AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

12/40

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Dr Joanne Katsoris
Executive Officer
Medical
Australian Health Practitioner Regulation Agency
GPO Box 9958
MELBOURNE VICTORIA 3001
By email: medboardconsultation@ahpra.gov.au

Dear Dr Katsoris

**RE: CONSULTATION ON THE BOARD FUNDING EXTERNAL DOCTORS' HEALTH PROGRAMS**

I am writing in response to the above consultation paper released by the Medical Board of Australia (MBA). The AMA welcomes the decision by the MBA to consult with the profession regarding the role the Board should play in relation to support for external doctors' health advisory services.

The AMA has strong links to most existing doctors' health services. State AMAs provide financial and in-kind support for doctors' health advisory services in a number of states and territories and AMA Victoria has a long association with the Victorian Doctors' Health Program (VDHP).

In responding to your consultation paper the AMA has consulted widely with its membership, a process that encompassed our normal committee meetings as well as an electronic survey of members that attracted 2057 responses (the AMA doctors' health survey). The AMA also convened a meeting of existing doctors' health advisory services to seek their views on future funding requirements as well as suitable models of service delivery.

Before answering the specific questions posed by the Board in its consultation paper, it is important to stress that the AMA would not support any framework for the funding of doctors' health advisory services from medical registration fees unless it was structured so that the services were totally independent of the MBA and the Australian Health Practitioner Regulation Agency (AHPRA).

There are significant barriers that discourage doctors from accessing health services and these can result in doctors using inappropriate practices rather than seeking formal health healthcare[1]. Concerns over confidentiality, the impact on career progression and mandatory reporting would appear to be particularly relevant to the consideration of funding for doctors' health advisory services from fees collected by the MBA.

With this in mind, the AMA would propose a framework whereby the funds allocated to doctors' health advisory services are directed to an independent entity (eg trust), which can distribute funding to individual services according to appropriate guidelines (the latter are discussed in response to question 2 later in this submission).

[1] Australian Medical Association. Health and wellbeing of doctors and medical students. Canberra: Australian Medical Association; 2011.

The proposed entity would be required to have in place appropriate governance arrangements as well as provide proper audited accounts to the Board. It would also be required to publish relevant statistics regarding the operation of doctors' health advisory services that were funded through this entity. It would **not** publish information on individual practitioners accessing doctors' health advisory services and nor would this information be made available to the MBA or AHPRA.

This approach would ensure the independence of such services from the MBA and AHPRA and, just as importantly, mean that they were perceived as being independent. These services would be trusted by the profession and this would encourage doctors to utilise these services, particularly at an earlier stage in their illness.

**Q1. Is there a need for health programs?**

In order to deliver high-quality health care to their patients and the community, and to experience medicine as a rewarding and satisfying career, doctors need to be well. Research has consistently shown that doctors with healthy personal lifestyle habits are more likely to impart healthy behaviours to their patients[2]. Doctors' health programs are important to facilitate doctors' access to health services, along with the education and research roles some of these programs currently undertake.

The results of the AMA doctors' health survey clearly show that the profession believes that external doctors' health advisory services are a vital support for medical practitioners and that many doctors would access these services if they could not utilise an alternative service. In addition, the survey suggests that many doctors would encourage their colleagues to contact a doctors' health advisory service if they were concerned for their health or wellbeing.

These results are illustrated in table one below where survey participants were asked to respond to a series of statements that allowed them to nominate one of the following options - strongly disagree, disagree, neither agree or disagree, agree or strongly agree.

**Table One**

| **Statement** | **Percentage agree/strongly agree** |
|---|---|
| Independently run doctors' health advisory services are an essential support for medical practitioners, particularly in times of distress. | 73.7% |
| I would contact a doctors' health advisory service if I could not access an alternative service | 78% |
| I would advise a colleague to contact a doctors' health advisory service in circumstances where I was concerned for their health or wellbeing | 80.4% |

The AMA position statement on the health and wellbeing of doctors and medical students[3] (a copy of which is attached) highlights that most doctors have an above average health status similar to others in advantaged socio-economic groups. They are less likely than the general population to suffer lifestyle-related illnesses, such as heart and smoking-related disease[4-5].

[2] Oberg EB, Frank E. Physicians' health practices strongly influence patient health practices. J R Coll Physicians 2009; 39(4): 290-1.
[3] Op cit.
[4] Carpenter L, Swerdlow A, Fear N. Mortality of doctors in different specialties: findings from a cohort of 20,000 NHS hospital consultants. Occup Environ Med 1997; 54: 388-395.
[5] Clode D. The conspiracy of silence: emotional health among doctors. Melbourne: Royal Australian College of General Doctors. 2004.

However, the position statement also highlights evidence that doctors are at greater risk of mental illness and stress-related problems and more susceptible to substance abuse[6-7] Further, depression and anxiety are common among doctors and their suicide rate is higher than in the general population[8]. Medical students also experience higher rates of depression and stress[9].

Some sub-groups of doctors may be at greater risk of poorer health and wellbeing because of their professional circumstances. These include, but are not limited to:

- doctors working in rural and remote areas with inadequate resources and professional support,
- doctors who work excessive hours and/or are unable to access sufficient leave,
- international medical students and graduates and doctors from non-English speaking backgrounds,
- doctors who work shift work[10],
- Aboriginal and Torres Strait Islander doctors,
- those exposed to blood-borne diseases and other specific occupational risks, and
- doctors who are the subject of medico-legal process such as lawsuits, complaints and inquiries[11].

In 2008 the AMA conducted a confidential survey of doctors in training regarding their health and wellbeing, with the results published in the Medical Journal of Australia in 2009[12]. Based on ProQOL cut-off points,

- 54 per cent of respondents met the criteria for compassion fatigue;
- 69 per cent met the criteria for burnout;

In addition,

- 71 per cent reported being concerned about their own physical or mental health during the previous twelve months;
- 63 per cent had been concerned about the health of a colleague;
- 5 per cent reported using a doctors' health advisory or similar service in the previous year; and
- 39 per cent reported that they had self-prescribed or self medicated during the previous year.

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[6] Willcock SM, Daly MG, Tennant CC, Allard BJ. Burnout and psychiatric morbidity in new medical graduates. Med J Aust 2004; 181: 357-360

[7] Schattner P, Davidson S, Serry N. Doctors' health and wellbeing: taking up the challenge in Australia. Med J Aust 2004; 181: 348-349

[8] Elliot L, Tan J, Norris S. The mental health of doctors –A systematic literature review executive summary. Melbourne: beyondblue: the national depression initiative, 2010. http://www.beyondblue.org.au /index.aspx? link_ id=4.1262&tmp=FileDownload&fid=1947 (accessed December 2010).

[9] Dahlin M, Joneborg N, Runeson B. Stress and depression among medical students: a cross-sectional study. Med Educ 2005; 39: 594–604.

[10] Reid K, Dawson D, Comparing performance on a simulated 12 hour shift rotation in young and older subjects. Occup Environ Med 2001; 58:58-62

[11] Nash LM, Daly MG, Kelly PJ, van Ekert EH, Walter G, Walton M, Willcock SM, Tennant CC. Factors associated with psychiatric morbidity and hazardous alcohol use in Australian doctors. Med J Aust 2010; 193 (3): 161-166.

[12] Markwell A, Wainer Z. The health and wellbeing of junior doctors: insights from a national survey. Medical Journal of Australia; 2009; 191:441 – 444.

The survey also found that fewer junior doctors (66%) have their own GP compared with the general population (80%). Bearing in mind the significant barriers to doctors accessing care, such as those referred to earlier in this submission, there is clearly a need for doctors to be able to access confidential, high quality doctors' health services that promote early access to treatment in a respectful and non-judgemental way.

**Q2. Preferred model for external doctors' health programs**

The MBA's consultation acknowledges that there is significant variation in the existing doctors' health advisory service models across the country. These have been developed in response to local needs and circumstances and, for the most part, rely on volunteers along with a well-developed understanding of locally available services that doctors can be referred to.

The AMA does not agree that a new model should be superimposed over the top of existing arrangements. This would potentially lead to a loss of goodwill among doctors who have supported these services and the loss of understanding of local circumstances and services.

There is significant scope to build on existing services through better and more robust funding arrangements and, over time, move towards a more consistent level of service across the country. Rather than prescribe a particular model, the AMA believes that the funding should made available to services that meet agreed criteria – with the level of funding being commensurate with the scope of services provided.

The AMA understands that existing doctors' health advisory services support this approach and generally agree that funding principles should encompass prevention, contact services, a network of practitioners prepared to treat colleagues and education. The AMA also believes that geography should be taken into account to ensure that funding arrangements recognise the higher costs that may be associated with providing services in states/territories with more dispersed populations.

**Q3. The role of the Board in funding external health programs?**

Subject to our opening comments about the independence of services, the AMA agrees that the MBA has a role to play in facilitating funding for external doctors' health advisory services. In this regard, the profession has a responsibility to ensure that programs exist to assist doctors to access quality health care and the MBA is clearly well positioned to collect fees on behalf of the profession for this purpose.

This view is supported by the results of the AMA doctors' health survey, with only 26 per cent of respondents disagreeing or strongly disagreeing with the proposition that the Board had a role to play in this regard.

The experience of existing doctors' health advisory services and the available (albeit limited) evidence in the literature supports structured and accessible programs being in place to assist doctors to maintain their health and access appropriate health services. This would be good for doctors and patients alike and it could encourage doctors to engage earlier with high quality care. This approach is clearly in the public interest and, as such, deserves the support of the MBA.

**Q4. Range of services to be provided by doctors' health programs**

It is important to stress that doctors' health advisory services should not be seen as an alternative to mainstream health services. As far as possible, doctors should be encouraged to have their own GP and to utilise available services in the health system.

However, acknowledging there are barriers that discourage this, the AMA believes that doctors' health advisory services should offer the following core services:

- triage and assessment,
- referral to appropriate services, and
- the development and maintenance of lists of practitioners who are willing to treat colleagues.

Based on the VDHP experience and the excellent programs delivered in that state, we also understand that some existing doctors' health advisory services also wish to offer case management services and want to be more involved in finding services to assist with rehabilitation so as to support doctors to re-enter/remain in the workforce. The AMA agrees that funding should be available to those services that wish to take up these options. It is also important that funding be available to support the ongoing evaluation of doctors' health advisory services as well as money to support more research in this area.

The above is consistent with the results of the AMA doctors' health survey, with the followings levels of support expressed for specific services identified in the MBA's consultation paper.

| **Service** | **Percentage support** |
|---|---|
| Telephone advice during office hours | 32.0% |
| Telephone advice available 24/7 | 66.0% |
| Referral to expert practitioners for assessment and management | 80.8% |
| Develop and maintain a list of practitioners who are willing to treat colleagues | 80.1% |
| Education services for medical practitioners and medical students to raise awareness of health issues for the medical profession and to encourage practitioners and students to have a general practitioner | 54.9% |
| Programs to enhance the skills of medical practitioners who assess and manage the health of doctors | 52.9% |
| Case management and monitoring (including workplace monitoring) the progress of those who voluntarily enter into Case Management agreements (or similar) with the service | 48.3% |
| Follow up of all participants contacting or attending the service | 51.8% |
| Assistance in finding support for re-entry to work and rehabilitation | 62.0% |
| Research on doctors' health issues | 47.3% |
| Publication of resources – maintaining a website, newsletters, journal articles | 45.8% |

## Q.5 Funding

From our discussions with existing doctors' health advisory services, it would appear that an annual funding goal of around $25 per registered medical practitioner would secure the future of the VDHP and put doctors' health advisory services in other states/territories on a more sustainable footing – enabling them to expand the services that they provide. However, it would appear that a transition to this funding goal would be appropriate, particularly as some services would need time to identify local needs and expand in a gradual way.

The MBA is well aware of the profession's concerns at the significant increase in medical registration fees since the advent of national registration arrangements. The most recent annual report of AHPRA sheds very little light on the MBA's finances and how it spends the funds it receives from the profession. Given that the costs of the transition to national registration should now be fully accounted for, it is unclear as to why the Board is unable to keep fees steady while providing reasonable funding to doctors' health advisory services.

For the Board to justify a specific levy on top of the existing registration fees paid by the profession, it needs to provide more transparent information on the state of the MBA's finances as well as details of projected future surpluses.

The AMA doctors' health survey reveals that, if the MBA agreed to facilitate funding for doctors' health advisory services, doctors believe this funding should come from existing registration fees. Only 15.6 per cent of respondents to the survey disagreed or strongly disagreed with this proposition.

On this basis, the AMA believes funding for doctors' health advisory services should come from existing fees. In this regard, we would urge the Board to look at a phased approach where funding for doctors' health advisory services was progressively increased over a two year period, such that it could be more easily accommodated from the Board's anticipated revenue streams including any planned CPI increases– avoiding the need for an additional levy or charge.

In addition, funding for doctors' health advisory services should be specifically detailed in the annual report of AHPRA so that the funding provided is accounted for in a totally transparent way.

The AMA believes that the above proposition would be more acceptable to the profession and would provide for a gradual increase in funding to underpin an informed and orderly expansion of existing services across the country. In the event that the MBA was able to demonstrate that it had no alternative but to increase fees to cover the funding required for doctors' health advisory services, the AMA would be prepared to discuss this further with the MBA, including the appropriate quantum.

The health and wellbeing of the medical profession is a very important issue for the AMA. It is in the interests of the profession and quality patient care that we work to ensure that barriers to accessing health care for doctors are properly addressed and doctors are encouraged to better manage their own health. Our position statement on the health and well being of doctors and medical students supports the establishment of a profession funded, nationally available, confidential health program to improve the health and wellbeing of medical professionals.

The AMA is keen to work with the MBA to deliver sustainable funding streams for doctors' health advisory services. This would represent a significant step forward from current arrangements, which in most jurisdictions rely on the good will and voluntary contributions from local doctors.

Yours sincerely

Dr Steve Hambleton
President

Attachment AMA Position Statement, Health and wellbeing of doctors and medical students - 2011

# Health and wellbeing of doctors and medical students

## 2011

### Preamble

This position statement focuses on promoting the health and wellbeing of doctors and medical students during their training and professional careers. In order to deliver high-quality health care to their patients and the community, and to experience medicine as a rewarding and satisfying career, doctors need to be well. Research has consistently shown that doctors with healthy personal lifestyle habits are more likely to impart healthy behaviours to their patients.[1]

The addition of 'wellbeing' to this position statement emphasises promotion of health and contentment, and supports the World Health Organisation definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

There has been a welcome increase in the awareness of doctors' health issues in recent years and this position statement reflects the medical community's changing attitude to the promotion of health amongst our colleagues.

Most doctors have an above average health status similar to others in advantaged socio-economic groups. They are less likely than the general population to suffer lifestyle-related illnesses, such as heart and smoking-related disease.[2-3] However, there is evidence that doctors are at greater risk of mental illness and stress-related problems and more susceptible to substance abuse.[4-5] Further, depression and anxiety are common among doctors and their suicide rate is higher than in the general population.[6] Medical students also experience higher rates of depression and stress.[7]

Some sub-groups of doctors may be at greater risk of poorer health and wellbeing because of their professional circumstances. These include, but are not limited to:

- doctors working in rural and remote areas with inadequate resources and professional support,
- doctors who work excessive hours and/or are unable to access sufficient leave,
- international medical students and graduates and doctors from non-English speaking backgrounds,
- doctors who work shift work, [8]
- Aboriginal and Torres Strait Islander doctors,
- those exposed to blood-borne diseases and other specific occupational risks, and
- doctors who are the subject of medico-legal process such as lawsuits, complaints and inquiries.[9]

### Medicine and stress

While not all stress is negative (and some stress is necessary), there are multiple internal and external stressors in medicine. Internal stressors may come from the personality traits of the individual that chooses to practise medicine. These qualities include dedication, commitment, and a sense of responsibility, competitiveness and altruism. These attributes underpin professional success but can become a source of pressure in a doctor's or medical student's working or study life and increase the risk of anxiety and depression. A proportion of doctors and students have obsessional traits, which can predispose them to stress.[10]

There are also a large number of external pressures including but not limited to:

- innate professional responsibilities of doctors,
- increased clinical workload due to insufficient staffing and resources in the health system,
- lack of control over work-life balance,

- professional, social and geographical isolation,
- the requirement for ongoing medical education,
- the demands of keeping pace with rapid developments in medical technology and knowledge,
- changes in the administration and regulations in the health system, and
- community expectations.

Encounters with patients and their families, which often involves dealing with suffering and death in emotionally charged clinical situations, can drain the "reserves" of doctors with repercussions on their personal lives. Such experiences are in addition to the pressures experienced outside the workplace such as relationship and financial problems.

Junior doctors experience specific pressures related to their professional stage and development and can be at risk of poor health.[11] Compared to most professionals of a similar stage, junior doctors can be expected to work longer hours without adequate recovery time. It can be difficult to balance training and educational commitments with a heavy workload. Unpredictable schedules can prevent junior doctors from committing to regular social activities or meeting family and other commitments. A perceived lack of control over work-life balance has the potential to lead to exhaustion and job burnout.

For senior doctors, dealing with stress can be made more difficult by professional isolation, especially for those in private practice without access to institutional support.[12] The stresses that doctors experience change over time, and for senior doctors these can include the challenges of managing a business, employing staff, juggling commitments to patient care, teaching, administration, professional development, family and caring responsibilities.[12] Older doctors will also have increasing frequencies of chronic disease.

Some stressors such as long hours have been traditionally associated with the medical profession, but there is evidence that some doctors are less willing to accept the personal costs of medical culture. Many junior and senior doctors view their identity and responsibilities to the profession differently from previous generations.[13]

**Barriers to own health care**

Governments, the public and the medical profession have high expectations that doctors will be competent, compassionate, professional and resilient under stressful circumstances. There is also a strong community expectation that doctors will seek appropriate medical care from another doctor when they are unwell. The reality is that there are significant barriers, real and perceived, that prevent some doctors and students from seeking access to formal healthcare. [14] These include:

- concerns of lack of confidentiality,
- embarrassment and perceptions of weakness,
- stigma of ill-health in the medical profession,
- perceived impact on career development,
- perceived impact on colleagues and patients,
- expectation that doctors will work while unwell,
- implications of Mandatory Notification, and
- difficulty of access (time, experienced personnel, geographic isolation) to professional treatment.

Barriers to care can result in doctors using inappropriate practices rather than seeking formal healthcare. These include inadequate preventative care, self-diagnosis, self-treatment and delayed presentation to other practitioners. Students and doctors are often reluctant to have a general practitioner for independent medical advice. Similarly, they may not adhere to routine preventative health measures, such as screening tests and vaccinations. Doctors may also be unable to correctly identify the early warning signs of mental illness and burnout.

The reluctance of doctors to consult a general practitioner about their medical problems and ready access to knowledge and medications in the workplace can encourage self-treatment and self-prescribing. Self-treatment can also include informal pathways of care such as 'corridor' consultations and self-referring to a specialist. The literature suggests that prescription drugs are used more frequently by doctors than the general public and the practice of self-treatment and self-prescription is common.[8]

**Key issues for doctors and medical students**

Doctors and their families should have their own general practitioner and manage their own health within the usual professional context of a doctor/patient relationship. This practice should be fostered as a medical student, in order to promote a life-long pattern of seeking professional care. Other than in an emergency or working in an under-serviced area, it is advisable for doctors to avoid treating themselves or their family. If living in an under-serviced area, doctors should be encouraged to investigate other ways to get access to formal health care.

In these situations, they should also be aware of the emergency phone advice services available to them.

The AMA encourages doctors and medical students to practise good lifestyle behaviours and to seek formal health care when necessary. It is valuable for doctors to find that which energises, restores and nourishes them as a person, whether this is creatively, physically or spiritually, and to make time for this in their lives.

Doctors and medical students must be able to obtain access to confidential medical and other health services so that they are confident that seeking help will not stigmatise them or affect their career progression. There must be clear referral pathways and models of care for those in need of assistance. The profession needs to develop a culture that supports those in difficulty without judgement.

Doctors must know how and when to respond if they are concerned about the health of a colleague. When a doctor has concerns about a colleague's health, there is a legal and ethical responsibility to take action to minimise the risk to patients and the doctor's health. Such action should be seen as an act of caring for which the majority of unwell doctors, many of whom have exhausted their personal resources to deal with their problem, are ultimately grateful.

Advice can be sought from local state-based doctors' health programs and the Medical Board of Australia. Where a significant risk to patients exists, or the doctor lacks the insight, capacity or willingness to participate, mandatory notification must take place.

The AMA encourages doctors and medical students to:

- take responsibility for their own physical and psychological health,
- establish a continuing therapeutic relationship with a general practitioner,
- ensure they have all relevant evidence-based preventative health,
- ensure all appropriate insurances are in place to support them through illness,
- incorporate regular leave, good nutrition, exercise, leisure, spirituality and family time into a healthy and balanced lifestyle,
- recognise the dangers to others associated with:

(i) a reluctance to admit illness or failing competence, and

(ii) continued or regular self-diagnosis, treatment and prescribing, and

- provide treatment to doctors and medical students with the same skill and professionalism provided to all other patients, with particular emphasis on confidentiality.

To support doctors and medical students, the AMA believes medical schools, hospitals, medical colleges, the Medical Board of Australia as well as State and Federal governments should:

- promote good health and the adoption of a healthy lifestyle throughout their medical training and career,
- address issues which compromise the ability to provide formal medical care,
- ensure access to confidential and high-quality medical and health services,
- establish professional debriefing, support and mentorship,
- identify internal and/or external stress factors contributing to, and recognise the warning signs and behaviour patterns of, poor health,
- promote access to early and expert assistance from professional services and providers,
- incorporate skills such as stress and time management into continuing medical education,
- establish clear referral pathways for doctors and medical students in need of assistance,
- adopt a "no-judgement" culture that supports those in difficulty, so that doctors are confident that seeking help will not affect their career,
- ensure that the training and workplace environment supports doctors' health, conduct and performance – and therefore helps to promote good patient health and reduce patient risk,
- implement and support safe rostering practices and safe working hours, [15] and
- provide exemptions from mandatory notification requirements for doctors treating colleagues and medical students.

**Sick leave**

Employers of doctors must ensure they have access to sick leave that at least meets the standards for public sector employees. Self-employed doctors should ensure they have income protection insurance for accidents or sickness to provide an adequate income to cover their essential financial obligations so financial worries do not compound the effects of ill health.

**Research into the health and welfare of doctors and medical students**

The AMA will continue to advocate for and support research into the health and welfare of doctors and medical students, with specific attention to such issues as safe working hours and the recognition of vulnerable sub-groups.

There is limited research in Australia on doctors and medical students who are at risk of suicide or who have taken their own lives. Similarly, there are no national information systems on the suicide or attempted suicide of doctors and medical students that could guide systemic improvements to the health and wellbeing of the profession.

The AMA supports:

- the establishment of a research, epidemiological database of doctors and medical students at risk of suicide and completed suicide,
- systematic research on coronial and other reports of completed suicides of doctors and medical students to ensure system failures are identified and rectified, and
- the establishment of a profession-funded national confidential health program to improve and promote the health and wellbeing of the medical profession.

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