A Conversation About… Health in all its Complexity: Systems of Care

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Host (00:01):

Hi there. Welcome to Mental Health Professionals Network podcast series MHPN's aim is to promote and celebrate interdisciplinary collaborative mental health care.

May Su (00:19):

Welcome to the Mental Health Professionals Network, Presents A Conversation About health in its complexity. So my name is Dr May Su and I'm joined here today by my co-host, associate professor Louise Stone.

Louise Stone (00:34):

Hi, May. It's nice to be here.

May Su (00:37):

It's a wonderful to have you here as well, Louise. We've worked a lot together and in this podcast series we are going to over three episodes talk about health in all of its complexity. I know that this is a podcast for the Mental Health Professionals Network. However, I resonate with this quote from the World Health Organisation. There is no health without mental health, so we're going to be exploring health in all of its complexity from the top-down health systems to the coalface working with patients. In this episode, we're going to introduce the concepts about health in its complexity. In episode two, we're going to talk about working with the inexplicable, the rare, the unknown, the complex, the not learned about or the different. And in episode three, we're going to talk about working when it might stretch our moral code, and we'll be supported by some special guests to help us do so. So a brief introduction about ourselves. I'm an academic GP with interest in complexity, mental health abuse and violence and neurodiversity. I've also recently started a higher degree research and that'll be a Master of

Philosophy with hopefully by the end of this year starting a PhD, which is what sparked off some of my thinking about these topics. Louise, do you mind sharing a little bit about yourself?

Louise Stone (02:06):

It's wonderful to talk to you. May and I have worked together for many years and I had the great pleasure of working with Michael many years ago too. And we've had conversations over the years about mental health in particular. So I'm a GP. I've been a GP now for over 35 years. My goodness. I live and work in Canberra. I work in a practise where I'm the only GP. It's run by psychologists and psychiatrists, so that's a change for me. But I've worked in rural and remote and I've also done a lot of teaching. And I think this topic started for me when I did my PhD May some time ago on medically unexplained symptoms because I was in a position where everyone seemed to have an opinion, but I wanted to know what expert and novice GP's did in that space. And it's still an area where I constantly learn about not only mental wellbeing, but also physical health where people are coming with rare, vague zebras into my office with unusual diagnoses that stretch me every day and make me sometimes feel that I just haven't quite got there yet. So it's a continuing learning experience.

May Su (03:13):

Thanks, Louise. I would also like to introduce our guest speaker as well. Professor Michael Kidd, would you mind telling us a little bit about yourself as well?

Michael Kidd (03:25):

Hi, May and hi Louise, and thank you very much for the invitation to join with you today. Like both of you, I'm a general practitioner, worked in general practise for many years with a particular interest in the care of people with HIV /AIDS in mental health and also Aboriginal and Torres Strait Islander Health. But I've also been an academic throughout my career and a dean as well as head of the department of General practise at the University of Sydney and also the University of Toronto. I now have a joint appointment with the University of New South Wales and the University of Oxford in the United Kingdom. Throughout my career, I've been involved in medical leadership. I've been president of the Royal Australian College of General Practitioners and also president of the World Organisation of Family Doctors, which we call WONCA. And during the COVID-19 pandemic, over the first three and a half years, I was deputy chief medical officer for Australia.

May Su (04:19):

That is an illustrious, illustrious resume. Thank you so much. And I feel like a baby when I talk to both you and Louise, Michael. I have to say that all of the conversations that I hope to have today probably stem from my babyhood in this topic where I've started to really explore some of these concepts. So it's been very interesting to consider even just the way that Louise, you talked about doing a PhD and Michael, you talked about actually a number of different avenues in which you would've intersected with health at really quite senior roles and international roles. I might speak to maybe being really new in the field. And I think the idea of this series of podcasts actually started because of a series of conversations Louise and I have had over the years, and Louise talked about how she started off looking at this in terms of her PhD. And very similarly, I've found myself in a very similar ground now that I'm looking at my own high degree research where it's this whole grappling about what do we know about health, what's there in the literature, and then what do we actually do on the ground and how does that

work in terms of in practise and in health systems? I guess for me it's all been a very new learning curve going into that.

Louise Stone (05:54):

I think one of the things that's always struck me with patients is that when patients get a serious illness, and particularly if it's likely to be chronic, there's always a period of time where everything's very bewildering. And Arthur Frank talks about this in terms of his narratives. He says, you have this idea that you're travelling towards a certain place in your ship and you've got it all marked out and you're all ready to go, and then bang, you're hit with some sort of illness or some sort of accident and you have a shipwreck. And it's not just a shipwreck in terms of what your body or your mind can or can't do. You start to question where you were heading and how you can repair that ship to keep going. And I must say that in my years with patients, that's always been the biggest shock.

(06:45):

And as a GP, I think we do a lot of narrative work on that wreck of talking to people of what their life now looks like. When I was in the country, it was often farmers having their first heart attack and realising that they weren't going to be able to continue what they'd always done on the farm and perhaps that their son was not going to take over and that their life's work was now not what they thought it was. But I think it's particularly hard when we can't fish a diagnosis out of the base because in our environment, in our western world, we think that you get sick, you get a diagnosis. If you were House, you get it very quickly and you follow a protocol and you get all better. When that doesn't happen and you don't have a name and you don't have any way to find other people who are experiencing what you're experiencing, it's a very lost feeling and you can feel quite invisible.

(07:37):

And often people will almost disengage because the first thing everyone asks is, well, what's wrong with you? What did the doctor say? And if you don't have an answer to that, it's a lost feeling. And I think as primary health professionals of whatever ilk and psychology particularly, I've really appreciated some of the fields of inquiry and some of the ways that psychologists talk about what they do and social work too, because of the way they bring in family. There's a beautiful, beautiful structure around family and just trying to help people make sense of what it is to have an invisible illness and how they can be in the world with this when it's really difficult for them to even find anyone else in this story. And I think post covid, that's getting harder because the invisible illnesses seem to be coming out of the woods that'd be left, right and centre, particularly in autoimmune illnesses and long covid, those sorts of things where we don't have even a diagnostic name, let alone an answer to their troubles.

(08:37):

We can't cure, we can't are helping them cope with it, a huge amount of uncertainty. And in our current world, that's a really uncomfortable space to be in and we don't have a lot of language around it. So it's a field where I feel very strongly how important it is for us to be there while patients grapple with that in their own ways, with their own language and their own stories to make sense of something that is very difficult to get your head around and certainly very difficult for the community to get their head around. Michael, you must have come across very different ways of doing this in different cultures. You've

travelled a lot and you've certainly worked a lot overseas. Have any of the places that you've been or positions that you've been in illustrated that sort of issue in other cultures?

Michael Kidd (09:23):

Look, I think the answer is yes, Louise. As health professionals, it doesn't matter where we're working. We are all aware that we need to be providing care to the whole person. And I remember in my own training when I was doing my training as a general practitioner after graduation from medical school, I realised that I was quite good at managing the physical issues for my patients, but I struggled with dealing with the mental health concerns, which so many of our patients have. And so I did some further training in a liaison psychiatry to try and increase my own skillset. And I think a lot of us do that over time. Certainly travelling around the world, this is not unusual. One of the features of Australia, which is different to some other countries is in general practise. For example, we do look after the physical and the mental health of our patients and also the social issues which are affecting both the physical and mental health as well.

(10:27):

In many other countries, doctors in particular will just focus on the physical issues. And then if someone has a mental health issue, if you're lucky enough to be in a country which has psychiatrists and psychologists, then you may be sent to see one of those people. But in many countries there's little access to mental health services. A lot of the work which I've been doing over the last decades with the World Health Organisation has been trying to get that integration of mental health and into primary care health services in countries all around the world. We do see it working really well in some places. One country I like to talk about quite a lot is Brazil. Brazil is a country which it's a very large population, over 200 million people. And to address the healthcare needs of that population, the government has established family health teams, which involve a general practitioner working with a couple of community health nurses and also with a number of community health workers.

(11:28):

They call them community health agents from the local geographic community that the GP and the nurses are serving. The role there is for these community health agents to actually know everybody in the community of patients who are being looked after and to act as an agent. They're a bit like we see in Australia with Aboriginal health workers and Aboriginal health professionals in our Aboriginal community controlled health organisations. And with these family health teams, one of the things I really like is they actually take the psychiatrists out of hospitals and they attach them to 10 of these teams. So for half a day a week, the psychiatrist will be visiting the team. They'll be able to see the patients who are referred to them by the doctor or the nurses or the community health agents. They'll be able to provide some education or management of mental health concerns to the other health professionals in that team. And it means of course, that patients who need to see a psychiatrist don't have to travel outside of their home location. So it's much more convenient and patient centred or person-centred if you like. But there are models like this all around the world where people are trying to do their best to integrate physical health, mental health, social health, so that we are meeting all the needs of our patients.

Louise Stone (12:43):

I got involved with Christine Phillips and Katrina Anderson writing a self-care manual for the World Health Organisation to try and help health workers around the world teach their patients how to care for themselves to hand over some responsibilities. I still remember when I was working out with a flying doctor service with a nurse who said, if we fly around the area every two weeks, then we don't get emergency mental health from emergencies every three weeks. In other words, if we check in with people and make sure they're okay, it makes things work. I know that often it's about education. Again, flying doctor service. I still remember as a young doctor and having a person with asthma who just wasn't getting better and finally, I mean I would do it earlier now, but then I didn't realise, asked him to show me how he used his Ventolin and he was throwing out the canister and just using the little plastic container, which of course wasn't working because there was no drugs in it. And then you've got the very delicate thing of, well, we find it works better if you do it like this. Try not to make people feel foolish. So I think that educational piece of people who are accessible and like you and understand you, the Aboriginal medical services have done an awesome job of this for so many years in chronic health management. And I think we've got so much to learn from the richness of what they've brought to us.

May Su (14:11):

Louise and Michael, it's just gotten me thinking, listening to both of you, and it's really bringing it all together into the idea of bringing health to the person and within the community regardless of where you live. And I think, Michael, you talked about this, that it might sound different in different health systems, but at the core essence of it, that's kind of what we're trying to do.

Michael Kidd (14:37):

You're right. In fact, this is part of the global movement. The biggest challenge identified by the World Health Organisation is universal health coverage. It's providing healthcare to every person on the planet no matter where they may live. And one of the big solutions to universal health coverage is around strengthening primary care, strengthening healthcare, which is available out in the community where people are living and hopefully providing healthcare that is more targeted to the needs of specific populations based on where they're living. So it's very much part of a global health movement and there's a lot of work happening there. I mean in Australia, we're deemed by the rest of the world to be quite fortunate because we have a strong system of primary care through general practise, community nurses, allied health professionals, community pharmacy, community dentistry, lots of people who are delivering care out in the community to the members of our populations, which we tend to take for granted, but which is not necessarily the case in many other parts of the world.

May Su (15:43):

This is a really a topic dear to your heart, Michael as well. I'm aware. So it speaks to your current role that you are undertaking as well.

Michael Kidd (15:51):

It does, and part of my current role is looking at where we would like our healthcare systems to be a decade or more from now and then what sort of research and policy and advocacy work do we need to be doing now in order to achieve that. And part of that is continuing to strengthen the system of primary care here in Australia and also looking at better integration between our primary care services and aged care and disability care and social care and mental health services. So you're delivering more

comprehensive care to all people. And of course built in with that as well is a big focus on prevention and health promotion, as Louise mentioned earlier, trying to prevent crises from occurring by identifying problems and challenges early on.

May Su (16:40):

So you're really hitting on the heart of what we kind of were interested in this podcast was how do we do that, particularly in Australia, I think you touched on this, that sometimes we are in a strong position internationally, but if you're only exposed to Australia, sometimes we don't always see that and we don't always see the strengths that we have, but also how even with our strengths, how do we get better at what we do?

Michael Kidd (17:06):

Yes. I mean, often what we hear is of course coloured by our own experience and what happens with our family and our friends, but also what we read about in the media and the sort of stories that we see. And the media of course is often demonstrating to us the extremes of what happens rather than the experience which is being felt by most people in the community. But there's no doubt that we need to continue to look at ways of supporting our health professionals. And I think this is really a very important issue in Australia and around the world following the first few years of the COVID-19 pandemic where a lot of people experienced the challenges of COVID-19. There was a lot of people experiencing our personal loss through the loss of loved ones to the virus, but also loss related to, especially for younger people, their dreams and hopes and aspirations being put on hold for a number of years, especially here in Australia where we were in lockdown from the rest of the world for a number of years until the population had very high levels of vaccination protection.

(18:13):

So I think there's a lot of challenges we're seeing among healthcare workers in many parts of the world, an increase in what's called moral distress or moral injury where people feel that they have the training and the expertise to know what to do, but the health system is not providing them with the equipment supporting personnel, the supplies, the capacity to deliver the care that they feel that their patients need. And that has a very significant impact on the mental health and wellbeing of many health professionals right across the sphere. But in Australia, we're looking more and more at particularly models of multidisciplinary team-based primary care and mental health is a very important part of that team-based care and looking at what contributions different health professionals can be making to the health and wellbeing of individuals, and especially for people with more complex health concerns. And those health concerns of course, again, being a blend often of physical health and mental health issues. And as Louise was mentioning also a lot of undifferentiated health conditions where a diagnosis may be quite difficult, but where a lot can be done through a multidisciplinary team-based approach to actually help people to deal with the challenges they're facing in their daily life.

Louise Stone (19:35):

I must say May today's a good day to make me reflect on this. I am going to a funeral tomorrow of my patient who nearly got to a hundred and was able to do what she really wanted to do, which was die at home. And so I've been able to look after her and get to know her family very well, who are just the most lovely family. And it struck me as I was doing that. And the palliative care nurses of course were

marvellous and she was able to have a peaceful death. And I think one of the things that struck me most was that I realised that in order for me to survive the slings and arrows of outrageous regulation that sometimes land on our heads, one of the things that I have to do is to maintain that sort of patient contact, that it's important for me to survive some of what I see to be the damaging or difficult policy decisions around me to keep those connections with people because that mitigates the moral distress.

(20:36):

And I think one of the things that we have to guard against is fracturing those therapeutic relationships too far by making all health into aliquots of transactions of bits of this and bits of that we lose something precious in not knowing and not being there. I had the conversation about the advanced care directive. I knew exactly what she wanted. I knew exactly what the family wanted. I knew that she wanted to die at home, and I knew that was more important than any fancy intervention that I could possibly have done. And that made it very easy in a lot of ways to make decisions as she became less competent. And the other thing I was thinking is I'm doing a study of young people and I'm following them for 12 months, not in a creepy way, but we've interviewing them several times over 12 months, getting mental healthcare in the ACT.

(21:30):

And one of the things they tell me often is that they need their health practitioner to be authentic. They said, we don't want to know about their children or their life history. But one of them told me that six years ago, one of the psychologists had said to her, yeah, I used to have trouble answering the phone too. I used to get really nervous. And she said, that made her human. And they described to me how they test the authenticity as teenagers do in the first while. And if someone isn't authentic, they sort of nod and smile and never see them again. And it struck me how important that personhood is no matter what label, we carry that connection and I'm a human. You are a human. It makes me sad to think about my elderly patient who's no longer here. I'll go to the funeral because I know her so well and that will make me sad because she was my patient and she was a very special person.

(22:27):

So I think we have to keep holding onto that and resist that temptation to fracture. And I think one of the things about those teams, you're talking about Michael, when you have multidisciplinary teams, when I was in the country, it was district nurses and they were awesome. They would go out and have the conversations about things that needed to happen and they knew people. I think we have to fight for that fight for connection in healthcare and resist industrialising too far in a way that might reduce our connection because that feeds us and allows us to survive as well as I think providing much, much better tailored personalised care.

May Su (23:09):

Louise, I'm so glad you spoke to that. It really resonated because as Michael was talking about moral distress and moral injury, I've certainly had similar thoughts about what things keep me going within my own. Well, it's not only just professional, it's what you refer to. It's actually one of the things that I think we even started to talk about. It's about the health professional as a person. We're talking about personhood as the patients we see, but it's also personhood as us as professionals and how do we as part of that whole community work together and collaborate with people that we're seeing, but also the

people that we are collaborating with and working with. Michael, something you were saying before was when you started off working in this area and you started seeing mental health and undifferentiated I was nodding my head because I was like, oh yes, I remembered that period of time and then I went off to do a master's in mental health and then I realised you didn't give me all the answers and so now I'm going to do a higher degree. I think it's that whole process where it's that journey as a professional where you try to work out whether as an expert, you get all the answers and then the further along you go you kind of go, well, actually no I don't. But how do we, in the midst of not necessarily having all the answers and developing these relationships, if we're okay with developing these relationships with everyone, kind of keep going.

Michael Kidd (24:38):

I think one of the things about being a health professional and becoming competent in helping people with mental health concerns is you don't need to go and do a degree to do this. I mean, you get the experience through your day-to-Day clinical practise. You learn from your colleagues and in particular as Louise has beautifully outlined, you learn from your patients every day. I've always said to my students that my best teachers are my patients. They teach me what it's like to live with particular conditions and how to manage that and what are they doing to address things. And I take those learnings and wisdom and then incorporate them and share them with other people so other people benefit as well. I think also it is one of these nice things about working as part of a team is being able to gain experience from each other.

(25:35):

When I first finished on my GP training and went out into practise, many of us when we start looking at where we're going to set up practise after graduation, look around, and for me it was the late 1980s, the HIV pandemic was at its peak here in Australia. HIV was still an inevitably terminal disease for people who were infected with HIV. And I started working in a community practise providing care to people with HIV and it was a multidisciplinary team. And this is in the late eighties with doctors and nurses and psychologists, allied health professionals including a dietitian and acupuncturist, a massage therapist, all working together to try and do what we could to assist our patients and supported by an amazing army of community volunteers at a level which I don't think we've seen in Australian healthcare in any other way. People who were willing to volunteer to provide care to the young people that we were looking after who were approaching the end of their lives. But I learned a huge amount through both working with the members of those teams, but also through working with the people who I was privileged to be their doctor.

May Su (26:50):

We were actually working at the same practise. And I was thinking about that. I returned to the same practise and it was really this success story, wasn't it, of this really awful situation where it wasn't just health, it was the whole community rallied around and actually people were really invested in this because they were seeing the outcomes and so they invested of themselves. They really started new ways of practise and new ways of research. And we think you talk about that being in the eighties now, Michael, today we can potentially talk about HIV. It's not the same connotation that it used to be in the eighties.

Michael Kidd (27:38):

In most parts of the world. So for people who are fortunate enough to live in countries where health systems can afford the antiviral treatments to help keep people well and alive, it's been a remarkable change, but there are still people dying from AIDS in parts of the world.

Louise Stone (27:58):

I think one of the things that struck me, I was at a meeting recently listening to the amazing general surgeon from Lismore, and she was talking about her experience of the two floods. The first flood wiped out the general practise, the second flood wiped out the restored general practise and talking about how she had to battle to make it possible for this general practise to continue to work because there were some crazy regulations that meant that general practise was not considered to be a core business. And I think one of the things that's really important is we don't lose that community support. It's really easy to over professionalise health and it's bad news because we lose that amazing community input. I still remember when I had my first child, I was in another country town and I had set up a women's clinic with one of the local nurses who was also a midwife and one of the doctor's wives, and she was incredible.

(29:01):

And the women of the town got together and put themselves on a roster to mins the baby so I could come back to the women's clinic, which was quite lovely. And they were quite happy to do that, to make that because I was the only female GP within three hours and they knew that it was difficult for me. There was a funny moment when my husband used to bring the baby down for a feed every now and then because we lived up the hill and one of the old men sitting in the waiting room came up to the receptionist and said, I dunno what's wrong with that man? There's obviously nothing wrong with that baby. He's here every five minutes, every time I come here he is down here with that baby, which is really quite funny. But I do think having worked in rural communities, you have similar multidisciplinary approaches and you have people who are prepared to pitch in and clean out the general practise and get it running again.

(29:51):

It's important we don't over-regulate to move everything into professional spaces. We need the community. We need their wisdom, we need their talents. We needed the guys who built the bridge up at Lismore because nobody else was doing it and they happened to have a tractor. And we need that stuff. And I think as primary care practitioners, it's terribly important that we keep celebrating the way the community can support us so that they don't get marginalised by being overregulated. I do worry about over professionalising, we saw what it did to maternity care and it wasn't good. We saw how things sometimes can get to the point where there's so much paperwork. And just coming back to your comment, one of the things that really troubles me having worked with homeless young people while I've been in Canberra is digital poverty. We now access to health services requires a device a lot of the time, requires you to fill out your own admission form your own my aged care, which is really, really challenging unless you have carers and the load on carers is getting heavier and heavier.

(31:00):

And I think every time we make the health system more complicated, we marginalise people with low literacy, with low health literacy and with no device. And I do worry that with all our excitement about

AI and all the streamlining that can go on, but I have met the ones who beg because they can't fill out a Centrelink form. And that's a travesty in this day and age in Australia. So I think we have to be very careful that there are always health professionals who can sit and talk face-to-face without a device in the middle to escalate people like that up the chain so that they can actually get through the highly complex systems that we've created bureaucratically that get in the way of good care.

May Su (31:46):

Louise, I think you kind of hit at the heart of what we do. I read a statistic actually just the other day where some of the skill sets of what we do in medicine that people attribute to having benefit is about 40% of the interaction, whereas the other 60% is that personal sort of interaction that you're alluding to. And well, Michael, I might agree we don't need a degree to learn about. I do wonder whether it's having an inquiring open mind regardless of how you then might formalise that. I mean it's kind of what you're alluding to here, Louise, and that you've been talking to Michael. It's about the fact that we are open to this open dialogue to be creative and to learn mutually regardless of who sits in which role. And I think one of the challenges we have if we are looking at that in systemized ways is that people fall through the gaps otherwise. And Michael, you really reminded me there, it's that challenge then when we are seeing people fall through the gap. So we can't necessarily catch.

Michael Kidd (32:59):

Yeah as general practitioners, which we three are, we've all had experiences where we've had people who we've known what we thought needed to happen, but we haven't been able to get the resources in order to support them even in a wealthy country like Australia. I agree with you as well, May that importance of being open to your patients and the open communication which we are taught, enabling our patients to talk to us about what they're worried about and what are the challenges to the care that we are wanting to provide. I think that one of the things which can impair that is our own mental health and wellbeing. So doctors who are experiencing the moral injury and moral distress may not be in the position of being as open to listening to their patients and may fall into that trap of just doing things in a rather regimented way rather than individualising the care which individuals need. Providing that comprehensive whole person care I think is one of the great contributions that Australia's general practitioners make to our healthcare system. We're not the only ones who practise in that way, other healthcare professionals do as well, but it's something that I know many people in our community really valued.

Louise Stone (34:17):

I do worry May one group that I really worry about is our lived experience colleagues. I worry about them because they provide such an important service, but I've seen over and over and over again that often the people that other services may not want may find too complex, will trickle down to the lowest paid worker in the system. And I know that sounds awful, but I had a role leading GP training in Australia for about 10 years and part of that role was remediation. And I think it's easy to underestimate just how complicated maintaining a therapeutic relationship can be. Sometimes it's really hard. You can get yourself into all sorts of trouble and that won't surprise any of the people on this line I'm sure who've worked in nursing or social work or psychology or any of the other. But for our lived experience colleagues, I do worry that sometimes they don't get the support that they need in order to do the best job that they possibly can.

(35:20):

And I certainly have heard of environments where they're on their own at night in an open service in a city, and that's a very vulnerable position that I don't think I would put myself in. And I just think it's really important that we embrace them as part of teams to provide them with any of the resources and the knowledge and the training that we have had around challenging patient interactions that we still have trouble doing after. Oh, I do after 35 years of the business, but I do worry about them, I guess. And I do have half an eye out, I look after a few of my colleagues who are lived experience workers, and I just wish we gave them more support and more supervision. I wish we had more supervision. I wish there was more available because I think that it hasn't yet sort of worked out how to use their expertise best in a safe way that doesn't put them at risk and doesn't mean that they're left holding the interaction without support.

May Su (36:24):

Yeah. Louise, you are speaking to something really in my area of passion. For those of you who know, I also have a hat where I chair the rural Australian college of general practise specific interest group abuse and violence and families. And this has been something which we've had a lot of discussion and focus on particularly in the past year, recognising the lived experience component of practitioners and how to best support people who may themselves be vulnerable but might be spoke about moral injury. In some ways, their way of addressing the previous experiences that they had may be actually to be able to give of themselves and sometimes give of themselves in a way which may not always be sustainable. So I don't think we know enough in this area. Louise, I don't think our system knows enough at the moment about how best to support.

Michael Kidd (37:21):

I think for each of us, there are times in our careers we all need mentors and throughout our careers as clinicians, we all need trusted colleagues who we can talk to about individual patients, but also about how we are dealing with other challenges which arise again and again throughout our professional careers. And the other side is true as well. We can all be in the position where we are that trusted colleague to others who we work with. We can take on that role of being a mentor to younger colleagues who may be dealing with some of the challenges that we've dealt with over our lives. So I think that being kind and generous goes both ways. It's something that I've been privileged in my career to have some wonderful colleagues who've been very kind and generous in the support that they've provided, which has enabled me to continue to do the work that I do. And I hope that that's something that I've been able to contribute to as well.

May Su (38:21):

I can attest to that. Michael, having called you out of the blue, you've been there throughout my professional career. So Michael, I'm conscious that we've had such a wonderful evolving discussion, but look, is there anything else that you think would be a really important message, Michael? All the ways on talking about health and mental health professionals working with undifferentiated complex health and psychosocial conditions, how that sits within health and our health systems.

Michael Kidd (38:54):

Look, I think for me, my parting comment is just my thanks to everybody who's listening into this podcast, thank you for the work that you are doing every day to support the people who trust you for their care, who trust you for the advice that you provide. Our work is not easy. There are all sorts of barriers and challenges, and it's probably always been so for those of us who have chosen to be health professionals as part of our careers. But thank you to everybody who's listening, and if you are feeling a little bit lost in your daily work, please reach out to colleagues and find someone who you can trust, who can provide you with some support.

May Su (39:40):

Thanks Michael. Louise, do you have any thoughts to follow on from that?

Louise Stone (39:46):

Yeah, when I was in my probably late thirties, I think a couple of my children were very unwell and I realised that I didn't want the things that were happening at home to trickle into my therapeutic environment. And I was looking after a lot of kids at the time and had a wonderful psychologist who was a supervisor for me that we don't have a tradition of supervision in the way that psychologists and social workers do. She was awesome until she had the audacity to retire after 15 years, which I thought was very unfair, but I certainly learned, I think more from her and having that formal relationship was right for me. I know some colleagues do Balint groups, others just do peer discussions. There's a load of ways to do that, but it always makes me really sad, particularly with the young doctors when they don't have that and they think they're failing when in reality it's just the job's really hard.

(40:41):

So I would echo Michael's comments and to just recognise the complexity. Sometimes the solutions that are offered to us are simple solutions to complex problems that don't work. When I was in a practise, I used to be told I didn't have great time management skills. And I remember coming back one day with, I don't have a time management problem. I have a complexity allocation problem because I was seeing all the complicated mental health patients who couldn't possibly have fitted in with the space. So I just think with all this stuff about wellness and resilience to remember that the environment is hard and sometimes you do need intelligent, careful collegiate support to manage it. It isn't just that you're not doing enough simple things. You need somebody who is wise and just thank you very much to the aunties and the uncles in the crew who were my mentors as I was growing up. And I hope now I can be the sort of wise auntie for a few young doctors who were trying to make their way. So I agree, and you were one of mine, Michael, talking about leadership all that time ago. So there you go. It goes around and comes around again, doesn't it.

May Su (41:52):

Thank you so much, Louise and Michael for sharing this really insightful and thoughtful discussion listening in. I'd also just like to reiterate, you are not alone. Never feel alone. The point of us talking about this is that we are working in the system where hopefully there will be someone to catch you, so just reach out. And health is complex, so it can be hard, but can also be really rewarding as well. Thank you for joining us on this episode of Mental Health Professionals Network Presents a conversation about health in its complexity, and that was a mouthful, and you've been listening to me, Dr. Ma Su and my co-host, Associate Professor Louise Stone and Professor Michael Kidd. Thank you so much for joining us.

We hope you've enjoyed this conversation as much as we have. If you want to learn more about your hosts or our guests, or if you want access to the resources to which we've referred third in this episode's landing page and follow the hyperlinks, the Mental Health Professionals Network values, your feedback, and on the landing page, you'll also find a link to a feedback survey. Please fill out the survey and let us know whether you found this episode helpful. We'll provide comments and suggestions about how Mental Health Professionals Network might better meet your listening needs. Thank you everyone for listening.

Host (43:19):

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