment are the most important reasons for not choosing, or quitting, a general practice career.

Learning objectives:

- Gain knowledge about why doctors don't choose General practice.
- Reflect on differences in reasons for either not choosing or quitting General practice.
- Reflect and discuss important work conditions for General practitioners.

82.

The 21st Century Physician – Empowered Physicians in the Digital Health Era

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Introduction: Being 21st century healthcare workers is extremely demanding. The growing number of chronic diseases, lack of medical workforce, increasing amount of administrative tasks and cost of medical treatment and the rising of life expectancy mean immense challenge on medical professionals. This transformation is triggered by the appearance of digital health. Digital health doesn't only mean technological transformation but it fundamentally reshapes physician-patient relationship and treatment circumstances. We argue that patient empowerment, the spread of digital health, the bio-psycho-social-digital approach and the disappearance of the ivory tower of medicine lead to a new role for physicians. The era of

digital health not only meant to equip e-patients with information, tools and technologies, but also equip e-physicians with time, opportunity and technologies to fulfil the modern vision of a practicing physician. Our aim is to discuss the potential ways of facilitating this transition.

Results: Digital health offers the opportunity to make the job of being a medical professional rewarding and creative. The e-physicians are "enabled" by regulations and guidelines and "empowered" by technologies that support their job and e-patients. They are "experts" of using technologies in their practice or know the best and most reliable and trustworthy sources and technologies. And they are also "engaged" to understand the feelings and point of view of the patients, giving relevant feedback and involving them throughout the whole healing process.

Conclusion: There are major factors that facilitate this transition from demigods to guides who enjoy their job. Examples include meaningful incentives proposed by providers; a well-designed medical curriculum, post-graduate education teaching relevant skills; the wider availability of technologies; useful recommendations from peers; a rising number of evidence-based papers and guidelines; technologies that help save time and effort; and generally, a good experience with e-patients.

WORKSHOPS

17.

An evidence based check-up for docs in an Amsterdam university hospital: how to implement a health surveillance program for hospital physicians using occupational health

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Introduction / Aim: Healthy physicians make for happier patients and better quality of care. And prevention is better and more cost effective than cure. But how to start and with whom and where? In this workshop we will demonstrate an evidence based way to assess and address both the mental and physical health of medical specialist and determine job specific health threats. We will show the most striking and common health problems amongst clinical specialists and show various ways how to improve and monitor their health using an occupational health surveillance program developed in the Amsterdam Medical Centre.

Method and Results: We will show an overview of the development, testing and results of the Amsterdam Medical Centre occupational health surveillance program. Participants will be able to focus on specific mental and physical health hazards applicable to their own or their peers/employees work place or specialty, by discussion them in small groups guided by a psychiatrist and an occupational health physician specialized in physician health. We will show how to have physician health monitored and addressed in order to improve their ability to work and prevent impairment.

Discussion and Conclusions: By attending this workshop, participants will have knowledge about most prevalent and pressing health hazards as well as a hands on model and work flow how to assess and address mental and physical health of medical specialists

Learning objectives:

- Have a thorough understanding of prevalent and pressing health hazards among medical specialists
- Understand how to implement a health surveillance program for hospital physicians
- Have addressed and shared their specific questions, needs or ideas in a network setting and peers, guided by a psychiatrist and an occupational health physician specialized in physician health

18.

How the break the conspiracy of silence among possible impaired physicians; an peer intervention strategy to help your fellow physician

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Introduction / Aim: Healthy physicians make for happier patients and better quality of care. Impaired physicians may pose a threat quality of patient care. Since many physicians prove to be hesitant to call for help when having a mental or physical health problem, there is a need for intervention to prevent unsafe working conditions from peers; both for the doctor concerned as well as the surrounding colleagues and patients. In this workshop we will demonstrate ways to either connect to a possible impaired peer to offer support or when not effective, how to use a workflow and checklist how to prepare for a successful intervention.

Method and Results: We will show the most common reasons why physicians do not like to seek help when in trouble and why peers have trouble to intervene. Participants will be able to recognize behavioral change that may point to possible impairment. We will be using non-violent communication strategies combined with methods how to break bad news. We will have a plenary live demonstration of an intervention, where attendees participate in turns, supported by peers.

Discussion and Conclusions: By attending this workshop, participants will have knowledge about most prevalent mental health problems and how these may pose a risk in the work place. They will also practice their skills to help a possible impaired physician to make changes in order to improve their mental and physical health.

Learning objectives:

- Have a thorough understanding of most prevalent and pressing mental health issues among physicians
- Understand how to recognize and address behavioral change that may point to possible impairment
- Have an intervention model to address possible impaired physicians and help them to accept help or treatment

21.**Designing an Appropriate Evaluation Tool in Understand Organizational Impact on Physician Health**

Presenting authors: **Elizabeth Brooks**, PhD / **Sarah R. Early**, PsyD, Colorado, US

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Introduction / Aim: Measuring the impact of a program, activity, or intervention is an important component of ensuring the provision of quality health services. To better understand the effectiveness of organizational activities, the Colorado Physician Health Program, in the United States, created the Provider's Exit Survey. The instrument captures improvement in a doctor's professional, personal, and interpersonal outcomes after participation.

In this workshop, we will guide participants through a 5-stage process of creating similar quality improvement efforts for their physician-focused program.

Method and Results: The workshop will include brief lecture components, live polling questions, a simulated survey activity, and open discussion. As a result of participating in this workshop, audience members will be able to:

- 1) Recognize how to use a systematic, 5-step process as the framework for survey design
- 2) Identify best practices in survey questions
- 3) Identify common pitfalls in quality improvement activities

Discussion and Conclusions: Understanding program effectiveness is particularly important for physician health programs and mental health facilities, as such information can help to ensure continued funding, encourage voluntary and early care-seeking, identify areas for service improvement, and help prioritize resource allocation. Many quality improvement efforts, such as the one featured here, can be created in-house and administered at negligible additional cost.

Learning objectives:

- Recognize how to use a systematic, 5-step process as the framework for survey design
- Identify best practices in survey questions
- Identify common pitfalls in quality improvement activities

22.**Balancing the needs of the individual and the team: implications for professional behaviour**

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Introduction / Aim:

The team, as a group, and, as a group of individuals, with whom an individual doctor in difficulty works should not be ignored. They are affected by illness/difficulties in a colleague and team effectiveness and professional behaviour and satisfaction is at risk.

The aim of this workshop is to:

- Raise awareness of the impact of the doctor in difficulty on team effectiveness and functionality
- Explore the relationship between individual pathology and team dynamics in creating dysfunctional team work in medicine
- Consider how best to intervene in the interests of the individual clinician and the team

Method and Results: 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 or conduct, the index doctor can deeply affect and test both individual and team resilience, and challenge effective management intervention. In some situations the wounded healer can be helped and supported by colleagues in the healing process but in others the team needs support because of that colleague. 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.

Discussion and Conclusions: These factors influence the interpersonal dynamics which can have a deleterious impact on performance, staff wellbeing and on patient safety. The sense of perceived inequity and fairness of allowances made by management for the colleague in question can have a significant influence on the team's empathy and support for their colleague contributing to the development of toxic group processes such as scapegoating and disengagement. Interventions that could mitigate the risk to the team and to individuals will be discussed. Case examples will illustrate relevant psychological theory. Experience of working with teams in difficulty will inform suggestions for interventions.

Learning objectives:

- Appreciate the importance of attending to the team in which the doctor in difficulty works
- Understand the concept of team resilience and team dynamics that affect the performance of both the doctor concerned and the rest of the team

- Understand the concept of organisational justice and how it applies in the case of a doctor in difficulty and the team in which they work and its potential impact on professional behaviour

33.

"Working stress": exploring staff wellbeing through the medium of a board game

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Introduction and aim: Several work pressures experienced by doctors make them prone to occupational distress. On top of that, there is the culture among some doctors of viewing difficult emotions as a sign of weakness or something to be avoided which increases the risk of ill-health. Such culture should be challenged and there is a need to initiate sometimes difficult conversations about health and well-being among health care professionals. The aim of this workshop is to explore the power of opening up the conversation about occupational distress through the medium of a board game.

Methods: During this workshop, participants will explore why talking about stress at work is important and how it might affect the whole team. Participants will also have an opportunity to play the board game - "Working stress", and discuss how it might be used to open up the difficult conversation about occupational distress and health. This board game was developed based on the research which will also be briefly discussed.

Results and conclusion: By attending this session participants will have an opportunity to discuss the topic of occupational distress and health among doctors and learn about the innovative intervention, board game, and the ways this intervention might be used in education/training and day-to-day practice.

Learning objectives:

- Explore the power of opening the conversation about occupational distress
- Learn about the "Working stress" board game and explore the ways this game could be used in education/training and day-to-day practice.

42.

Doctors' Professional Performance in Turbulent Times: Exploring Performance Evidence, Needs and Counterproductive Forces

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Introduction / Aim of the workshop: High quality, patient-centered and cost-effective care relies on doctors' professional performance (pp), which can be defined as 'that what doctors are actually seen to do in practice'. Top performance levels can only be achieved when adhering to the medical profession's values. These values are reflected in the pp-domains: the pursuit for excellence, humanistic practice and accountability. The operationalization of these values varies over time. Clearly, *knowing* what it takes to be a good doctor, and *being* one in everyday practice is not self-evident. Counterproductive forces to doctors' pp are for example the commercialization of healthcare institutions and acceleration and individualization trends in society. In reaction, doctors are (collectively) developing various strategies to address, maintain or improve their pp. In this workshop we aim to (1) discuss and define the domains of doctors' pp, (2) to explore counterproductive forces challenging pp and (3) share dilemma's and best practices to address and manage their pp.

Method and Results: We use the pp domains– developed based on extensive literature reviews and our own studies and experiences in teaching and consulting doctors – as a framework to discuss and define what it takes to be a 'good' doctor today. Next we will ask participants in groups to reflect on the counterproductive forces they experience in their daily work and how this impairs their pp. Lastly, in a plenary discussion, we share dilemmas and reflect on participants' best practices to maintain or improve their pp. Previous projects and studies of our research group have shown the usefulness of these interactive, knowledge sharing, discussions.

Discussion and Conclusions: For doctors, reflection on their performance is essential to be a top performer. This workshop offers them a structured framework to reflect on 1) their pp and 2) on best practices to maintain or improve performance levels in turbulent times.

Learning objectives:

- Gain insight into a professional performance framework as defined for doctors', and learn about the evidence underpinning (achieving) expert performance (levels).
- Reflect on identified counterproductive forces that doctors are facing in displaying expert performance and providing high quality patient care.
- Discuss how hospital-based doctors in different healthcare contexts collectively may facilitate expert performance and high quality, patient-centered and cost-effective care.

51.

"The Valued and Appreciated (V&A) Group" – An Innovative Peer Support Reflective Practice Model for Physician Wellbeing utilising Medical Humanities and Arts for Health

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Co-authors: Camille Gajria, Natalie Karim, Shabana Bharmal – all UK

Introduction / Aim: This experiential workshop will introduce participants to practices utilised in the Valued and Appreciated (V&A) Group. This small peer group approach offers an alternative to Balint groups, Action learning groups and Schwartz rounds encouraging participants to share reflection on positive experiences in their work. Strong evidence from the field of Arts in Health demonstrates the benefits of creative practice for physical and mental health. Participants use creative writing, poetry, graphics, photography, zines and music to share reflections. The workshop draws on tools and approaches from positive psychology, the Medical Humanities, Graphic Medicine and Narrative Medicine and Coaching practice. An Appreciative Inquiry approach enhances participants sense of community and self-efficacy sharing their experiences. Self efficacy is a neglected aspect of physician well-being and resilience. Countering burn out is essential for patient safety, effective health care and retention .

Method and Results: The workshop will be facilitated by the V and A Group who co-created the sessions. Common approaches to group supervision in healthcare will be critiqued.

The rationale behind this novel approach will be explained and principles from Coaching Supervision, Positive Psychology and Appreciative Inquiry introduced.

Participants will experiment with a range of activities in small groups and using an Appreciative Inquiry stance.

Discussion: Learning objectives of workshop, Participants will:

- Recall current practices in healthcare supervision
- Recognise principles of positive psychology and Appreciative Inquiry
- Experiment with practices offered to reflect on work
- Evaluate where this might be relevant in their work setting
- Create a plan for using these practices or cascading the "Valued and Appreciated" model

Conclusions: Participants will be invited to consider the potential impact of the workshop for daily practice.

Learning objectives:

- Critique reflective practice activities
- Experiment with a new reflective practice methodology using the Medical Humanities
- Evaluate the benefits of this type of restorative supervision for well being and retention

54.

Designing a healthy workplace

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Co-authors: Efharis Panagopoulou, Greece

Introduction / Aim: Most individuals accept that building a healthy workplace is desirable. However, taking the first steps in doing this can be difficult as the objective and subjective barriers to changing organizational culture are considerable. The proposed workshop should be of interest to individuals engaged in organisational change in their organisation.

Method and Results: The proposed workshop will utilize a critical incident methodology to demonstrate how positive incidents in the workplace can be captured, recognised and repeated.

Discussion and Conclusions: Participants will be provided with ways as to make the first steps in building a healthy workplace, and an approach that can be applied in diverse healthcare work places, ranging from primary care settings to hospital departments.

Learning objectives:

- Be able to identify the connection between psychological needs and job-person fit in the workplace.
- Be able to use positive critical incident methods in their own organisation.
- Be able to differentiate the contribution of individual and group factors to organizational functioning

62.

Virtual Support Forum for Doctors: Managing transitions – finding balance – a highly interactive online course offering a safe space to share experiences and develop strategies to deal with change

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Co-authors: Jude Tavanyar, Linda Miller, UK

Introduction / Aim: Trainee doctors can experience isolation and overwhelm as they face challenging changes throughout their career. A lack of trusted confidantes can amplify these difficulties even further. In this workshop we will describe the

design, delivery and evaluation of a 4-month virtual support forum piloted in London (Sept-Dec 2018). We will explore the rich opportunities for creativity that virtual space offers for building trust, creating safety in discussing emotional as well as physical and intellectual challenges, and enabling the development of supportive ongoing relationships amongst junior doctors.

Method and Results:

- Learning in a virtual forum can be supportive, engaging, even inspirational. It can also be a space where participants get bored, switch off or hide behind their screens. Alongside the multiple (sometimes unexpected) advantages of online discussion groups, we will draw on our experience to highlight the potential traps and pitfalls, and demonstrate how the technology can be used to avoid them.
- We will present and review the online support currently available to trainee doctors in the UK, and consider the impact of virtual groups in breaking down inter-professional silos.
- Finally, we will share our rationale for, and experience of, introducing the virtual support forum as an alternative offering to 'traditional' face-to-face professional support.

Discussion and Conclusions: Participants will evaluate the benefits of virtual support forums generally and then consider how they might introduce them in their own practice, taking the authors' experience into account.

Learning objectives:

- **Discuss the challenges and benefits** of an interactive virtual forum for supporting doctors as they manage a key transition in their career
- **Identify practical approaches** to setting up a closed group online forum and facilitating learning in a virtual space
- **Discover the session design, interactive tools and features** that enable emotional engagement, interaction, and motivation in an online learning / support environment.

70.

The relationship between body fluid exposure, shift pattern and time of accident

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Aims and Introduction: Body fluid exposure (BFE) accidents are a relatively common hazard in the healthcare setting. There are scarce data on contributing factors to sustaining a BFE. The aim of this study is to summarise BFE accidents amongst doctors at a large London teaching hospital, with a focus on the shift pattern and timing of the accidents as a potential contributory factor.

Methods: All BFEs reported to the OH service of a large teaching hospital between 2014 and 2019 will be reviewed and analysed. In addition to the descriptive analysis, the relationship between shift patterns, timing of shift and number of BFEs will be measured and reported with effect size and CI. The results will be stratified based on confounding factor such as seniority of the person suffering BFE, educational and practice issue and use of PPE

Results: Based on the preliminary analysis, 3930 BFEs were reported, 678 (17.2%) of which were sustained by doctors (including students and dentists). Amongst doctors, more than half (55%) of the accidents happened in the middle of the shift, followed by 27% towards the end and 18% at the start of the shift. The majority of accidents (76%) occurred during the procedure with 23% and 1% after or before the procedure, respectively. BEF accident occurred most commonly during day shifts (84%), followed by twilight (9%) and night (6%) shift.

Conclusions: The analysis is ongoing and is expected to finish by end of March 2019. The conclusions will be determined after the analysis is completed.

73.

The Commission on Mental Health and Wellbeing of NHS Staff and Learners Report: Leading change

Presenting author: Dr. **Katie Knight**, UK

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Co-authors: Kathryn Grayling, Tahreema Matin, Mia Skelly, Simon Gregory, Teresa Hewitt-Moran, Hatim Abdulhussein – all UK

Introduction/Aim: In response to reports of rising levels of mental distress amongst its staff and learners, Health Education England commissioned a large scale report on mental health and wellbeing in the NHS which was undertaken during 2018 by an expert panel under the guidance of Sir Keith Pearson, titled the Staff and Learners Mental Health and Wellbeing Commission. The Commission panel sought and assimilated evidence from clinicians and students that have suffered, and are suffering, with mental ill health, mental health conditions and mental distress. In addition there has been significant engagement with families and colleagues of NHS staff that have been bereaved by suicide, an extensive literature review and an online engagement forum.

Method and Results: The resulting report, which was submitted to the Secretary of State for Health, set out 33 system wide recommendations which will contribute to the NHS Long Term Plan. The recommendations were co-created by a panel of experts working with staff, patients and learners on how to improve mental health and wellbeing within the NHS. The most important of these is the introduction of two new roles within the NHS at a trust level, the Wellbeing Guardian and Wellbeing Leader.

Discussion and Conclusions: Within this workshop, we will discuss the implications of the new roles, and lessons learned so

far in implementing them. We will also ask the audience to consider how the recommendations of the report might translate to their own workplaces.

Learning objectives:

- Gain an understanding of the outcomes and recommendations of the Mental Health and Wellbeing of NHS Staff and Learners Commission report
- Encourage policy makers, Healthcare Leaders, Managers and healthcare staff to consider how to make improvements to their own workplace wellbeing and positively impact the culture and stigma surrounding mental ill health at work
- Have the opportunity to discuss the process of the mental health and wellbeing review with members of the Health Education England expert panel

74.

A “Baker’s Dozen” – a performance enhancing self-skill set

Presenting authors: Dr. **Mark Stacey** / Dr. **Thomas Kitchen**, UK

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Introduction: Doctors are under increasing pressure to perform without making mistakes in an environment that expects perfection. There is increasing medicolegal pressure combined with complex medical problems and often unrealistic public expectations. This is occurring on a background of increasing workload and decreasing resources.

Doctors have always been expected to be resilient or mentally tough without necessarily having any training to develop the appropriate skill set. In recent years, changes to medical practice and training have resulted in further erosion of formal and informal support networks while the consequences of performance failure, either perceived or real, remain significant for both patients and staff.

Method: This will be a 60 minute long evidence-based interactive workshop that describes a “Baker's Dozen” suite of skills that can be easily learnt, implemented and taught to others. The workshop organisers are experienced anaesthetists, who have an interest in performance and well-being.

Introduction (5 minutes): The rationale behind the importance of teaching and learning mental toughness skills.

Content (50 minutes): This will be highly interactive session incorporating generalizable, real-clinical and real-life scenarios. We will explore skills such as decision-making, human factors and performance, developing an optimistic outlook. Active stress management and meditation will be demonstrated. Many of these skills have been field tested by elite sports persons and the armed services.

Summary and conclusions (5 minutes): Those attending will commit to introducing three of the skills they have learnt over the next six months, to improve their clinical performance and those they support.

Participants are encouraged to wear comfortable clothing for this “work”shop.

Conclusion: This workshop will support and enable participants to explore a number of mental toughness skills, which if used appropriately, can enhance performance and aid individuals to construct and maintain a balance between professional and personal needs.

Learning objectives:

- Be given opportunity to explore a range of skills and tools to support balancing professional and personal self-care needs.
- Leave with a practical, personalized plan to implement a number of the tools and skills.

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11.

Onboarding – increasing the quality of the introduction

Presenting author: Dr. **Sofie Hjortø**, Board member, Yngre Læger/Junior Doctors Association, and Gynecologist, Denmark

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Introduction/Aim: During specialisation physicians experience frequent workplace changes with employment durations of typically 6 to 12 months for a period of 7 to 14 years. The quality of the introduction varies. Surveys have shown that the better the introduction of new physicians, the faster they can perform and the better they rate their job satisfaction. The aim was to produce a general guidance for a good introduction, a checklist and a proposal for introductory letter.

Method and results: A working group consisting of physicians during specialisation made a review of their own introduction to various departments including examples of satisfactory as well as inadequate onboarding. The review uncovered what physicians need to be introduced to in order to perform independently. The data were used to create a checklist, a general guidance and a standard introductory letter from the management to the new physician. These materials describe the information and procedures needed to make onboarding successful, and are available and adaptable for local needs.

Discussion and Conclusions: By uncovering what physicians need to be introduced to, we have made standard material with the purpose of onboarding including a general guidance for an adequate introduction, a checklist and a proposal for an introductory letter freely available for use and adaptable to local needs. Application of systematic introduction increases the return of investment, and is therefore valuable for the management, but also for the patient in terms of better quality, and the physician in term of better job satisfaction.

Learning objectives:

- Be inspired to improve and work with introduction/onboarding

12.

Time 'n' Clock

Presenting author: Dr. **Sofie Hjortø**, Board member, Yngre Læger/Junior Doctors Association, and Gynecologist, Denmark

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Introduction/Aim: Danish physicians are short of time with the patients, of supervision and of breaks. The aim of this study was to quantify the time spend on various task by the physician to quality the discussion about appropriate use of the physicians time.

Method: Medical students followed physician for 24 hours in 15 departments across specialities and across Denmark. They timed all the tasks and grouped them into direct patient-contact, documentation with the patient, documentation without the patient, challenges with clinical information systems, supervision, breaks, waiting and other issues. They also monitored the number of interruptions. Data were collected in October and November 2017.

Results: Physicians were in direct patient-contact 21,7% of the time, whereas they used 5,3% of the time documenting with the patient, and 40,0% documenting without the patient. Supervision and education was found 6% of the time. Breaks (15,5%) were found, but less during the day than the night, and with great variation. Approximately 8,5% of the time was spend waiting on others, whereas other issues and technical break down was found in 3% of the time. During 8 hours of work the doctors were interrupted 14,3 times, more during evening and night, less during the day.

Discussion and Conclusions: The quantification of time spend on different tasks raises the question: do physicians use their working hours appropriately? Only 21,7% of the time is spend with direct patient-contact, whereas 40% of the time is used writing the journal, documenting and following-up. Work slip from physicians to medical secretaries of writing and documentation tasks could release valuable time for more patients to be seen and/or increase quality of each contact. Supervision and education was sparse, whereas interruptions were plentiful. There is an organisational and cultural work to be done to minimize workflow interruptions, since it takes time to get back into flow.

16.

Health of health professionals – ReMed: the support network for physicians Accompanying research in Switzerland

Presenting author: Dr. med. **Peter Christen**, Switzerland

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Aim and Introduction: Maintaining physician's health is increasingly recognised as a matter to discuss in public and research. Physician health is a critical issue, because poor physician's health can have severe impact on doctor's performance, patient safety, quality of care and may affect standards of care. To help doctors in crisis, the Swiss Medical Association (FMH) founded the support Network ReMed in 2007. An experienced team of counsellors takes care of doctors suffering from various crises. In 2015, the program leaders initiated an ongoing external evaluation on the mode of operation, awareness of the network, numbers of contacts, and statistical data.

Methods: In Switzerland there exists only this specific helpline for physicians. Data source is limited to data available from this program. The executive committee of ReMed collected data over the last 9 years. The counsellors of ReMed gathered semi-structured reasons for encounter as well as gender, age, professional activity and marital status. In 2018, the data collected was revised and complemented with new aspects concerning reasons for encounter and additional information (nationality, degree, workload.). Descriptive analyses is used to create profiles of doctors being engaged with ReMed.

Results: By means of descriptive analyses and presented as poster, the collected data serves as unique fundus of information on reasons for encounter as well as for various other gathered variables. The newer part of the ongoing evaluation (started 2018) will take into consideration the additional information collected by the counsellors. First insights on the planned quantitative social research study are available by spring 2019.

Conclusion: The past and future analysis helps to identify what variables might refer to a greater risk of health problems and where preventive implications might be possible. ReMed plans to answer the following objectives within the accompanying study:

- Create profiles of doctors getting engaged with ReMed in relation to variables collected
- Compare the findings to find similarities, patterns and other regularities or irregularities
- Discuss the preventive implications of the findings

Learning objectives:

- Get to know more about the support Network ReMed from Switzerland
- Get an insight on an unique fundus of data
- Know more about possible preventive implications of the findings

27.

When the glass is half full: Increasing professional recognition in physicians

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Introduction / Aim: The aim of this pilot study was to design, implement and evaluate an intervention aiming at increasing professional recognition among healthcare professionals working in primary care. Professional recognition was operationalized at three levels: self, co-workers and patients/recipients of care.

Method and Results: Thirty six (n=36) residents and consultants working in primary health care settings in Greece participated in the study. Emotional states of participants were measured before and after the intervention with the Self-Assessment Manikin, Positive and Negative Affect Schedule and an open-ended question. Results showed significantly higher levels of dominance after the intervention, $t(35) = -3.014$, $p = .005$, higher levels of enthusiasm, $t(37) = -2.158$, $p = .038$, feelings of being proud, $t(37) = -2.485$, $p = .018$ and being inspired, $t(37) = -2.490$, $p = .017$. Furthermore, the analysis of open ended responses using the Pleasure-Arousal-Dominance model showed that participants reported higher levels of positive emotions and lower levels of arousal emotions after receiving the intervention, $\chi^2(4, N=36) = 35.526$, $p < .001$.

Discussion and Conclusions: To our knowledge this is the first intervention targeting professional recognition implemented in healthcare settings. Results indicate significant changes on the emotional states of participants after receiving the intervention. Future research is needed to evaluate the effectiveness of the intervention increasing resilience and reducing burnout in health professionals.

Learning objectives:

- Learn about how positive psychology could be implemented to increase professional recognition in HPs working in primary healthcare settings
- Learn about the results of an innovative intervention implemented in HPs working in primary healthcare settings

28.

Disruptive behaviors in caregivers on technical platforms in France

Presenting author: Dr. **Segolene Arzallier-Daret**, France

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Introduction / Aim: The production pressure in the technical areas and the operating theater in hospitals can generate tensions in medical teams. Conflicts impact the quality of care and affect the health of caregivers. Improving team cohesion could contribute to the decrease in psychosocial disorders. Team cohesion is poorly performed in French hospital. The Committee of Anesthetist's Occupational Health (SMART) of the French College Of Anesthetists and Intensivists (CFAR) conducted a study making an inventory of interprofessional conflicts on the technical areas and propositions for conflicts resolution and team cohesion.

Method and Results: Declarative study using an online questionnaire from 5 November to 6 December 2018, available on www.cfar.org and distributed to the professional organizations of the different actors of the technical platforms. In one month, 1885 (34 % anesthetists, 9% surgeons, 45% nurses, 1% midwives) have completed the enquiry. Respondents reported having witnessed (90%), victims (64%), perpetrators (30%) of a conflict. These were verbal abuse in 98% of cases. The 3 main causes were poor communication, workload, and misunderstanding of everyone's problems. 76% felt helpless in the face of conflict. In only 16% of the cases, a procedure formalized in the hospital was available. Resources to overpass the situation were mainly to connect to a supervisor (62%). Working relationship had deteriorated over the last 10 years in 63% of participants and 80% considered that a campaign on conflict prevention and management would be useful to improve team cohesion.

Discussion and Conclusions: Operating theater and technical areas where anesthetists are working with others health professionals are under pressure in French hospitals. Verbal abuse may be considered as an "everyday" condition. The caregivers do not feel to be prepared to face them. The SMART Committee plans to launch a 2019 campaign for conflict prevention and development of tools. These might be a charter of good conduct, conflict management training, and cognitive help for conflict analysis to help teams to identify root causes and promote team cohesion.

Learning objectives:

- Discover the reality of disruptive behavior between team members
- Understand the main causes of conflicts at work
- Reflect on solutions to reduce conflict and improve team cohesion

29.

The Observatory of suffering at work: assessment at one year after its implementation in French public hospitals

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Introduction / Aim: In France, near 40% of medical doctors in public hospitals are suffering from burnout. The Committee of Anesthetists' Occupational Health (SMART) of the French College of Anesthetists and Intensivists (CFAR) is the partner of the Observatory of suffering at work (OSAT) for the doctors in public hospitals. The OSAT website was launched on December 7, 2017 by the Union Action Practitioner Hospital (APH). Doctors have the opportunity to report their suffering online (<https://osat.aph-france.fr>) using an anonymous system.

Method and Results: a retrospective study of the declarations from December 7, 2017 to December 6, 2018 was undergone. All grids filed were analyzed. The results of the quantitative variables are expressed in median [IQR]. The others results are expressed in percentage of reporters. In one year 103 declarations were analyzed. The level of suffering was evaluated at 8 [6-9] on a scale of 0 to 10, 54% of respondents considered themselves in imminent danger and 13% had suicide ideations. The main causes of suffering were conflicts with managers (55%), the emotional overload (52%) and the disorganization of care (51%). An experience of being bullied was reported in 37% of cases. Sleep disorders (84%), anxiety and depressive disorders (60%), antidepressant or anxiolytic drugs consumption (30%), eating disorders (36%) were also reported. Absenteeism with extended sick leave more than two weeks (34%) and family conflicts with relatives (32%) or children (22%) were mentioned. Intention to leave their job was reported (42%). More than half (56%) wanted benefit from telephone assistance by one of the OSAT volunteers which are doctors pertaining to the APH Union like the SMART committee.

Discussion and Conclusions: Those having used OSAT website were in poor condition regarding their occupational health. The OSAT allows a health watch on the physician population in public hospital. OSAT allows signaling the Union in case of multiple declarations coming from the same place. Consequently, OSAT helps the Union to warn the local or regional institution about concerns on their occupational health politics.

Learning objectives:

- Discover an inventory of the reality of the suffering among French doctors in public hospitals
- Understand the main causes and consequences of suffering at work
- Appreciate a national system to support doctors in pain and provide them with union support

34.

Weathering the storms: Waterproofs, Warm clothing and Welcome mats help!

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Aims: Physicians in difficulty often describe the feeling they are falling apart. During the longitudinal career of a doctor there will inevitably be experiences of stress from both life changes and professional pressures.

Research evidence points to isolation being strongly associated with poor performance and health concerns in doctors. The roots of isolation are many and can be self-reinforcing resulting in the doctor feeling exposed to the elements.

Metaphor is used to explore this encouraging teams to develop a 'weather forecast' and protective measures.

Methods: Understanding the background to isolation is an important step in countering this. Metaphor is a powerful approach to reduce defensiveness and encourage self-awareness. This can help identify early indicators, leading to prevention or minimisation of burnout.

Introductory exercise: Use of metaphor of the 'ready position' on sports court. Centralised, balanced and with good all round vision this is the place to be.

- *Stage 1 Weather forecast:* The doctor in the here and now, reality check, anticipating how to navigate stressors. Task: Acceptance of vulnerability, being off balance.
- *Stage 2 Packing a bag:* A personalised portable tool kit, a metaphorical raincoat. Put it on before deluge starts! Task: Developing self-awareness.
- *Stage 3 Finding respite:* Coaching approach exploration of aims, intentions, role and leadership. Task: Get to centre of court. Resilience.
- *Stage 4 Welcome mat:* Engaged and safe, confident, alive and curious. Task: Freedom to learn and explore full court.

Results: Using a visual metaphor is welcomed by individuals and teams who are then able to develop dialogue in a manner that poses a low level of threat. The playfulness of metaphor helps this process, reducing intensity, facilitating creativity and shared understanding.

This approach while requiring further evaluation is promising in reducing the cycle of build up of defensive functions that can lead to isolated working and burnout.

Alongside this the individual doctor is seen as part of a wider system in which adoption of a common language and familiarity in talking about difficulties can help normalise and share the pressures.

Teams that work in this way can predict storms, ensure they have protective gear available and can find places of respite. In the longer term such teams can develop lasting creative changes.

Conclusions: The doctor is part of a system where engagement with colleagues and team work are essential for high quality health care. It is the responsibility of all, individuals, teams and services, to minimise isolation.

Promising indications emerge from team work and reflection, using a structured framework and metaphor to develop creative dialogue.

While there is a strong case to assist those with difficulties this approach highlights the importance of working with well-functioning doctors and teams to proactively prevent burnout and health difficulties.

Further evaluation including qualitative and quantitative approaches is required to elicit positive factors and allow for further refinement.

35.

Linking doctor's work-life balance and care quality: why is it such a challenge in the case of French family doctors? A sociological eye on an inherited model and some adverse representations

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Abstract: Traditionally French GPs have proudly worked very long hours, in a context where nobody seriously questioned the impact of this extensive commitment neither on themselves nor on care quality. Connecting care quality and doctors' work-life-balance was almost unthinkable. Although the link is today well-documented, adverse socio-professional representations persist.

This presentation aims to explicit through a socio-political analysis the resistance to consider it: Why has it been inaudible for such a long time? What makes the resistance weaken gradually? Is there a shift toward a shared awareness or interpretation? Our interpretation is grounded in long-lasting sociological qualitative inquiries among French GPs (hundreds of interviews with seniors and juniors), a close observation of their public management, and a literature review.

A part of the ideological foundation and the value/recognition of French family medicine was based on an inherited male permanent availability model. Although this traditional model has been recently challenged by doctors feminization and by a generational effect supposedly altering the extensive commitment to medical practice, the average working-time is still estimated 57 hours/week. The expectations of young physicians in terms of professional satisfaction, firstly disqualified, became more audible and even legitimate when a global alert on a deep malaise among GPs and medical students was raised. Anyway, few changes have occurred in training or professional models. The demographic context and the new public management of doctors could even lead to more pressure and a lengthened working time.

The social recognition of GPs' complaints on their working conditions, also damaging patient care, remains hesitant. Interpretations among stakeholders tend to embed it in the interests and values promoted by the diverse actors, rather than framing it as an autonomous matter of public interest. This detour via a socio-historical contextualization can help to understand socio-professional resistance to evidence linking work-life balance and care quality.

Learning objectives:

- Understand why traditional heroic representations resist in and about the medical profession
- Understand how the problem of doctor's work-life balance is framed by the socio-historical context

38.

Dignity in clinical training environments: the role of the SOS (Sanitary protection On Site) box

Presenting author: Dr. **Josie Cheetham**, UK

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Introduction / Aim: There is growing awareness of the impact of periods and the need for timely access to sanitary products for females as they function in society. However, there has been little acknowledgement of the challenges faced by female healthcare professionals in managing their menstrual cycle in a dignified manner whilst at work. This study has two aims. Firstly, to determine the impact of female junior doctors' menstrual cycle needs on their wellbeing, dignity and access to training opportunities. Secondly, to test the utility of an "SOS box" providing free sanitary products for female junior doctors.

Method and Results: The study is being conducted in three hospitals in Southeast Wales. The experiences of female junior doctors are being determined by a) an anonymous online 12-question survey pre- and post-box introduction and b) focused interviews. An SOS box containing various sanitary products of different absorbencies was placed in the Junior Doctors' mess at each hospital. SOS boxes were advertised by group emails, WhatsApp messages and posters around the hospitals. Each SOS box had a maintenance guardian responsible for maintaining supplies. Usage is monitored by users taking numbered tear-off strips and regular stock count. Users provide feedback by selecting a green (positive), yellow (mixed) or red (negative) sticker.

The study is ongoing. Survey and interview results will be collated to provide percentages of participants reporting challenges accessing sanitary products at work, impact on dignity, wellbeing, perceived work productivity and learning ability. SOS box usage and feedback will be collated.

Discussion and Conclusions: This study will provide the first direct empirical evidence on the difficulties faced by female junior doctors in accessing sanitary products at work, and the impact on their wellbeing, dignity, training and work

productivity. It will furthermore determine the utility of the SOS box, a novel intervention aimed at alleviating these challenges.

Learning objectives:

- To consider the effect small working environment changes can have on reducing gender inequalities and barriers to equal levels of dignity
- To appreciate the potential for cost effective, discrete interventions that can be easily translated to other areas
- To appreciate the inherent inequalities female healthcare professionals face and how junior doctors can be a force for positive change

45.

Burnout in European Junior Doctors – a review of burnout data from ten countries

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Co-authors: Josephine Elliot, Vicky Soomers, Brigita Jazbar, Kitty Mohan – all Belgium

Introduction: Burnout amongst doctors is characterized by emotional exhaustion, depersonalisation and reduced feelings of work-related personal accomplishment. Previous studies have shown that doctors are at an increased risk of mental health issues compared to the general public and burn-out amongst doctors in Europe is a major concern in healthcare. However, there are currently no studies that have addressed burnout in junior doctors from a pan-European perspective.

Method: The European Junior Doctors' Association (EJD) reviewed data from existing surveys amongst member countries. Data was reviewed in order to quantify the rate of burnout, identify recurring themes and define contributing factors.

Results: Ten EJD member countries provided data: Croatia, Finland, Greece, Germany, Ireland, Italy, The Netherlands, Portugal, Sweden and the UK. Levels of reported burnout ranged from 30-63% in the countries studied. Recurring themes were: (1) junior doctors consistently working more than their scheduled hours; (2) issues with poor work-life balance (3) lack of support for administrative tasks. Contributing factors to burnout included staff shortages, high workload, increasing administrative burden, low professional autonomy, dissatisfaction with working environment, and lack of appreciation. Several of the studies found that high workloads lead to less time for sleep, exercise and healthy eating, all of which can contribute to poor physical and psychological health.

Conclusions: Burnout is a major concern in terms of both the professional and personal needs of doctors. Our review shows the culture of healthcare as one of the issues contributing to burnout. This data suggests that action should be taken at an organisational level, rather than individual level, to reduce burnout rates amongst doctors across Europe.

Learning objectives:

- Rates of burnout amongst junior doctors in Europe
- Recurring themes relating to burnout in junior doctors in Europe
- Factors contributing to burnout amongst junior doctors in Europe

64.

Investigating social support of Hungarian medical students, as a protective factor against burn-out

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Introduction: It is well known that burn-out and poor mental health of medical students and medical professionals can seriously affect the quality of healthcare. The students more exposed to stress, mistreatment and who lack social support have poorer mental and physical health and are less resilient for burnout. Some studies indicated that peer and mentor support reduces particular dimensions of burnout, therefore social support might be an agreeable and important preventive factor against burnout.

Method: An online questionnaire was made among medical students of the 4 Hungarian medical universities. The survey contained questions about mental and physical health issues (State-Trait Anxiety Inventory, Maslach Burnout Inventory – Students' Scale, Perceived Stress Scale, Patient Health Questionnaire, Multidimensional Scale of Perceived Social Support, Connor-Davidson Resilience Scale and WHO Well-Being 5 Questionnaire), perceived discrimination, general demographics and personal background characteristics. In this analysis we investigated how the perceived social support of medical students related to their general demographic data and mental health.

Results: 530 medical students filled our questionnaire out in total. The average score on MSPSS was 5.76 (SD=1.18); comparing the three subscales of the questionnaire (family, friend, significant other) the lowest scores were earned on the family subscale of social support, which was 5.61 (SD=1.50). In the univariate analysis, social support was negatively associated with belonging to minority, higher level of burnout, more severe perceived stress and more frequent occurrence of psychosomatic issues, but positively correlates with female gender, well-being and resilience. In our multivariate analysis, students' social support had a significant negative relation with PHQ15, and a positive association with female gender, non-minority status, resilience and well-being.

Discussion: In our study, social support correlates with several mental health indicators (well-being, resilience, psychosomatic symptoms) and some of the demographic data (gender, minority status). Therefore, we should pay more attention to social support, and especially those students belonging to minority groups (e.g. student groups, doctor-mentors or

role models), because it might be essential for their well-being and may reduce their risk for burnout. It is important to remember that we should heed those most who are in need (e.g. minority students, students with mental or physical health issues).

77.

A preliminary case study of organizational development in a physician health organization (Doctors4Doctors)

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Abstract: The Belgian organization Doctors4Doctors arose from a base of physicians concerned about their colleagues health. Given the steady growth of the organization there originated some growing pains. After an internal initializing request stating 'co-doctors' progressively losing interest in the physician health organisation while keeping an interest in the cause, an intake procedure was planned to diagnose the organisational system in order to re-develop engagement.

The intake procedure or organizational diagnosis consisted of both a board member interview and a stakeholder focus group each driven by the integrative diagnostic model of Cummings and Worley (2005). A gap analysis perspective was used in the focus group to assess input and design components within the organization. It resulted in the present report consisting of three sections (organisational, group and individual level), each containing an analysis and proposed intervention.

A parallel twofold intervention was proposed to simultaneously create a group-level pilot functioning as a concrete example and motivating the organizational leadership team making progress in the organizational level development (strategy, technology, structure, human resources systems, and measurement systems).