Identifying and Supporting GP Supervisors in Difficulty

GPSA
GENERAL PRACTICE SUPERVISION AUSTRALIA

About this guide

GP supervisors make a vital contribution to the provision of quality training for the next generation of family doctors. They are the cornerstone of the 'apprenticeship–style' GP training program in Australia. Both the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) in their standards documents identify the importance of GP supervisor and team for the training of GPs.

The GP supervisor's role is complex, diverse and can be challenging. It includes the roles of mentor, role model, clinical educator, assessor, pastoral carer, and also very often employer.[1] One of their most important tasks is the early recognition of GP registrars in difficulty so that appropriate interventions and support can be put in place. But what about GP supervisors themselves? They too can find themselves in difficulty. How can this be identified early? What interventions and supports are there?

This guide aims to assist GP supervisors to:

- Identify signs of a GP supervisor in difficulty.
- Appreciate some of the potential causes of difficulties.
- Recognise the challenges in identifying and managing a GP supervisor in difficulty.
- Identify preventive strategies.
- Understand the staged processes for managing a GP supervisor in difficulty.
- Identify appropriate supports.
- Understand the various roles and responsibilities of involved parties.

This guide is not intended to be used as a definitive reference and should be used in conjunction with the policies and guidelines of your own College, medical defence organisations and regulatory authorities.

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GPSA produce a number of relevant guides for GP supervisors and practices, visit www.gpsupervisorsaustralia.org.au/guides to view additional guides.

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What does it mean to be a **GP supervisor?**

Having been supervised during your own training and now working in general practice as a GP supervisor you probably feel you already have a clear idea of what it means to be a GP supervisor. So briefly we will look at some definitions and supervision models which have some similarities and some different emphases.

Health Workforce Australia (2014) defines a clinical supervisor as "an appropriately qualified and recognised professional who guides students' education and training during clinical placements. The clinical supervisor's role may encompass educational, support and managerial functions. The clinical supervisor is responsible for ensuring safe, appropriate and high-quality patient care."[2]

The RACGP Standards for General Practice Training 2nd Edition describe supervision as "the immediate and primary way in which patients are kept safe and enjoy quality care, and registrars are kept safe and enjoy quality training."[3]

Their definition of a GP supervisor is "an accredited GP who is both a clinician and role model who takes responsibility for the educational and training needs of the registrar while in the practice".[3] These responsibilities are to:

- Orientate GP registrars to practice.
- Monitor GP registrars' competence
- Assist GP registrars with planning their learning.
- Provide feedback to the GP registrar.
- Provide in-practice teaching.

The ACRRM Primary Rural and Remote Training Standards for Supervisors and Teaching Posts identify the GP supervisor as "the doctor responsible for the day-to-day performance of a registrar", and that supervision "involves providing monitoring, guidance and feedback on matters of personal, professional and educational development in the context of the doctor's care of patients. This would include the ability to anticipate a doctor's strengths and weaknesses in particular clinical situations, in order to maximise patient safety."[4]

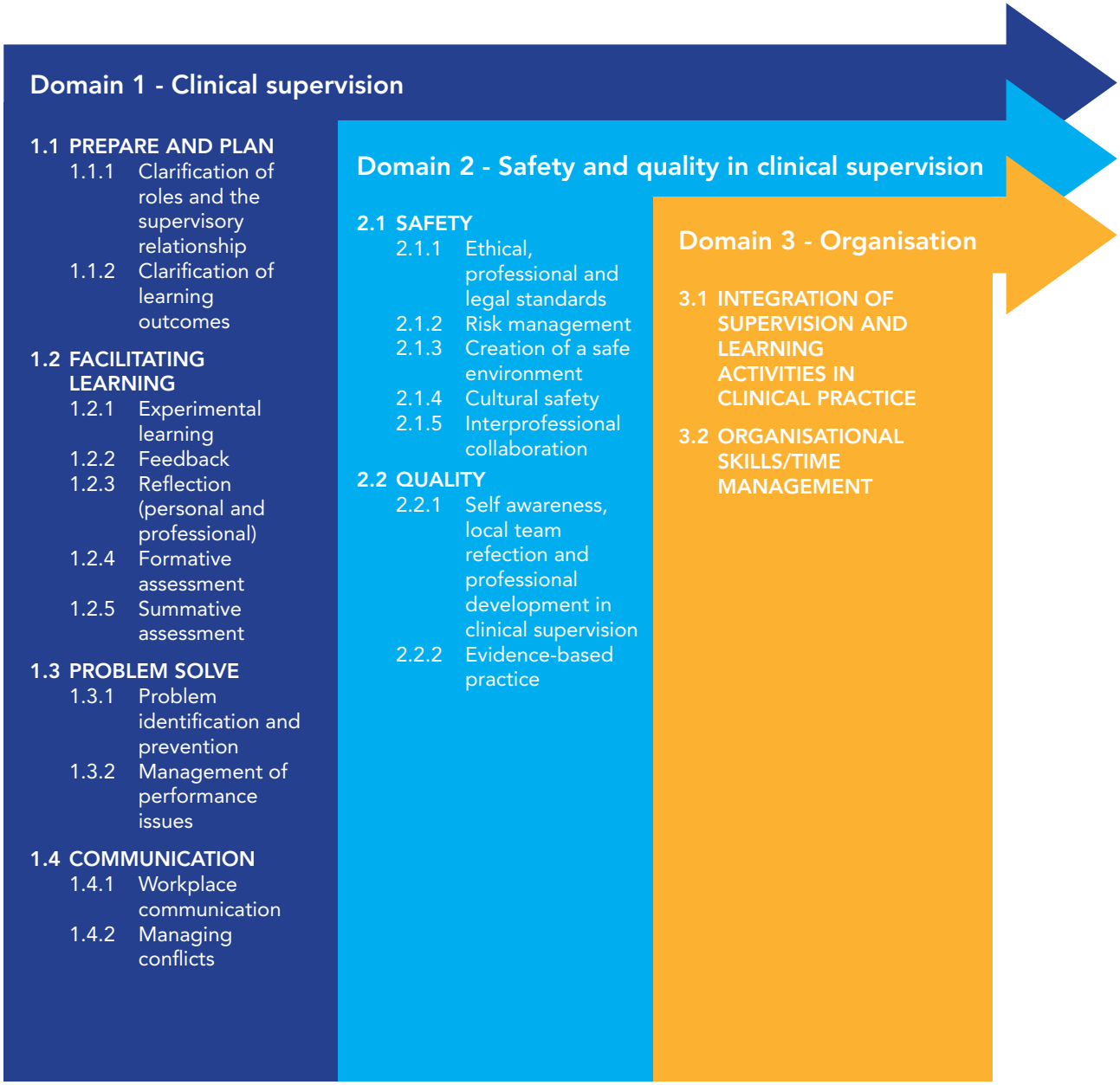
The functions of supervision

These definitions and much of the literature focus on three functions of supervision. These functions often overlap.[1,5]

- **Normative – Managerial/professional accountability**
  Focus is on ongoing monitoring and evaluation, the quality control aspects of professional practice.
- **Formative – Educational/skill and knowledge development**
  Focus is on development of knowledge and skills.
- **Restorative – Support**
  Focus is on health and wellbeing supportive help for professionals working constantly with stress and distress.

Within the Australian context these functions have been diagrammatically represented in two different ways. Health Workforce Australia[2] (Diagram 1) represents these as three domains of activity which they see as common to all Australian clinical supervision workforce and healthcare disciplines.

DIAGRAM 1 DOMAINS OF CLINICAL SUPERVISION (HEALTH WORKFORCE AUSTRALIA 2014)[2]



Australian GP supervisor Susan Wearne, from her research into supervision and remote supervision,[6] highlights the importance of the supervisor-registrar relationship. She describes a supervisor-registrar 'educational alliance' as the foundation of learning, and which comprises a web of activities (Diagram 2). These activities are encompassed in the three functions previously described. Evidence in other fields, for example, psychology is identifying that this supervisor-supervisee alliance may be the most robust and significant variable in whether supervision is effective or ineffective.[7]

DIAGRAM 2 THE GP SUPERVISOR'S WEB OF EDUCATIONAL ACTIVITIES WITHIN THE SUPERVISOR REGISTRAR EDUCATIONAL ALLIANCE.[6]

Supervisor and registrar educational alliance:
the foundation of learning

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Identifying the GP supervisor in difficulty

Doctors report substantially higher rates of psychological distress compared to both the Australian population and other Australian professionals.[8] The general work experience for Australian doctors is stressful and demanding,[8] which for GPs may be exacerbated by the changing context of general practice in Australia. The role of the GP supervisor is diverse, complex and can be challenging.[1] These factors make it important to recognise that GP supervisors can find themselves in difficulty.

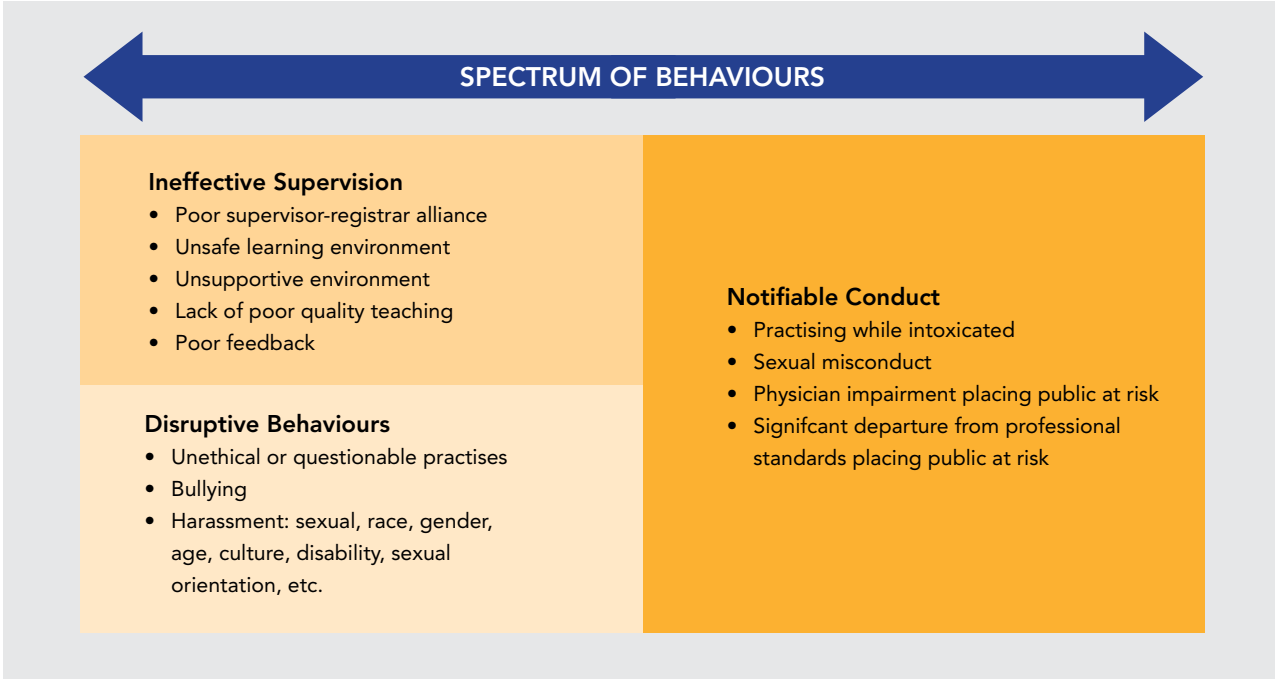
The spectrum of behaviours of a GP supervisor in difficulty are wide and range from minor, momentary aberrations to persistent behaviours or even notifiable conduct. They are not unique to GPs and many of the behaviours have been identified in all of the health professions and in other professional groups who provide supervision.[9-17]

This behaviour spectrum can be divided into three areas, although there may be a degree of overlap between them (Diagram 3):

1. Ineffective supervision.
2. 'Disruptive' behaviour.
3. Notifiable conduct.

While behaviours may initially impact in one of these areas only, if the pattern becomes an enduring one or there is escalation of the behaviours, the impact is likely to spread across the areas.

DIAGRAM 3 SPECTRUM OF BEHAVIOURS IN A GP SUPERVISOR IN DIFFICULTY



Ineffective supervision

Ineffective supervision can also be described as the underperforming GP supervisor. Usually it is not one behaviour in isolation that is a cause for concern, it is where there are a number of behaviours occurring together or where there is an enduring or escalating pattern. At one end the impact for the GP registrar may be minimal, however at the other extreme enduring or escalating behaviours can lead to the breakdown of the supervisor-registrar alliance. It is important to recognise that effective practice systems and other doctors and staff members the GP registrar engages with can mitigate the effect of ineffective supervision behaviours by a GP supervisor.[14, 37]

There are a number of different categories of ineffective supervision behaviours,[14-18] and it is likely that a GP supervisor in difficulty will be underperforming across a number of these.[16]

POOR SUPERVISOR-REGISTRAR ALLIANCE

Examples include:

- GP supervisor is rigid, critical, distant, aloof, distracted.
- GP supervisor doesn't take an interest in the GP registrar's interests.
- No role induction process that explores how supervision should proceed.
- GP supervisor is often irritable or annoyed with interruptions for a clinical question or issue.
- GP supervisor treats the GP registrar as a student rather than a colleague.
- GP supervisor doesn't reveal any sense of own shortcomings.
- Inappropriate self-disclosure from GP supervisor. For example, they talk too much about their personal lives, treat the GP registrar as a confidante or counsellor.
- GP supervisor doesn't take GP registrar's expressed concerns about any behaviours or issues seriously.

UNSAFE LEARNING ENVIRONMENT

Examples include:

- No sense of safety so the GP registrar can reveal his/her doubts and fears about competency.
- GP supervisor is unapproachable to talk about things.
- GP supervisor feels threatened and retaliates if the GP registrar is more competent or mature in one or more areas.
- GP supervisor blames GP registrar if they haven't adhered to guidelines.

UNSUPPORTIVE ENVIRONMENT

Examples of GP supervisor's behaviour include:

- Isn't available or accessible.
- Ignores GP registrar's need for emotional support in a new and challenging environment.
- Places the importance of service delivery above the GP registrar's educational needs.
- Doesn't encourage anyone in the practice to be supportive of the GP registrar or interested in teaching.
- Doesn't reflect, audit, evaluate the practice system or culture.

LACK OF / POOR QUALITY OF TEACHING

Examples of GP supervisor's behaviour include:

- Lack of or no structured teaching.
- No regular observation and feedback.
- Is disorganised, late or misses education sessions.
- Focuses on the presenting problems only.
- Trainer centred:
  - Insists that the GP registrar work from the same theoretical basis and learn the same way as they do.
  - Has a rigid teaching structure with fixed views on what education to 'feed' the GP registrar.
  - Talks mostly about their own cases with the GP registrar.
  - Talks a lot and tells the GP registrar everything they know.
  - Is black and white and protocol driven, expecting the GP registrar to adhere to guidelines.
  - Interrogates the GP registrar.
- Leaves the responsibility for learning to the GP registrar alone.
- Takes over the clinical management of the patient.
- Avoids answering direct questions.

POOR QUALITY FEEDBACK

Examples of GP supervisor's behaviour include:

- Gives little or no feedback, or tells the GP registrar what they have done wrong.
- Doesn't support the GP registrar's strengths, only points out weaknesses.
- Doesn't give specific or timely feedback. Avoids giving negative feedback.
- Often interrupts when observing a consultation.
- Little positive reinforcement when the GP registrar does well.
- Fails to complete assessment and submit other required paperwork on time.

Disruptive behaviour

'Disruptive' behaviour is demonstrated when inappropriate conduct, whether in words or action, interferes with, or has the potential to interfere with, quality healthcare delivery.[11, 12]

Disruptive behaviour may be demonstrated in a single act (often bullying or harassment) but is more often composed of behaviours that have an enduring or escalation pattern. The gravity of disruptive behaviour depends on the nature of the behaviour, the context in which it arises, and the consequences flowing from it. While it is often seen as active behaviours for example, objectional language, it can also manifest as passive behaviours, for example, choosing not to complete paperwork requirements.[11, 12]

Disruptive behaviour is said to subvert the ability of an organisation to develop a culture of safety for the physician and ultimately the patient.[19]

Disruptive behaviours can be divided into three categories, although behaviours may merge across these areas.[11, 12, 20-23]

UNETHICAL OR QUESTIONABLE PRACTICES

Examples include:

- Using inappropriate labels or making unprofessional comments when discussing patients and colleagues.
- Sidestepping reasonable administrative and clinical policies and requirements. For example, refusing or just not completing forms, failing to complete assessments etc.
- Involving the GP registrar in the conflicted dynamics among the staff in the work context.
- Coming back to the clinic with alcohol on their breath.
- Unethical prescribing especially Schedule 8 medications and benzodiazepines.
- Apparent Medicare fraud and inducing the GP registrar to do the same.

BULLYING

In Australia the Fair Work Amendment Act 2013 defines workplace bullying as "repeated unreasonable behaviour by an individual towards a worker which creates a risk to health and safety".[22]

There are three essential elements of bullying:[10]

1. It has a negative impact on the victim.
2. It is persistent.
3. It is subjective. This is challenging as there may not be 'objective' evidence but is dependent on the bullied person's views.

Importantly, a conflict cannot be defined as bullying if two parties of approximately equal strength are in conflict.[24]

Factors that contribute to the workplace bullying include the individual psyche of bully; the institutional culture which may normalise the behaviour or even reward it; and independent of institutional culture high workloads, power imbalances or hierarchical structures and management.[24]

It is important to distinguish between bullying, which is inherently undermining and corrosive, and constructive supervision and performance management, which is developmental and supportive.[10]

Examples include:

- Berating or criticising an individual in public or private settings.
- Patronising and insulting remarks. For example, about an employee's intelligence.
- Intimidating, threatening or coercive actions.
- Yelling or using foul, insulting or demeaning language.
- Using intimidation tactics to gain compliance or control of others.

- Abusive comments in email or via phone to individuals or organisations.
- Threatening, unwarranted discipline or loss of job.
- Excessive and unreasonable monitoring of employee's work progress.

HARASSMENT

Harassment is unwanted, unwelcome or uninvited behaviour that makes a person feel humiliated, intimidated or offended. Harassment can include racial hatred and vilification, be related to a disability, or the victimisation of a person who has made a complaint.[22]

Under Australian discrimination law, it is unlawful to treat a person less favourably on the basis of particular protected attributes such as a person's sex, race, disability, age or sexual orientation. The Australian Human Rights Commission Act (1986) protects people from discrimination in employment because of their religion, political opinion, national extraction, nationality, social origin, medical record, criminal record or trade union activity.[20]

It is important to understand that a one-off incident that relates to these protected attributes (one's social identity) can constitute harassment.[10,22]

Examples include:

- Telling sexist jokes that are clearly embarrassing or offensive, especially if the 'joker' has been asked not to.
- Leering, staring, commenting or gesturing in an obscene or sexual manner.
- Making unwelcome enquiries or comments about a person's sexual life.
- Revealing intimate details of their own sexual experiences.
- Requesting sexual favours.
- Making derogatory comments.
- Telling or posting of jokes, slurs, posters, cartoons, based on the protected attributes etc.
- Drawing attention to an individual's protected attributes to undermine his/her role in a professional or business environment.
- Innuendo, taunting, or ostracising an employee based on the protected attributes.
- Making an employment decision on protected attributes that negatively affect the individual.

DISRUPTIVE BEHAVIOURS – INCIDENCE IN MEDICINE

Unfortunately, disruptive behaviours in medicine are not uncommon. A systematic review in 2014 in the United States found that verbal harassment was common. In 2015 a US study identified 91 per cent of women experienced or observed gender-based discrimination in practice[25]

In the postgraduate setting in the United Kingdom 37 per cent of junior doctors had been bullied and 69 per cent witnessed bullying. Black Asian and female doctors were more likely to have been bullied.[26]

In Australia in 2015 the Royal Australasian College of Surgeons established an Expert Advisory Panel which found that 49 per cent of fellows, trainees and international medical graduates reported being subjected to discrimination, bullying or sexual harassment and that only 12 per cent of discrimination cases were effectively resolved.[27]

While general practice may be a safer environment than surgery for example, it cannot assume that these behaviours are not occurring. In 2008 a survey[28] of Australian doctors (of which 31 per cent were GPs) found that 25 per cent of respondents reported being bullied in the last 12 months. Of the 69 per cent who made a complaint only 24 per cent were satisfied with the outcome. Bullied doctors had poorer mental health, higher levels of workplace stress, were least satisfied with their jobs, had taken more sick leave in the last 12 months, and were more likely to be planning to decrease their hours of work in medicine or ceasing direct patient care in the next five years.

In the National Mental Health Survey of Doctors and Medical Students[8] overseas trained and indigenous doctors were more likely to report being very stressed by racism and bullying.

Notifiable conduct

The national law imposes a mandatory obligation on registered health practitioners, employers and education providers to report notifiable conduct to AHPRA. 'Notifiable conduct' means that the practitioner has:[29]

- Practised the practitioner's profession while intoxicated by alcohol or drugs.
- Engaged in sexual misconduct in connection with the practice of the practitioner's profession.
- Placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment.
- Placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

The objective of the notification requirement is to protect members of the public from unsafe health practice.[30]

Importantly this obligation to report notifiable conduct falls on all registered health practitioners, not just those within the practitioner's own health profession. Thus the obligation to report notifiable conduct of a GP supervisor, should this occur, falls on a GP registrar, medical practitioners in the College(s), other medical practitioners, but also nurses and other health professionals who have become aware of the conduct.[30]

More detail is provided in mandatory reporting section on page 30.

There are a number of challenges in identifying the GP supervisor at risk and then managing the behaviours.[10-12, 21]

Challenges to identification and management of the GP supervisor at risk

DIAGRAM 4 CHALLENGES IN IDENTIFYING AND MANAGING THE GP SUPERVISOR AT RISK

Unrecognised behaviour

The behaviours may go unrecognised for a range of reasons:

- GP registrars, GP supervisors, educators may be ill equipped to recognise the behaviours.
- There may be a perception, or the GP supervisor may actually report, that it is the GP registrar who is the problem/at risk.
- Structured feedback is not fine grained enough or broad enough to identify problems.
- As a helping profession we may create excuses for colleagues' initial bad behaviours.
- There may be no longitudinal feedback data available or analysis of feedback is not timely.
- Independence is valued so health professionals are loathe to evaluate or confront a colleague perceived to have a problem.

Late recognition of longstanding behaviour

There are a number of reasons for longstanding behaviours being recognised late.

- GP registrars, GP supervisors, educators may be ill equipped to manage the behaviours, especially the disruptive behaviours.
- The issues are consciously ignored:
  - Too time consuming and difficult to deal with.
  - Policies at different levels. For example, College and practice are vague on expectations and lack clear protocols.
  - There are fears that there will be personal or professional repercussions.
  - That saying something will make matters worse, that they will be labelled a troublemaker.
- As GPs there is recognition that there may be underlying problems, and greater latitude is given.
- Don't want to be responsible for additional stress or distress to a GP supervisor colleague.
- Don't want to 'trash' a colleague's reputation.
- Power differential and perception that the GP registrar won't be believed.
- Minor issues are dealt with informally and if there is continued behaviour or escalation it is more difficult to manage.
- Often there is recognition of longstanding behaviours – "*We all know he/she can be difficult…*" or "*We all know these practices…*" – but little is actually done.

Belief that the behaviour is acceptable or even helpful

In some cases the GP supervisor may be unaware that they are intimidating or their behaviour constitutes harassment. However, a number of factors, including the hierarchical nature of medicine and the approach to learning in medical schools (and beyond) has created a culture that believes the teaching approach or conduct is acceptable or even helpful. This has been called a "transgenerational legacy".[10]

- GP supervisors may believe their approach is the best way for learning.
- GP supervisors (especially young GP supervisors) were harassed or intimidated during their residency and can't 'wait to dish it out'.
- The perception that the GP registrar needs to learn to deal with it because it happens in the real world, or it is good experience and learning for them.
- Workplace lauds or rewards the behaviour.
- The perception, or the reality, is that little or nothing has been done in the past, so nothing can be done.

Support and/or tolerance of the behaviours

Often there is support or at least tolerance of the behaviours.

- There is collusion because the GP registrar/ organisation might be worse off.
  - The practice offers good experience.
  - There is a need for training practices/posts.
  - Training benefits for the GP registrar staying.
- The GP supervisor is a good clinician.
- Easier to learn from other people or in other ways.
- GP registrars have a limited time in the practice so it is easier to 'put up with it'.

Deferring the issue

The perception that others will or should deal with the issue. This even occurs with mandatory reporting.

Revert to previous behaviours after management/resolution

These are difficult situations when education and behaviour change has occurred, but later there is a reversion to previous behaviours.

Understanding the **underlying causes**

These supervision performance issues and disruptive behaviours are best thought of as symptoms or flags of an underlying cause(s). Often there are a number of causes contributing to the behaviours, but for simplicity they have been divided into three areas – systems, educational and personal issues.

Systems

The system at the practice level or the College level may be contributing to the behaviours with:

- Lack of support for education and supervision at the practice level.
- Workload commitments within the practice.
- A dysfunctional work environment.
- Complexity of balancing clinical, supervision and teaching.
- Lack of broader support and networking.
- Tolerance of behaviours.
- Limited or poor supervision training.

Educational

Being an effective GP supervisor requires different knowledge and skills to being a good clinician and the general competencies of a teacher or trainer.[13]

The underlying issues may include:

- Lack of confidence in supervision skills especially for new GP supervisors.
- Lack of knowledge and skills in supervision and teaching.
- Poor demarcation of the multiple roles of the GP supervisor.
- Lack of interest in education with a larger focus on workforce.
- Inadequate skills and/or support to deal with a particularly challenging GP registrar.

Personal

Some behaviours may be exaggerations of personal character traits, for example rigidity, perfectionism, compulsiveness and independence. Coupled with insecurity, feeling threatened or jealous of another's success may heighten these behaviours.

Stress, burnout and mental illness may be present. Indeed, these are significant issues for doctors with the Australian National Mental Health Survey of Doctors and Medical Students (2013) key findings[8] that:

- Doctors report substantially higher rates of psychological distress and attempted suicide compared to both the Australian population and other Australian professionals.
- Young doctors and female doctors appeared to have higher levels of general distress and specific mental health problems.
- The general work experience for Australian doctors is stressful and demanding. They reported levels of burnout across three domains:
    - Emotional exhaustion, 30.8 per cent.
    - Cynicism, 34.1 per cent.
    - Low professional efficacy, 14.7 per cent.
- Young doctors and female doctors reported higher burnout rates compared to older doctors (51 to 60 years).
- Stigmatising attitudes regarding the performance of doctors with mental health conditions persist.
- Approximately 40 per cent of doctors felt that medical professionals with a history of mental health disorders were perceived as less competent than their peers.

On a positive note they also identified that:

- Doctors appear to have a greater degree of resilience to the negative impacts of poor mental health.
- Doctors reported high rates of treatment and medication use for both depression and anxiety in comparison to the general population.

Appendix 1 outlines the executive summary findings of this survey in more detail.

The GP supervisor may be the victim of disruptive behaviour themselves and their behaviour is only a reflection of the impacts of bullying and/or harassment.

Of course doctors are not immune to physical illness including age-related and disease-related cognitive impairment and these may be significant underlying causes. Family stressors such as financial problems, family illness, dysfunction, separation, divorce or a combination of these may also be contributing.

Alcohol and drug dependency can also be present, however it is not necessarily the direct cause of the behaviours and may be symptoms too.[12]

Thinking **protective/prevention factors**

The focus so far has been on the behaviours of the GP supervisor in difficulty. But before we explore how to manage these, it is important to highlight strategies/approaches that may be protective for GP supervisors and thus preventative. These strategies are represented as cogs because they are interconnected and a change in one can affect the others.

DIAGRAM 5 PROTECTIVE AND PREVENTATIVE FACTORS

Clear expectations

Having clear roles, responsibilities, expectations and lines of accountability supports the supervision process.[14] Both colleges have articulated these in their standards documents may have additional regional requirements. Knowing these and understanding them is essential. It is just as important at the practice level to have these expectations articulated, with doctors and staff clear about their roles and responsibilities.

On a personal level, recognising the differing roles you have as a GP supervisor has the benefit of being able to clarify any role ambiguities, and identify and manage potential or actual role conflicts of each aspect of the role. This can minimise supervisor-registrar mismatch of expectations or misunderstandings and may also improve GP supervisor satisfaction and sustainability.[1]

When considering disruptive behaviours it is especially important to have clear and well publicised policies or code of conduct in place. This is important at all organisational levels including practices, irrespective of size or number of employees. There needs to be a zero tolerance for these behaviours. In addition, there needs to be safe procedures for reporting that provides informal and formal strategies for prompt resolution in a sensitive, rather than a punitive way.[11, 12, 23, 24]

Choice/motivation

In most circumstances GP supervisors have chosen to be involved in GP training. As this is often driven by the GP supervisor's personal motivations and interest and to some extent the practice's interest, this is likely to be a highly protective strategy, and in itself is a protective factor. In Australia, GP supervisors have identified many positive motivations for being involved in the GP training programs.[31-34] These include:

- **Personal and professional benefits of being a GP supervisor** – enjoying teaching; learning through teaching; developing teaching skills and interests; having a sense of pride; being challenged; having intellectual stimulation; teaching enhances their own understanding of general practice; and adds a variety to their practice.
- **Responsibility to the profession of general practice** – keen to model and promulgate a high standard of care; a sense of responsibility; and development of the next generation of GPs.
- **Benefits for the GP practice or business** – increased capacity to meet patient needs (workforce); development of a practice learning environment; improving collegiate relationships and shared learning; less use of locums; and some reduction in after-hours work.
- **Responsibility to the community** – by being involved in training they were improving the standard of healthcare provided; improved own practice care; and GP registrars remain in the area (especially rural).

In other health professions there is evidence that better satisfaction and outcome are achieved if the learner has the opportunity of choosing their own supervisor.[14, 15, 35] In GP training this option is available to many GP registrars who have the opportunity to choose their practice, and the GP supervisor to choose their GP registrar. Interestingly while choice of practice is often made on grounds of location (proximity to home) the other important factor for choosing a practice is the GP supervisor. Even within the practice there may be further opportunities to provide a choice of GP supervisor to support an effective supervisor-registrar alliance.

Shared responsibility, the team

Supervision is more likely to have a positive impact and outcome where there is a supportive culture in the organisation. It is difficult for a keen GP supervisor to provide effective supervision when the organisation is not supportive. On the other hand, the impacts on a learner of a GP supervisor at risk is often mitigated by a positive organisational culture and other doctors and staff involvement.[14, 15, 36, 37, 38]

It is also important for a GP supervisor to utilise the supportive practice culture. This means the GP supervisor should not feel they are totally responsible for delivering all aspects of teaching and training for the GP registrar. They should be comfortable to create a shared responsibility across the practice team. The RACGP standards specifically identify "The supervision team is headed by the lead general practice supervisor, and includes all others who work within the training post, including other doctors, nurses, allied health professionals and administration staff." (Standard 1.1)[3]

This team approach provides the GP registrar with a breadth of experiences and learning and teaching strategies. Australian GP practices identified as delivering higher quality GP training ensure that:[39, 40]

- Other members of the practice are readily available and accessible for corridor teaching.

- Other non-clinical members of the practice contribute to the GP registrar's learning.
- The practice has regular, structured clinical meetings that include all members of the practice team.

In addition, this team approach provides a support for the GP supervisor and reduces the likelihood of the GP supervisor finding themselves exceeding their own personal capacity for supervision.

Support networks

We have already identified the importance of the whole practice being part of the supervision team. In addition, the practice can develop a supportive culture for all of its doctors and staff. For example, by having formal or informal debriefing strategies, ensuring organisational boundaries are known and understood by patients. For example, home visits, consultation length, reviewing workload regularly, taking care in scheduling complex care needs patients etc.[38]

Having a local network of GP supervisors provides support and opportunities for sharing of strategies for teaching, supervision and the 'challenging' GP registrar. Each College has Supervisor Liaison Officers (SLO) who is available to discuss issues and provide support, along with the medical educators and Directors of Training. On a national level GPSA provides support, education and resources for all GP supervisors.

Self care

Australian GP practices identified a s d elivering higher quality GP training have a GP supervisor who the GP registrar feels demonstrates an appropriate model of self care.[39] This may be apparent to the GP registrar in the way the GP supervisor creates a work-life balance, and manages the stresses of general practice.

But achieving good self care needs to be an active process and having a well-considered self-care plan is important. As with any good plan it should be a plan that is achievable, concrete and also designed to attend to any particular sources of stresses.[14] Examples of categories to consider in the plan include organisational aspects such as workload; professional strategies for attending to your own professional development needs especially around the GP supervisor roles; and strategies that assist you on a personal level (especially recognising that doctors are at a higher risk of stress, burnout, and significant psychological distress).[8]

Another important self-care component is that the GP supervisor has their own GP, and where appropriate, a treating specialist.

Many other health professionals (for example nursing, psychology) have well-developed systems for supervision-of-supervision. Having this reflective space to review one's clinical supervision work is seen as essential to the wellbeing of GP supervisors, as well as a principle of accountability and good practice.[14] This is not common practice in medicine nor in the GP training programs, but may be a very important strategy to be considered for the future. While it is unlikely that a practice itself internally could provide supervision-of-supervision, other models can be considered such as:

- Engaging external clinical supervisors.
- Creating supervision-of-supervision groups facilitated by an external GP supervisor.
- Peer supervision-of-supervision groups in which GP supervisors meet to review their practises together and to offer one another feedback and support. (Note: this is not purely a group of GP supervisors meeting together but assumes a well-structured goal and process).

Balint groups have been conducted for GP supervisors in some areas may be the closest example of supervision-of-supervision in GP training.

A good resource on self care available to GPs is Keeping the Doctor Alive. This guidebook has information, activities and resources on strategies for self care. https://www.racgp.org.au/FSDEDEV/media/documents/Running%20a%20practice/Practice%20resources/Keeping-the-doctor-alive.pdf

The RACGP has a GP support program which can provide help to members with a range of issues, including: handling work pressures; managing conflict; grief and loss; relationship issues; concerns about children; anxiety and depression; alcohol and drug issues; and traumatic incidents. https://www.racgp.org.au/membership/the-gp-support-program

There is a doctor's health advisory service (or its equivalent) in each state. https://www.drs4drs.com.au/resource-hub/

Professional development/resources

Australian GP practices identified as delivering higher quality GP training have GP supervisors who have undertaken GP supervisor training and have GP supervisors who the GP registrars perceive as being open to learning from the GP registrar and other health professionals.[39, 40]

The literature also identifies that GP supervisors feel significant stress if they feel that they don't have a framework or training in effective supervision.[15] Indeed training is important because, as mentioned previously, a GP supervisor requires different knowledge and skills to those of a good clinician or the general competencies of a teacher or trainer.[13]

The training for this role needs to focus on a range of knowledge and skills including:[1, 3, 4, 13, 14, 15, 18]

- Competencies to develop, maintain and manage threats to an effective supervisor-registrar alliance.
- Effective supervision strategies especially feedback, appraisal and assessment.
- Competencies to gauge progress and support and manage the GP registrar at risk.
- Counselling skills.
- Effective teaching strategies.
- The ability to foster competence in working with difference. For example, culture and diversity.
- Ability to enable ethical practice.

This also needs to include the provision of resources including technologies and appropriate funding.

*Crucial conversations is a term used to describe a structured approach to tackling situations where the stakes are high, opinions vary and emotions start to run strong. *Patterson K, Grenny J, McMillan R, Switzler A. Crucial conversations. Tools for talking when stakes are high. McGraw-Hill, 2002.*

Effective supervision strategies

While last, this is certainly not the least. Supervision literature abounds with research and reviews which outline a myriad of strategies for effective supervision. These strategies are not medicine specific, and many of them will be apparent as the opposite of the behaviours identified earlier under ineffective supervision. Highlighted here are those that have been highly correlated with higher quality training. GP supervisors may already have a number of these skills as part of their psyche or because they are GPs, but importantly they are skills that can be learned as part of a GP supervisor's professional development.

Educational **alliance**

Wearne's supervisor-registrar educational alliance[6] highlights the importance of the supervisor-registrar relationship which, as mentioned previously, may be the most robust and significant variable in whether supervision is effective or ineffective.

The GP supervisor factors which increase the probability of forming a positive alliance include being:[2, 6, 13, 14, 16, 18, 40, 41,42]

- Flexible and allowing GP registrars to raise issues that are important to them.
- Respectful.
- Warm and affirming.
- Open.
- Alert and active.
- Able to show honesty through self-reflection.
- Trustworthy.

The capacity to develop the alliance includes many of the elements identified throughout this section including negotiating shared objectives, adjusting style to be congruent with the GP registrar, being open and responsive to feedback etc.

Importantly the GP supervisor needs to have developed skills in recognising when there are strains on this alliance, using appropriate interventions when there is a strain and the ability to recognise and take appropriate action if the alliance has broken down.[18]

Learner centred approach

This underpins all the strategies. In a similar way to the patient-centred model in general practice, this learner-centred approach is holistic, it considers learner needs and wants, individualises training and education and encourages negotiation, active participation and reflection. The learner assumes responsibility for the learning, the supervisor is responsible for facilitating the learning.[6, 13, 14, 15, 16, 17, 18, 35, 36, 38, 41, 42]

Structured orientation and planning

Australian GP practices identified as delivering higher quality GP training have a:[39, 40]

- Structured orientation that meets the GP registrar's needs.
- GP supervisor who worked with the GP registrar to develop and implement a learning plan for the placement. (This may have been a formal or informal plan).

The orientation is the basis for good planning throughout the term. Table 1 highlights some questions a GP supervisor can consider when preparing to work with each new GP registrar.

TABLE 1 GP SUPERVISOR QUESTIONS TO REFLECT ON WHEN PLANNING TO WORK WITH A NEW GP REGISTRAR. ADAPTED FROM BERNARD AND GOODYEAR AND WHITTLE ET AL[14]

- What do I know about the GP registrar I will work with? How does the GP registrar's and my learning style, cultural worldview, experience level, and so on, affect my thinking about working with them?
- In light of what I know about my GP registrar, is there any additional preparation I need to do in order to be helpful to this person?
- As I understand the GP registrar's goals, which are most likely to be met in this experience? Which are less likely to be met? Is the GP registrar clear about this?
- What supervision and teaching modalities are available to me? Can I supplement those that are provided by the training organisation? What is my rationale for beginning where I intend to begin? What teaching and supervision schedule will we adhere to?
- How will I determine if the supervisee is adequately aware of ethical and legal imperatives?
- When will I introduce my evaluation plan?
- Knowing the practice and training program as I do, what are the predictable challenges that will face the GP registrar? How can I make these productive learning opportunities?
- What areas are difficult for either of us to discuss and how can such discussions be facilitated, or supported?
- How will we identify if/when one person is becoming defensive and how will we best handle this?
- To whom will I turn for consultation when I am challenged in my work with this GP registrar?

Feedback

Australian GP practices identified as delivering higher quality GP training have:[39, 40]

- Feedback on clinical performance by the GP supervisor within four to six weeks of the placement starting.
- Regular feedback on clinical performance throughout the term.
- Feedback provided was constructive and valuable.
- Appraisals and assessments that were discussed with the GP registrar.

Learners often comment that they don't get enough feedback from their GP supervisors.[13, 14] Sometimes this is true – there is little or no feedback. Other times what the GP supervisor thinks is giving feedback isn't at all, it is 'telling' or only a single loop. True feedback is a dialogic, learner-driven, open adaptive/responsive system that has a double feedback loop for judgment performance improvement. It should include peers, other practitioners[43] and patients.

Appraisal, assessment and giving effective feedback are three important areas for professional development for GP supervisors.

Support

Australian GP practices identified as delivering higher quality GP training have:[39, 40]

- Support from their GP supervisor that was adequate to their needs.
- A GP supervisor who facilitated solutions to issues and problems that arose in the practice.
- A GP supervisor who provided good support when the GP registrar was delivering structured teaching to medical students or prevocational doctors.
- Support and supervision adequate to the GP registrar's needs if working at a branch practice.

Effective **teaching**

Australian GP practices identified as delivering higher quality GP training ensure that:[39, 40]

- The individual GP registrar's learning needs were addressed as part of the in-practice teaching.
- The required amount of teaching and supervision for this placement were provided (as a minimum).
- Regular, structured one-to-one teaching time occurred throughout the placement.
- The one-to-one teaching time was of a high quality throughout the placement.
- The GP supervisor demonstrated an evidence-based approach to clinical care in the in-practice teaching.
- Other members of the practice were readily available and accessible for corridor teaching.
- Other non-clinical members of the practice contributed to their learning.
- There was adequate time to attend formal educational activities outside the practice.
- The practice has regular structured clinical meetings that include all members of the practice team.

In terms of actual one-to-one teaching (not opportunistic or ad hoc teaching), the factors that are highly correlated with a high quality teaching encounter are:[41]

- Adequate preparation.
- Protected teaching time.
- Number of resources used in teaching – particularly patient files and professional guidelines.
- Presence of medical content of the encounter.
- Inclusion of follow-up activities that actively involved the GP registrar.
- Positive reinforcement. That is giving trainee feedback on what was done correctly.
- Direct observation by the GP supervisor with discussion of observations afterwards with the GP registrar.

Managing the GP supervisor **at risk**

In this guide we have focused on the GP supervisor as underperforming, demonstrating disruptive behaviour or even notifiable conduct. But it is important to recognise the underlying causes for these behaviours, and to particularly remember that the GP supervisor may themselves be the victim of bullying or harassment.

Early warning signs

The first step in management is to recognise the early warning signs of a GP supervisor in difficulty. Many of the early warning signs are similar to those identified for GP registrars at risk (see GPSA guide Identifying and Supporting GP Registrars at Risk). They may include:

- **The "disappearing act":** Not answering calls or messages; frequent sick leave or absence.
- **Change in work rate:** Tardiness in doing procedures, completing patient notes, dictating letters, making decisions; arriving early, leaving late and still not achieving a reasonable workload.
- **Unjustifiable anger:** Bursts of temper; shouting matches; real or imagined slights.
- **Emotional:** Refers emotionally, often to whoever will listen, to personal upset over recent events originating in the workplace or in personal life; is taking an emotional interest in the GP registrar or other staff's personal life; suspects the actions or motivations of others and holds grudges.[11]
- **Rigidity:** Poor tolerance of ambiguity; inability to compromise; difficulty prioritising; inappropriate blaming.
- **Bypass syndrome:** GP registrars or nurses find ways to avoid seeking the GP supervisor's opinion or help; GP registrars asking for second opinions after obtaining their GP supervisor's comments. Receptionists avoid booking patients when they otherwise could.
- **Career problems:** Disillusionment with medicine overall or general practice specifically.
- **Blames others:** Blames others for problems either at home or work.
- **Insight failure:** Rejection of constructive criticism; defensiveness; counter-challenge; over-arguing a point.
- **Lack of engagement in educational processes:** Late submission of GP registrar assessments and other training documentations required or failure to complete them altogether; failing to attend GP supervisor education.
- **Poor engagement in supervisor-registrar alliance:** Identifies that the GP registrar is a problem or 'difficult' but this is not the experience of others; regularly missing or arriving late for structured teaching sessions; makes derogatory remarks about the GP registrar; criticises or identifies failings in front of patients, colleagues, staff; is irritable or annoyed when interrupted by the GP registrar for opportunistic teaching: not available or easily accessible.
- **Inappropriate attitudes:** Makes inappropriate comments or jokes about the GP registrar's gender, race, religious beliefs etc.[11,12]
- **Change in work ethic:** Arriving late and leaving early; taking frequent tea breaks or extended lunch breaks; not engaging with practice staff.
- **Complaints:** Patients and/or GP registrars making informal comments or a formal complaint.

Who identifies the GP supervisor at risk?

Unlike the GP registrar who has a GP supervisor monitoring their progress, the GP supervisor is likely to have no-one who is closely monitoring them. Thus, early identification is most likely to fall on other GP supervisors or doctors in the practice, other members of the practice or the GP registrar. Ineffective supervision behaviours are in fact most likely to be identified by the GP registrar first because they are the ones who are experiencing the impacts.

While a GP registrar may feel comfortable to directly talk with their GP supervisor or other members of the practice, often the information is reported through other channels such as the External Clinical Teaching Visitor, the GP registrar's Training Advisor, Regional Medical Educators or Supervisor Liaison Officers, directly to the College or via another GP registrar or Registrar Liaison Officers raising the concern.

The formal post evaluations are another mechanism for identifying problems, however they may be more a medium-term identification mechanism as often the term has ended, the analysis of data can take time, or the feedback may not be fine grained enough to identify early signs etc.

MANAGEMENT APPROACH

Management is best approached in a staged, progressive way that is dictated by the behaviour trigger(s). Response strategies can be considered as personal or organisational. Table 2 shows a GP supervisor identifying problem behaviours in another GP supervisor may require a response at both levels.

TABLE 2 RESPONSE STRATEGIES[12]

Personal response strategies	Organisational response strategies
• Crucial conversation • Enlist the support of a colleague • Document ongoing or significant behaviour • Seek advice from an individual at a higher level • Report recurring or serious behaviours • Offer support to colleagues who are targets	• Formal reporting process • Evaluation and initial review (fact gathering) • Investigation • Progressive approach to intervention (dependent on severity, continuation of or escalations of behaviour) • Follow-up • Resolution • Documentation • Support for all involved.

In the investigation phase critical incident tools such as the fishbone cause effect analysis, timeline of events or a Haddon matrix may be helpful to explore all aspects of the events – processes, human factors, environmental factors etc.

Table 3 demonstrates intervention strategies depend on the severity of the behaviour and sometimes more than one intervention strategy may be used.

TABLE 3 INTERVENTION STRATEGIES. ADAPTED FROM HQCA (2013)[12]

Severity of behaviour	Intervention strategy
LEVEL 1 Low severity **LEVEL 2** Continuing behaviours Moderate severity **LEVEL 3** Persistent or escalating Medium to high severity **LEVEL 4** Critical Notifiable	• Crucial conversation (informal) on behalf of the GP registrar • Crucial conversation (informal) • Crucial conversation (informal) with SLO • Formal meeting • Formal meeting with College representative • Professional development • Coaching and mentoring • Referral to a support or assistance program • Assessment of contributing factors • Counselling • Clinical assessment and interventions • Mediation • Behaviour – focused training • Temporary withdrawal as GP supervisor • Report to RACGP/ACRRM • Withdrawal of practice from training program • Work restrictions • Report to AHPRA • Legal action

There are supports available for the GP supervisor at risk including the SLO, GPSA, and the College(s).

As mentioned previously the RACGP has a GP support program which can help members with a range of issues, including: handling work pressures; managing conflict; grief and loss; relationship issues; concerns about children; anxiety and depression; alcohol and drug issues; and traumatic incidents. https://www.racgp.org.au/membership/the-gp-support-program

There is a doctor's health advisory service (or its equivalent) in each state. https://www.drs4drs.com.au/resource-hub/

Mandatory reporting

What are mandatory notifications?

All registered health practitioners have a professional and ethical obligation to protect and promote public health and safe healthcare. Under the national law, health practitioners, employers (entities that employ or contract GP registrars and GPs and education providers (for example, universities) also have some mandatory reporting responsibilities.

The obligation to report notifiable conduct falls on all registered health practitioners, not just those within the practitioner's own health profession. Therefore, the obligation to report notifiable conduct of GP supervisors would fall on GP registrars, College medical educators and Directors of Training, and also nurses and other health practitioners.

Importantly Colleges are only considered employers for the purposes of health professional staff that they directly employ. Thus they are not obligated to report notifiable conduct for the vast majority of GP registrars and GP supervisors.

The national law also imposes a mandatory notification obligation on education providers with respect to some students who have an impairment. Colleges meet the definition of 'education provider' under the national law, but the term 'student' is defined in the national law to exclude registered medical practitioners. Therefore the obligation that falls on education providers to notify AHPRA about impaired students is not relevant to RTPs in the general practice context.

Note: Anyone can make a voluntary notification at any time.

For more information on mandatory and voluntary reporting visit: https://www.ahpra.gov.au/Notifications/Raise-a-concern/Mandatory-notifications.aspx

What is a reasonable belief?

The threshold to require mandatory reporting is high. 'Reasonable belief' is a term commonly used in legislation, including in criminal, consumer and administrative law. While it is not defined in the national law, in general, a reasonable belief is a belief based on reasonable grounds.

Each national board has published guidelines on mandatory notifications for its profession, which are published on each national board's website. These guidelines help individuals to decide whether they are required to make a mandatory notification or not.

Appendix 2 provides a simple decision guide for notifications.

Mandatory notification requirements for employers and registered health practitioners

The national law requires registered health practitioners and employers of registered health practitioners, to advise AHPRA or a national board if they have formed a reasonable belief that a health practitioner has behaved in a way that constitutes notifiable conduct in relation to the practice of their profession.

Notifiable conduct by registered health practitioners is defined as:

- Practising while intoxicated by alcohol or drugs.
- Sexual misconduct in the practice of the profession.
- Placing the public at risk of substantial harm because of an impairment (health issue).
- Placing the public at risk because of a significant departure from accepted professional standards.

Roles and responsibilities of the involved parties

The GP registrar, as an employee, has a contractual relationship with their employer and is subject to the terms of their contract, which is usually consistent with the National Terms and Conditions of Employment of GP registrars. This may include details relating to working hours, attendance, workload, leave allowances and remuneration. GP registrars also have a responsibility to fully engage with the educational requirements of their College in accordance with their AGPT Applicant Declaration.

The GP supervisor and training post, are similarly obliged by the terms of the employment contract signed with the GP registrar, but also bound by the training agreement in place with the College. The GP supervisor is responsible for ensuring the GP registrar is adequately supported in the care of their patients and receives the formal and informal teaching necessary to progress through their general practice training. As a member of the medical profession, they must protect patient safety, and are also obliged to report notifiable conduct.

The local medical educator is responsible for scheduling and facilitating regular formal teaching sessions, and for providing oversight of the training progress of the GP registrar in their training post. The medical educator also acts as the conduit for communication from the GP registrar and GP supervisor to the College. They may be required to provide additional teaching and support to a GP registrar in difficulty in accordance with their agreed action plan.

The College(s) must ensure that employment responsibilities are implemented. They are directly responsible for the management of performance and disciplinary matters, and that issues identified are addressed in a proportionate, timely and objective way. They should have robust processes for the identification, support and management of doctors whose conduct, health or performance is giving rise for concern. GP supervisors should receive training from the College (s) in how to identify and support trainees in difficulty, in partnership with training program directors as appropriate. College(s), through their director of education, should be aware of any regulatory changes that would impact on GP registrar training and standards. Employing organisations have a contractual responsibility to provide counselling and pastoral care for doctors in training.

The Royal Australian College of General Practice (RACGP), and Australian College of Rural and Remote Medicine (ACRRM), have responsibility for determining the standards necessary for Fellowship of their college, and for accreditation of the training practices in being capable of delivering these to enrolled GP registrars. Through their summative assessment process, the colleges decide on the appropriate professional standards expected of examination candidates, and have robust appeals processes in place for dissatisfied registrars to question their outcome.

Australian Government Department of Health has responsibility for funding and contracting of College(s) and therefore broadly for the administration of vocational general practice training in Australia. It executes this through the Australian General Practice Training (AGPT) program, and facilitates governance of the program with the RACGP and ACRRM via the General Practice Training Advisory Committee. It also has responsibility for overseeing effective systems exist for managing problems that arise which prevent normal progression through the training process, for whatever reason.

Australian Health Practitioner Regulation Agency (AHPRA) is responsible for ensuring compliance of the medical workforce with national standards and for managing complaints from the public or the profession regarding the conduct of medical practitioners.

Appendix 1

Reproduced from The National Mental Health Survey of Doctors and Medical Students (excerpts from Executive Summary 2013) -

Topics covered by the anonymous, self-complete survey included: specific and general mental health status; substance use and misuse; suicidal ideation and self-harm; workplace and life stressors; levels of burnout; impact of mental health symptoms; treatment and coping strategies employed to address mental health symptoms; barriers to seeking treatment and support; and attitudes regarding doctors with mental health conditions.

The sample comprised 42,942 doctors and 6,658 medical students. The final response rate was approximately 27 per cent for doctors and medical students, which resulted in 12,252 and 1,811 respondents respectively.

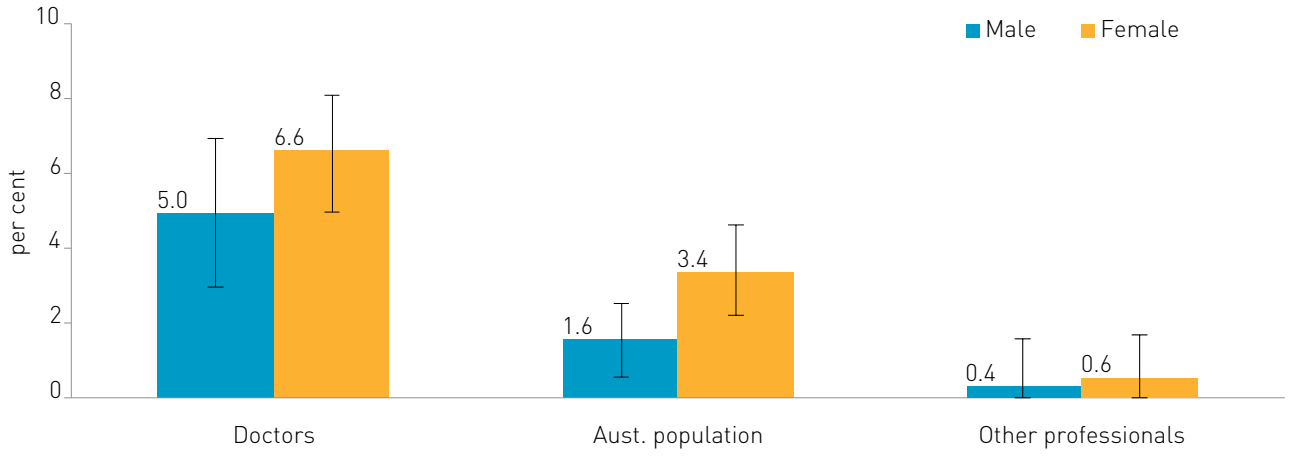
KEY FINDINGS FOR DOCTORS

Doctors reported substantially higher rates of psychological distress and attempted suicide compared to both the Australian population and other Australian professionals.

The level of psychological distress was assessed using the Kessler 10 (K10) scale. Doctors were asked if they had ever been, or were currently, diagnosed with anxiety or depression.

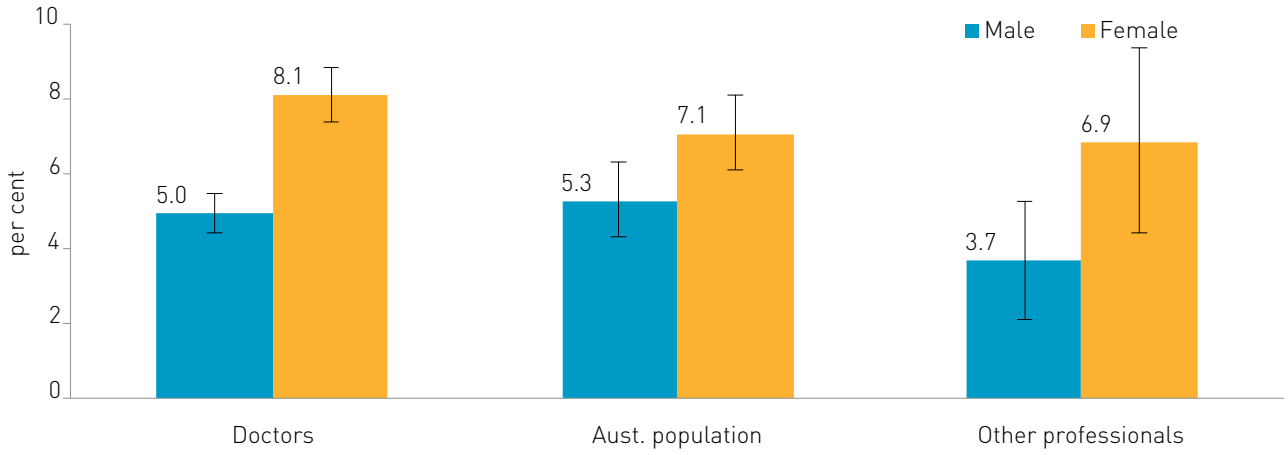
The level of both general distress and specific mental health diagnoses reported by medical professionals was high. In comparison to estimates obtained from the National Survey of Mental Health and Wellbeing 2007 (NSMHW, 2007), the level of very high psychological distress was significantly greater in doctors in comparison to the general population and other professionals (3.4% vs. 2.6% vs. 0.7%). In particular, the levels of very high psychological distress in doctors aged 30 years and below is significantly higher than individuals aged 30 years and under in the Australian population and other professionals (5.9% vs. 2.5% vs. 0.5%). (Figure 1).

FIGURE 1: LEVELS OF VERY HIGH PSYCHOLOGICAL DISTRESS BY GENDER IN DOCTORS, THE AUSTRALIAN POPULATION AND OTHER AUSTRALIAN PROFESSIONALS AGED 30 YEARS AND BELOW.



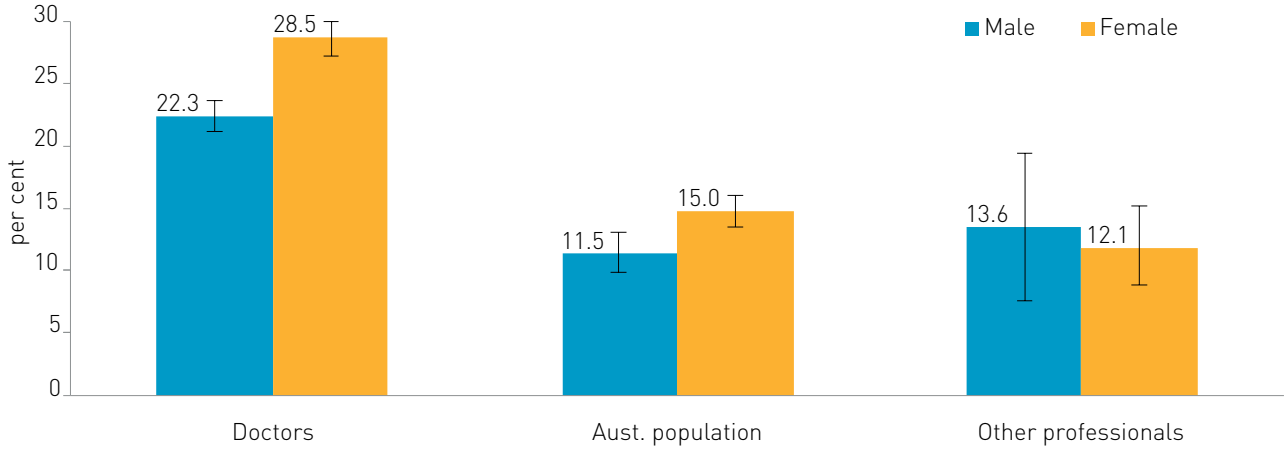
Approximately 21% of doctors reported having ever been diagnosed with, or treated for, depression and 6% had a current diagnosis. Current levels of depression were similar in doctors in comparison to the general population, but higher than other Australian professionals (6.2% vs. 6.2% vs. 5.3%). (Figure 2). Approximately 9% of doctors reported having ever been diagnosed with or treated for an anxiety disorder (Australian population 5.9%), and 3.7% reported having a current diagnosis (Australian population 2.7%).

FIGURE 2: CURRENT LEVELS OF DEPRESSION BY GENDER IN DOCTORS, THE AUSTRALIAN POPULATION AND OTHER PROFESSIONALS



Approximately a quarter of doctors reported having thoughts of suicide prior to the last 12 months (24.8%), and 10.4% reported having thoughts of suicide in the previous 12 months. As illustrated in Figure 3, thoughts of suicide are significantly higher in doctors compared to the general population and other professionals (24.8% vs. 13.3% vs 12.8%). Approximately 2% of doctors reported that they had attempted suicide.

FIGURE 3: SUICIDAL IDEATION BY GENDER IN DOCTORS, THE AUSTRALIAN POPULATION AND OTHER PROFESSIONALS PRIOR TO THE PREVIOUS 12 MONTHS



Young doctors and female doctors appeared to have higher levels of general and specific mental health problems and reported greater work stress.

General mental health problems were assessed with the use of the K10 and General Health Questionnaire (GHQ), which provides an indicator of the likelihood of minor psychiatric disorders. Specific distress was determined based on diagnoses of anxiety and depression.

Female doctors reported higher rates than male doctors of current psychological distress (4.1% vs 2.8%), high likelihood of minor psychiatric disorders (33.5% vs. 23.2%), and current diagnoses of specific mental health disorders (8.1% vs. 5.0% for depression; 5.1% vs. 2.9% for anxiety). In addition, they were more likely to have thoughts of suicide in the previous 12 months (11.0% vs. 10.0%), prior to the previous 12 months (28.5% vs. 22.3%), and attempted suicide (3.3% vs. 1.6%). They also reported greater work stress (e.g. 37.4% vs. 19.8% for conflict between career and family/personal responsibilities) and were more likely to report experiencing stressful life events in the past year compared to male doctors (e.g. 20.4% vs. 17.2% regarding caring for a family member)

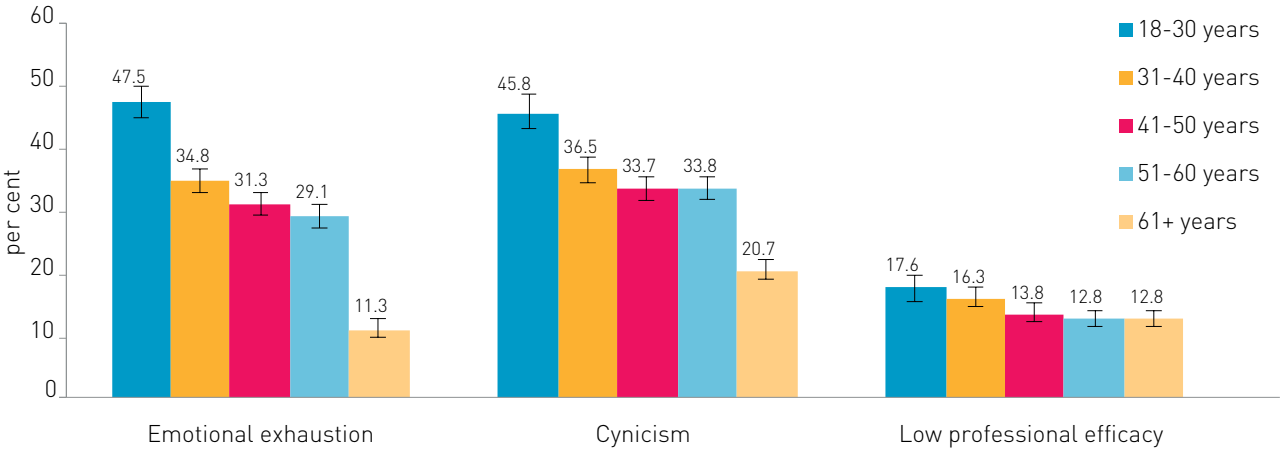
Young doctors appeared to be particularly vulnerable to poor mental health and high levels of stress. Compared to older doctors (51-60 years), younger doctors reported higher rates of burnout, as measured by the Maslach Burnout Inventory (MBI), across the three domains of emotional exhaustion (47.5% vs. 29.1%), low professional efficacy (17.6% vs. 12.8%) and high cynicism (45.8% vs. 33.8%).

The general work experience for Australian doctors is stressful and demanding.

The work experience of doctors was assessed with the use of the MBI. In addition, participants were asked about whether they experienced a number of work related stressors.

Reported levels of burnout were high across the three domains. Specific subgroups of the population, including young doctors (Figure 4) and female doctors, reported higher rates of burnout in comparison to others. Of interest, levels of cynicism were substantially higher in young doctors in comparison to both pre-clinical and clinical medical students (45.8% vs. 23.6% vs. 26.6%). This suggests that the transition from study to working may be a particularly difficult time for newly trained doctors and they may require additional support.

FIGURE 4: BURNOUT IN THE DOMAINS OF EMOTIONAL EXHAUSTION, CYNICISM AND PROFESSIONAL EFFICACY, BY AGE GROUP



The most common source of work stress reported by doctors related to the need to balance work and personal responsibilities (26.8%). Other sources of work related stress include too much to do at work (25.0%), responsibility at work (20.8%), long work hours (19.5%) and fear of making mistakes (18.7%). There were some differences in work stressors within subgroups of the population. For example, overseas trained and Indigenous doctors were more likely to report being very stressed by racism and bullying. Females were more likely than male doctors to report being very stressed by life and work stressors.

Stigmatising attitudes regarding the performance of doctors with mental health conditions persist.

Stigmatising attitudes regarding the competence of doctors with mental health conditions, and their opportunities for career progression, persist in the medical community.

Approximately 40% of doctors felt that medical professionals with a history of mental health disorders were perceived as less competent than their peers, and 48% felt that these doctors were less likely to be appointed compared to doctors without a history of mental health problems. Approximately 59% of doctors felt that being a patient causes embarrassment for a doctor.

The prevalence of stigmatising attitudes differed by gender. For example, female doctors were more likely than male doctors to view doctors with a mental health history to be as reliable as the average doctor (69% and 55% respectively).

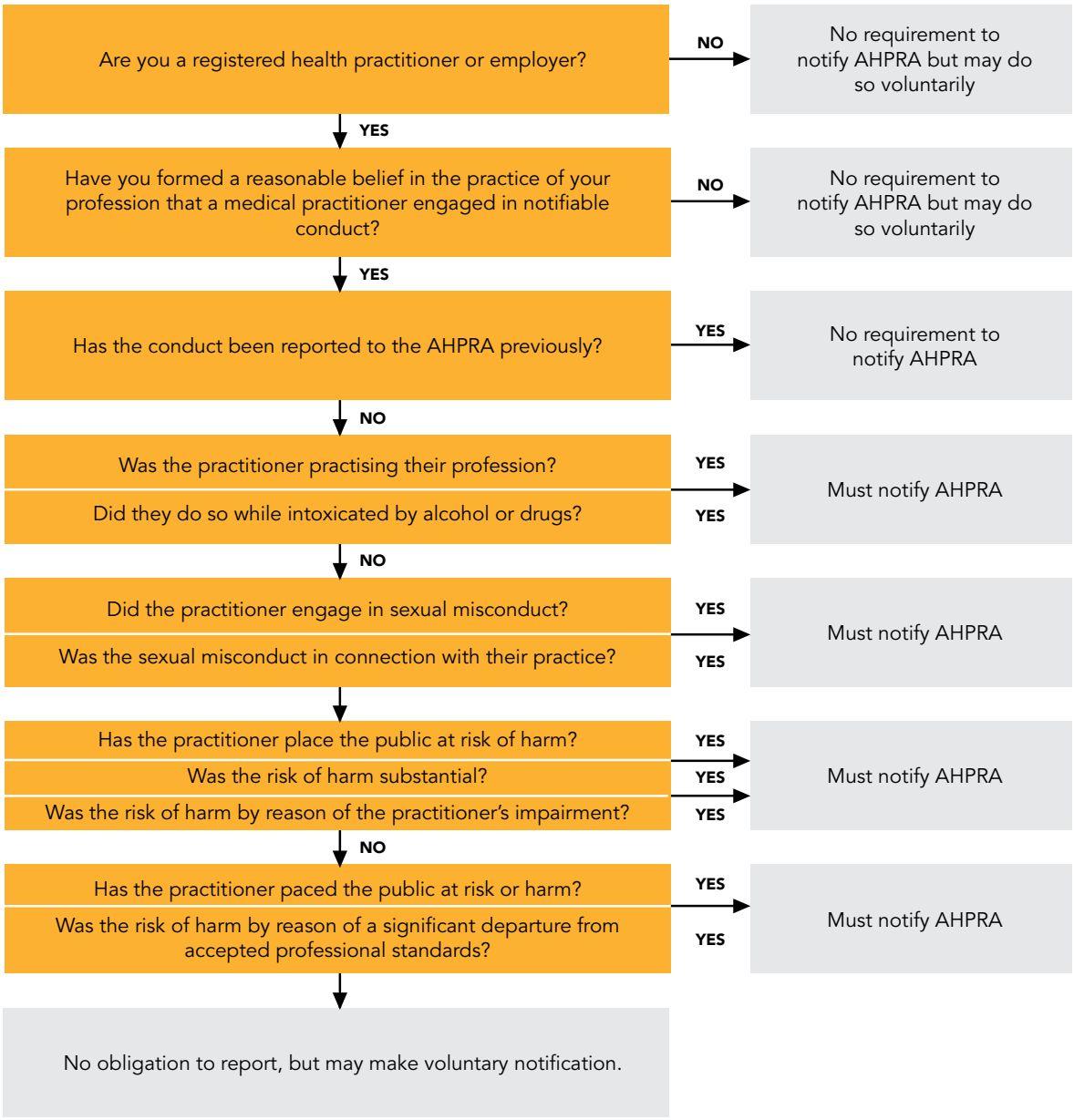
Doctors appear to have a greater degree of resilience to the negative impacts of poor mental health.

Impact was determined based on the reported impact of mental health symptoms in the areas of work and self, and the rates of treatment for specific mental health diagnoses. While rates of general and specific mental health problems were high, it appears that many doctors are able to limit the impact of these problems. However, barriers to seeking treatment and support for a mental health condition were identified, including a fear of a lack of confidentiality or privacy (52.5%), embarrassment (37.4%), impact on registration and right to practice (34.3%), preference to rely on self or not seek help (30.5%), lack of time (28.5%), and concerns about career development or progress (27.5%).

Few doctors reported being highly impacted by their mental health symptoms in the domain of work or self. Doctors reported high rates of treatment and medication use for both depression and anxiety in comparison to the general population. These findings suggest that despite having high levels of general and specific distress, doctors are more likely to seek treatment than the Australian population and are able to manage some of the negative effects of poor mental health. Jogging/exercise was the most commonly identified coping technique used by doctors (males 37.1%, females 35.9%).

Appendix 2: **Decision Guide for Notifications**

The AGPT Program Directors of Training engaged DLA Piper to develop a document to provide practical assistance to participants in the AGPT Program regarding the obligations and management of information related to notifiable conduct. This decision guide was reproduced from this document.



Reproduced from DLA Piper (2013)[30] AGPT Guidelines for managing notifiable conduct in GP training settings.

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