A Conversation About… Health in all its Complexity: When Practitioners' Moral Codes are Challenged

https://www.mhpn.org.au/podcasts

Release date:	Wednesday 30 October on MHPN Presents
Presenters:	Dr Wei-May Su, Academic GP and supervisor Prof Louise Stone, Academic GP Dr Hester Wilson, GP and Addiction Medicine Specialist

Disclaimer: The following transcript has been autogenerated and may contain occasional errors or inaccuracies resulting from the automated transcription process.

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 (00:18):

Welcome to the Mental Health Professionals Network Presents a conversation about health and its complexity. My name is Dr. May Su and I'm joined here today with my co-host, Associate Professor, Louise Stone. Welcome to third and final episode, of our three parts series where we've been talking about health and its complexity. I'm an academic GP with an interest in complexity, mental health, abuse and violence, and neurodiversity. I'm also the chair of the Royal Australian College of General Practise Abuse and Violence and Families. And I have an educational role in mental health, and I've just started a high degree of research, Master of philosophy with a view to PhD, which has started off this conversation. Louise, would you mind introducing a bit about yourself?

Louise Stone (01:08):

Sure. Hi everybody, I'm Louise Stone. I'm a GP in Canberra and I have clinical research teaching and policy expertise in mental health. So I've taught a lot of 30 years of mental health clinical training at least, and have spent a lot of time teaching younger doctors as well as all sorts of multidisciplinary teams. I suppose as far as this is concerned, because I've worked in complex mental health, I certainly have had my fair share of patients who have lived with all forms of trauma and have been on the receiving end of that precarious trauma and also the vicarious resilience that comes from treating patients with trauma. And at the moment I'm trying to finally finalise a 10 year project, which is looking at sexual harassment in the medical profession.

May Su (01:56):

In the first episode, we were joined by Professor Michael Kidd and we examined the concept from the top down and in the second episode we took the middle ground discussing the challenges of working with the inexplicable. In this third and final episode, we'll talk about working in the murky undifferentiated space where life is life in its beautiful and not so beautiful, complexity and chaos. What might happen when the people we work with may behave in ways that we don't agree with that are different from our own. It could be in the context of addiction. People use abuse or violence or someone who holds a strong religious or moral code different from what we consider our own. We also will discuss being different and how that works for us as professionals, and holding that. We're joined here today by Dr. Hester Wilson. Hester, would you mind sharing a little bit about yourself?

Hester Wilson (02:56):

Hi. Thanks May. Thanks, Louise. Yeah, everybody. I'm Hester. I'm a GP and addiction specialist. I'm also the chair in the college of GP's of a specific interest group in addiction and hold roles in New South Wales Health in drug and alcohol as well.

May Su (03:11):

Yeah, it's always a pleasure. And Louise and I have worked together for many years and Hester, so have we. And I realised, I dunno if the three of us have ever worked together actually. So, this is a real joy us having a conversation because I've had very similar conversations with both of you, but independently. Hester this episode really continues on a series of conversations that Louise and I have had, and it brought up this concept that we had about working in the swamp, which is this murky, undifferentiated space. And I think this particular topic that we are talking about, this podcast really encapsulates it because I think sometimes even when we talk about undifferentiated unclear spaces, poorly researched, we often do look at that in the context of other health complexity. But when we start talking about this kind of area of differentness, I feel like these priority areas are even less researched and they're even less understood, and they also have a lot of emotion involved with them.

Hester Wilson (04:26):

Yeah, totally, totally. Look, and I think how do you research something that is this complex? How do you make sense of it? How you make meaning and how you consider meaning? It's an extraordinarily complex area. And when I was thinking about this earlier on today, I was thinking about the emotional versus the rational brain for us as human beings and how as doctors, we think we're rational, but we're not. And our emotional brain is always working. And when we see something that brings up uncomfortable or negative emotions, a sense of shame, a sense of nihilism, a sense of sadness or despair, disdain or disgust, we're not supposed to feel these. We're not supposed to. We're supposed to be rational and calm and make diagnosis and treat things. But when you're sitting in this space where those emotions are being triggered, it's hard for us to acknowledge and accept them in ourselves. But also when you're in this space where, I dunno what the diagnosis is, I don't understand this person and I don't like them, it's a really, really hard space to sit in.

May Su (05:37):

And that's really interesting what you raised about the emotional versus rational because I don't remember us learning about that in medical school.

Louise Stone (05:47):

Ah there's a guy. Yes, we sort of did. There's a guy called Roger Neighbour and he was great. Coz he talked about, he's one of those fabulous British GP's in the sixties and seventies, and he said, we have a little person on each shoulder and one of our shoulders, it's looking at the rational side of things and what's the diagnosis and what's going on. And the other one is our feeling self that's going, I think I've lost her, she's not listening to me anymore and that kid's about to dismantle my light and she's looking really stressed and all that sort of stuff. So tick tacking is what I call it between the two where sometimes you're getting nowhere with one and you have to switch to the other to try and make sense of what's going on in front of you. And sometimes I think that's really protective with the students.

(06:36):

I often talk about cognitive empathy when you're down on Friday afternoon and you're absolutely exhausted and you've just given everything you've got to a really difficult series of cases in the morning. It's not phoning it in to sit there and do what you know is right without having it hit your heart. And if we don't do that, we burn out. We have to keep ourselves safe. And we all know how not to pretend, but to care about a person enough that we show empathy without necessarily it hitting the heart. And I think about this the way when you have kids and they ask you a million questions and talk at you for six or seven hours on end, you do get to the point where it's aha, right darling? Yes. Oh that's really great. Yes, I'm definitely watching you still. And you've run out of that energy.

(07:28):

You have to protect yourself. And one of my supervisors once had a great phrase. She said, boundaries are in the right place when on average your needs and the patient's needs are met in equal measure. And I think what that meant is that you're not constantly going into deficit because that's when you burn out. Sometimes of course you give more and sometimes you give less, but when you get to the point where you are always giving more than you've got, you just get down into the red and then you're no use to anyone really because you burn out.

Hester Wilson (08:01):

I think that's really interesting because as you were saying that, Louise, I was thinking about the training that I did some years ago as a medical student where there was such a focus on hospital medicine, specialty medicine, getting the diagnosis, differential diagnosis, the treatment. It was kind of we're trying to make sure that it was hard science. And then I started work and I dunno about it yet, but I don't really use a lot of hard science these days. And I dunno it's there, but it's like that's valued. The hard science and what we actually do day to day is not valued, but we choose to go into general practise because we value that non hard science in a way. And there's also, look, I don't think it's gendered and I suspect perhaps women do it a little bit more, but I'd have plenty of male colleagues that get into the same space of giving and giving, of caring, and getting that out of balance.

(08:58):

So they just feel burnt out. And certainly we saw that during Covid, the amount of burnout that we felt in general practise because there was such uncertainty and because we were just trying to deal with staff and such a lot of anxiety. And at the same time we were being beaten up in the media about being GP's that were scamming the system and all this absolute rubbish. But you're absolutely getting that balance right and it's okay to kind of notice how you're feeling and that you are tired. And on a Friday afternoon, yes, it's about safety and sometimes for the group of people I see, the Friday afternoon, many of us will use the word the Friday afternoon special, is the person that comes in, in crisis "'doc, doc, I've got to get this sorted now''. And our immediate response is right, we've got to get it sorted

now. And in fact you've got to go, okay, it's Friday afternoon, I need to understand this and I need to come back to the knowledge that what's actually going on here is chronic. And yes, you are in crisis now, but I'm actually not able to support you if I go into crisis as well. So sitting back and being compassionate and aware but not heart strong, it's a difficult balance and it's really important to do.

Louise Stone (10:19):

Yes, we call that housekeeping. That's another Roger Neighbour phrase that you have to do your housekeeping between patients to make sure that the patient after the one that's been really challenging doesn't cop it because they get the backlash of your feelings that you've had in the consultation before. I think one of the things that you've said there about the current world where although people say they value empathy, the structure is not set up so that we can actually use it. And I think that's, we privilege short consultations in the way that we fund things. Nurses are overwhelmed, everyone's got too many people. And I think we certainly don't seem to privilege the empathy, but we also don't respect the science in that there's more evidence for the therapeutic relationship than there is for any one technique. But I still remember when I was in the country, I'm here with six other blokes I still think of as some of the best GP's I've ever met.

(11:19):

I was so lucky in this little country town and one of them in particular was one of those amazing people who could hold a puppet in one hand and put a drip in the kid with the other. He's a great guy. And after 10 years at this stage, I was running a master's in psychiatry. I think after 10 years he came to a workshop I did and came up afterwards and in the nicest possible way said, I had no idea there was any theory behind what you do. And I said to him, what do you think I do? Just sit there and nod and smile and sit there in a dress. And he went, I think I did actually.

(11:55):

I think often people underestimate how much thinking and theory there is underneath what it is we do. I mean the psychologists and the social workers in the room I'm sure are not in a way here, but it's not respected how much intelligence and thought and experience and all those other things. We only seem to focus that at this time in history on the science and there is science. It's just the science that isn't as respected as the chemotherapy science. And I think that's such a shame because the number of psychologists have said to me exactly the same thing. We learned all these statistics and all this evidence-based stuff, and now it's all about the art, not the science. I think we don't respect how clever that art is.

May Su (12:41):

But Hester you must've been sitting in our second podcast, we were talking about in the whole challenge about hard science versus practise. There's a bit of both of it really, isn't it? Because I think sometimes when I talk to people who come from lived experience, it's what you talked about Hester, it's about being passionate, aware, but you also don't want to have your emotion get in the way of you helping the person as well. And so there's art to it, but there's also being pragmatic and practical at the same time. And there's another element of this which I just wanted to bring up. Louise, you and I talked about and Hester, you were just talking about the fact there is a bit of an imbalance sometimes about who does this work and part of that may be gender, but part of that may also be that many who do this work may also have their own lived experience as well.

Louise Stone (13:34):

With the gender question, it's really clear even with vets who look after animals, it's clear and everywhere in the world that the community have certain expectations of women health professionals, that they'll be kinder and nicer and more empathic and take more time. And from a general practise perspective where we're running our own businesses and so on, that they will be more compassionate on billing, that they will donate their services more because it's a vocation. And the number of doctors who said to me, oh look, when it's simple I'll go and see Doctor X, but when it's really complicated, I'll come to you. Now that does not mean those six doctors I trained with were awesome and in fact they delivered my babies. So they absolutely have the capacity, but the community has this view and often reception is part of it because they'll go, oh, they're crying and they've got four children, you'll want to see the lady doctor.

(14:35):

And we know that there's a 30% difference in mental health between female and male GP's. Female GP's do 30% more mental health and on average do five minutes per session longer and on average three more hours a week unpaid. So we do an average of 10 hours of admin time that we're not paid for and the blokes do about seven. So it is a gendered thing, but it's not that the women doctors are more capable, it's they are considered more capable. And I think with trauma, of course trauma can be experienced by all genders, but it is more likely to be perpetrated by males. And therefore anyone who has experienced perpetration from a male is likely to choose another gender as their health practitioner. And that means that as a woman doctor, I get more trauma than most. And then you get good at it because you do more of it and it's self-perpetuating. So it is a real thing. There is real evidence on it. I'm not sure of the other professions, but certainly in our discipline it's very, very clear.

May Su (15:45):

I think there actually is some evidence that in any health professions, not necessarily about the gender role, but about lived experience as well, that I think there is a higher prevalence of people with lived experience working in health. And I know many of you listeners are going to resonate with that. I wanted to come back to something you were saying, Louise, because I think the topic of today's episode is about what if the people that we are seeing may touch our own buttons as well. And I think this is an example where it might mean that the person who's working in this space may also be triggered by the very things that they're also working with as well. And I think abuse and violence and trauma is a really good example of that.

Louise Stone (16:31):

I remember as a medical student hitting the edge of my empathy, I thought as a medical student that I was pretty tolerant and I probably felt a little bulletproof when it came to tolerance. I thought that I could tolerate anything. I did train at Prince Alfred Hospital. It was a very prestigious place to train and had a very strong sense of hierarchy. So it wasn't difficult to be more tolerant than some of the models that I was working with. But nevertheless, I remember seeing a family who were Turkish and the older daughter was dying of bowel cancer. She had a condition called familial polyposis coli, which runs in families and is a precursor to bowel cancer. And the men in the family had decided that the younger sister could not have a colonoscopy and she was at risk because she would not be marriageable and I couldn't cope with it. You strike things a lot the first time in medical school, that was my first time and I still remember that's just wrong. I cannot feel that that is in any way, right? I can't get my head around, I can't think into that space. And it was quite shocking for me to feel that so strongly.

May Su (17:44):

It's interesting because I suspect you're not alone in that the Louise. And I suspect that what might push our buttons might differ for every professional. And again, I imagine for those of you that are listening into that, you might be thinking about your own practise and your own times where something might've come up in your own experience. I was actually reading an article the other day, I think I'd mentioned this to you before and it came up because I'm doing a scoping review at the moment and it came up and as you do in a scoping review, you get really interested in new articles which come up. But this article was a qualitative study based in Poland and it looked at family physicians problems with patients and their own limitation. And it really resonated with me because what they actually came up with was all the things that I suspect we might be talking about today.

(18:38):

It was that what clinicians found really hard with them, I don't think this is just clinicians, I think it's anyone working in health patients who may be aggressive, particularly when it might be like what you allude to there, Louise, where it might be the family, like the parents of a child where it might not just be about the aggression, but it might also just be about the aggression about a treatment choice. So not only that, but your authority and your expertise being questioned about what's going on. Professor Michael Kidd spoke about moral injury. So that helplessness, when you feel that what you feel is the right thing to do isn't necessarily going to happen. So it's that hopelessness of self-elimination and that disharmony between what you feel and your feelings and beliefs about the duty of a doctor compared with that discrepancy with what you feel should be patient autonomy. But at the same time that patient autonomy is not necessarily fitting in with what you think should be happening. And then you've got the communication style issues which sometimes spit into it. So all those things certainly I could see myself nodding and resonating with as I was reading that.

Louise Stone (19:56):

Hester, I'm interested from your perspective because one of the issues we have as doctors, and I'm sure it happens in other settings, is when we've got that dual role problem. So for me, if somebody has say an addiction to opiates and I'm the one prescribing more, in me it's often work cover where I'm trying to make an assessment of somebody and they're seeking work cover and I'm not necessarily convinced that they need it or those sorts of things, you must manage a lot more of that. How on earth do you cope with that?

Hester Wilson (20:31):

Yeah, look, I think it's interesting. Gosh, there's so much in that question. If you think about people who use drugs and alcohol, first of all, heaps of reasons why people use drug and alcohol, but one thing they don't use it for is to become unwilling to become dependent or addicted. They don't, and many of them scratch the surface and there's significant trauma and sometimes behaviours that they exhibit can be extremely challenging. And if we think about the stigma and discrimination, mental health is stigmatised and discriminated against, but drug and alcohol is worse. And if you're an injecting drug user, it's even worse. And if you are injecting your prescribed opioids, it's probably even worse. And there's that weird dichotomy that happens with people who have been prescribed opiates for chronic pain. And look, we as the medical board health professions have got to take our responsibility for the fact that we had this naive understanding, hey, opioids are great for acute pain, so they're going to be great for chronic as well, but that people are coming to get this psychoactive drug that has helped their pain in the past and helps their, what I always call life ache.

(21:36):

And then suddenly it's like a switch gets flipped and they're no longer a genuine pain patient, they're now this drug seeker. And certainly for me, the language that we use around this is so important. We really do need to think about how we talk about it and how the patients that we see, how they talk about it as well because that has such impact on our response and on our kind of emotional space to handle this. So for me, with drug and alcohol, just coming back to that issue around it, getting beyond your empathy, that can easily happen. The thing that always happens for me around this is, I have a role and it's a really clear role and being really clear around what those boundaries are and I can't move outside them. I'm really sorry if you're asking me for more than that, I'm going to be really clear that I actually can't do that.

(22:29):

The government won't let me. I'm not allowed to. It's not a part of my role. Whatever it is that is appropriate, I think that that can be hard for people when they come up against it that it actually creates safety for everybody involved. But this is a bit of an aside, but over the years I've had conversations with people who have accessed high risk medications from various doctors and they will say things like, I just go to that doctor to get my benzos or to get my roids or to get my opiates. I would never go to them if I was really sick because they're not good doctors. So they do have this kind of stuff around, yeah, they're where I go because I need to, but I don't actually trust them. So having those boundaries is really important, but it's also the way that you have those boundaries that supports people and just actually lets them know that you are a caring professional that is respectful with clear boundaries around what you can and can't do.

(23:25):

And it's up to them whether they choose to engage with what you can offer. They're experts in their own lives and you might look at them and go, oh my god, how can you do that? But that's not actually what it's about. So ours is to have a curiosity and a seeking to understand and therefore being able to offer our expertise to support them in what their goals are. But if their goals are things that we actually can't do, give you a certificate for work cover when in fact it's not indicated. It's a tough one. But for us in general practise, we are advocates for our patients. So they come in with an initial where there to help them. Part of the thing that happens with these tricky scenarios is, yes, I'm here to help, but at the same time I might make decisions that you don't agree with or don't like.

(24:14):

And this is the reason why. So for me, with the work that I do, I always think to myself, I totally believe everything you are saying. And at the same time, I don't believe any of it. It's sitting in dichotomy or complexity. And at the same time, you can be caring and respectful and certainly one of the things that I do see in some of the practitioners, I do some work through the medical board or the medical council in New South Wales is a group of doctors that have kind of fallen off down that road being super compassionate and making choices that are best practise and are dangerous, but it's because they care and they want to support and then they find themselves drifting down this road and it's really common to find yourself kind of being pulled down that road. And so having that sense of, okay, taking a breath, I don't need to respond, come back, just settle myself again to do what I know is the right thing and that stuff of it playing into your past experience, it can be that you over identify, I've had a similar experience.

(25:13):

I know what it's like. Well, you don't actually, you only know what your experience is and so you can get caught up in it that way. Or the other thing is that you can actually be disgusted and disdainful because of where that person has gone. And both those are really tough. It's really important to recognise them

in yourself and to not actually take that stuff out on the patient, whether it's overcompensating and doing too much. I had a colleague once who the patient decided that she wanted to get all her post delivered to our practise and somehow that was going to be okay. No, but also the pushing away of people because I am disdainful and disgusted by the way you present that to me, it's a really tricky one and certainly in the work that I'm doing at the moment as part of my PhD, looking at GP's experience of people who are prescribed opiates for chronic pains who may have developed a dependence, one of the outcomes of that is a kind of inertia, a kind of paralysis that you can't engage with it, that it's just too hard, that it's just makes you feel too bad, that you feel too responsible.

(26:18):

It can't possibly be that they've developed this condition because of what you've done or what I've done. And that stops us from being able to kind of sit back and go, let's rethink it. But the last thing I would say about that kind of stuff is, really important to get support. If you find yourself in this, you don't have to manage it on your own, you don't have to fix it all now. And it's important to get some support and use the 12 month PBS reviews for example, but also talk to your colleagues. If you're getting some supervision, make sure that you slow it down, you don't need to make any decisions, you can get people to come back. That's the real advantage of general practises. We have these longitudinal relationships where people can come back repeatedly. It's a little bit different perhaps for our colleagues working as psychologists where you might have Medicare item numbers and you've only got a certain number, but at the same time, really just slow it down. You don't need to make a decision. Not making a decision is a decision.

Louise Stone (27:19):

I think one of the best things anyone told me fairly early on was as the only female doctor within three hours in my practise when I first started, I had a certain cohort of patients and some of them were highly dependent and I really struggled with that because we don't call someone with renal failure dependent on their dialysis nurse and we don't call someone who's on chemotherapy dependent. So I don't like that word anyway, but it was relationally complex. And I remember talking to one of the psychiatrists I was working with, I was running a master's at the time saying that sometimes you can only hold the batten for 800 metres and then it's someone else's turn. And I think that's been helpful over the years to sort of look at some of my patients and decide when I think I can no longer be helpful, that I've given everything I've got and that I'm just at an impasse. I can't.

(28:20):

And I know it's tricky when you're rural and so on, but you can always find a way of having a team. But I found that quite helpful because often people will talk about, oh, well you just need better boundaries. And what they're really saying is don't see them, put up a barrier. And it makes me angry when I see barriers that are administrative like, oh, I'm sorry, but your patient who has unstable housing and no phone credit didn't turn up to their appointment, so we've transferred the referral and now they can't come. We're going to punish them for their poverty. But thinking about it that way of I've run my race, I've done my best, I have given what I have, and now this person needs someone different, is actually quite helpful in some ways, I think to think about some patients where you do get to the point where you can't be as helpful. And I think sometimes chronic pain patients are in that category that you need a different personality, a different person, a different strategy to try and help.

Hester Wilson (29:23):

Yeah, Louise the idea that better boundaries mean not seeing people. I think that you're right, that does happen. And frustratingly it happens with some of the specialist services. But I guess when I think about it, it's around what actually is my role? What actually do I have expertise for? And I can't manage this on my own. This needs a team.

Louise Stone (29:42):

Absolutely. And I agree. I'm not saying you should be boundaryless by any stretch. It's really important to have firm boundaries, but sometimes the discourse is around rejecting people who aren't ok. And if we all did that, then now the most traumatised patients would have no services. And that's just not on. It's not fair.

Hester Wilson (30:03):

It's not fair. And it's what happens.

Louise Stone (30:05):

Yes, it does. And I did have the other day, I'm used to patients bouncing. I had a patient with Marfan syndrome, which is, I think he's got Marfans, I'll never know because no one will accept him into care. And I went through cardiology and orthopaedics and a few others and psychiatry and he'd lost 40 kilos in six months and I thought that was a problem. He's 22 and he has chronic pain and he has problems with a number of substances and he lives in a family where his sister steals his drugs.

(30:38):

And what got me was that psychiatry said it was drug and alcohol. Drug and alcohol said it was psychiatry, which is normal, but then one of my drug and alcohol that said, oh, we can't take him until you've got him off his benzodiazepine. So then I went, hang on a minute, aren't you the drug and alcohol? And I can't do this. This man cannot be managed in the community. He's in this chaotic household where there's no security and no support and he just needs to be somewhere where he can get the care that he needs. So it is getting increasingly difficult, isn't it, to try and particularly getting residential support where he needs a week in rehab where someone can look after him in all ways to get him on track.

May Su (31:22):

Louise and Hester, I was wanting to come back to a couple of things that we talked about. Hester, one of the things you talked about was talking about working out what is our role and that it's part of a team. And I wonder, just expanding that analogy to what you were saying, Louise, about running your race, I wonder if it's maybe about thinking about our roles in a person's life are really small aspects about a person's life and it's in a certain time course. So that team might expand the whole person's life and they might be at different stages of their journey at different intersections that we might come across them as well. And what you were talking about, Hester really reminds me that people can make bad decisions with the best of attention. And that's not just our patients, that's us as professionals as well.

Hester Wilson (32:20):

Yeah, totally. I mean you make decisions based on the information you have at the time and what do you think is best. And we look at some patients and think, wow, on earth did you do that? Because that was the rational, most useful decision at the time in that particular situation. So actions, I mean, I know I talked about the emotional stuff, but they kind of are rational. There are reasons why people steal

scripts. There are reasons why people don't tell us everything that's going on. I haven't talked about this. I don't tell people about this because I know that they'll stop my scripts, they'll stop seeing me, they'll look at me and I'll feel so shamed. There are good reasons, there are always good reasons, but people do want to have lives of meaning. They do want to improve and people do make change. It can be small, it can be slow. And we as GP's over time, we do see that change even if it is small one. One of the things I always say to myself with some of the people that I see, if I just get a hep-b vax happening, I've done a good thing and if I can get the second one, I've done another good thing. Maybe that's it as well. On top of that, I think it is also that person having the experience of respectful care.

Louise Stone (33:29):

I agree. And one of the big barriers is health professionals getting care, of course, who are afraid that I'm going to report them to the board. And the mandatory reporting obligation. I actually did a workshop yesterday and I did this workshop about a few misfortune cookies where I give people these fortune cookies and inside they've suddenly got something like depression or fraud or dementia or something to talk about what they feel in the waiting room to go and see a gp if they were a survivor of domestic violence or they were a person who thought that they were losing their memory, how would they feel and what would they want from their doctor? And the mandatory reporting thing, I think sometimes when you were talking about boundaries, one of the things I was talking about is you have to be really upfront with health professionals.

(34:19):

And in that first consultation, I make sure I talk about whether or not I'm going to bulk bill them because some people prefer to be bulk billed and some people don't. And the other one is, these are the circumstances in which you're under a mandatory report. And mandatory reporting is about a risk to the patients. It's not about a risk to the professional. We've got plenty of people who are unwell, doctors who are off duty, who are at no risk to anybody. And if we took everyone with a mental illness out of the professions, we gut the entire industry because a lot of people are managing beautifully, even if they have pressure, anxiety. So I think it's really important to be upfront and to at the beginning say, these are the circumstances. If you are a risk to the public, I will tell you that I think you should take time off. And it is only if there is a phenomenal risk. And that's obvious. And it's pretty rare really. I remember reporting someone, was somebody who was actually drunk on duty and it was really obvious they were at work and they were drunk, and that's not okay. But most of the time I'm seeing people in the clinic, they might be fine at work. I don't know.

May Su (35:30):

So Louise, you are touching on really one, I think it's really important for health professionals or anyone working in health to actually name their emotion or at least be aware of their emotion. I think actually naming it's important because I think it actually helps us then reflect on how is that impacting on what we are doing, not just with our patients, but how that's influencing our care as well. Now I'm conscious we've had this wonderful conversation, but there's a few different areas that I wanted us to come back to. And we've kind of been talking about behaviours which we don't always agree with. I do reflect that for some professionals they may also make some of those decisions about who they might work with based on a moral decision. It's about who might be more deserved or who might be more appropriate for them to see. And some of those things are more about being different than necessarily being moral.

Louise Stone (36:31):

Sometimes you'll get a partnership though the two cases I remember which pushed my buttons were both parents who talked about the children in front of them in a really awful way. And I didn't look after the mothers. Mostly I'm happy to see families, but it went along the lines of this is Jane Jane's got a mental illness, she's ruined my life. She's the reason I can't retire comfortably. I wanted to go travelling, but I couldn't because of Jane, unlike her sister Sophie, who's just been amazing. I just love Sophie. And there is no way I could look after that parent. I just couldn't. I had that visceral reaction and I've had that twice where I've said, which isn't sort of true. I'm sorry, you're both in the same family. I can't possibly, even though sometimes I obviously do see the same family, but I couldn't in those cases. So sometimes you get that sort of, I cannot meet you where you're at. I just can't reaction. You just know you're not the right person, I think, but I know what you mean May sometimes it is they're smelly or they don't turn up or they difficult in whatever way or whatever it is. And I do find a lot of patients that have been rejected from multiple services, and I think that's really, really sad because they feel it. They feel unwanted. It's horrible.

May Su (37:55):

Well, the World Health Organisation does actually specify when there are processes where people are saying things or interacting in ways which may in some respects be considered cultural norms, but actually are still considered forms of abuse or violence. And I think specifically shaming your child would be considered not okay. And I think as a professional, it's very reasonable not to collude with that. So in collusion where we are endorsing an unsafe practise or behaviour or rephrasing how something might be able to be said or actually just naming it and calling out the behaviour as not being okay, I think what I wanted to talk to about was being different in terms of I work in a Sydney Darlinghurst and so a lot of the people that I work with, maybe neurodiverse, they may come from LGBTQ+ backgrounds and they've not always had good experiences personally or professionally. And I think being different can sometimes also be very rejecting. And I think it's important for us as health professionals to own and be aware of what part we might play to that as well. And I think that can be overt or sometimes inadvertently about how that could be.

Louise Stone (39:20):

On the oversight of the equation. I wanted to throw in that I run a Saturday morning clinic. Now I'm the only GP in my practise. I work with psychologists and psychiatrists and I'm really selective at who I'll let in the door on a Saturday when I'm the only one there. And I do think sometimes we are not as protective of ourselves as we should be. Sometimes we don't have the structures to keep ourselves safe. That's got nothing to do with your neurodiverse patients who deserve good culturally appropriate care. But just to say that particularly for the young ones who might be listening, I think I put up with things when I was younger that I wouldn't now that I would say, no, I don't feel that that's appropriate or I don't feel that that's safe. And occupational violence is rising. So 50% of the people who experience, of the doctors who experience bullying, discrimination and harassment experience it from patients and their families. So we do have to look after ourselves as well. And I would never do a first consultation on the Saturday morning when I'm alone, but I certainly would see patients that I know well that I'm very comfortable being in the room alone. And I guess we do need to make sure that we look after ourselves in that sense too.

Hester Wilson (40:40):

Absolutely, absolutely. And certainly when I'm thinking of some of the people that I see, GP setting as compared to a specialist setting where you're part of a multidisciplinary team and you've got other

people there with other skills and that in place, this set up to support staff safety that you do, absolutely do make choices around whether it's appropriate to see this person on a Saturday morning when you're on your own or when you're in the practise with one receptionist who's the 18-year-old girl that lives down the street. And it's okay to do that. And I think sometimes we are unaware of that and thinking about as practises, really thinking what are the safety concerns, really thinking about that beforehand. And yes, and even if it's not about behaviour, there are some people whose issues are just so complex. Once again, you can't manage them on your own in general practise. So they do need to be seen in a specialist setting and that's okay. And yes, it can be tricky, particularly if you're working in a rural regional remote area, but we do have increasing virtual options that we can be part of and so that we've got that specialist input as well. Sorry, just the other thing I wanted to say is sometimes services can actually set things up to stimulate people into quite strong behavioural responses where you can actually diffuse that if you have a setting that works better with that.

May Su (41:57):

Yeah, no, I really resonate with that. And I actually wanted to come back to something, and I know we're running out of time, but I just think this is a really important point. It really stems to safety as well, that sometimes when we are having dialogues and conversations on two different topics is sometimes this happens in these sort of difficult stigmatised areas because there's so much shame and guilt about it. The person might actually spin a different story to what they think is acceptable, what they think you want to hear, but it means that you're not actually addressing the core. And I actually think about it as, Hester you talked about listening and believing, but actually I talk about it actually listening to that underneath story, underneath what the person's actually saying and really trying to understand is what they're saying actually the story they're trying to tell me or is there something else that they're trying to say?

(42:50):

And when you understand that aspect, and then it goes to that systemic thing, Hester, that you can put in place where it's not about inciting emotion and not believing the person, but you're believing them much more to what is actually going on, not just a story that is superficially being told. And you do need to be careful with that because you can't trigger people or push people's buttons and it's nota that you're disbelieving them, it's just that there might be something else which is going on. And in abuse and violence, we recognise that sometimes you talked about it as, I love this term, the life ache. Those are the mechanisms that they have of managing the life ache and uncovering that might be too big, too hard, but with having a good relationship and understanding that, and maybe we might be able to safely, and I agree Louise and Hester, we have to be safe about this, but actually uncover why the presentation was occurring. And I'm going to bring this in the context of maybe decisions we don't agree with, but also about being different because sometimes being different is actually hidden and that's the underneath story, and that's causing the distress and the moral ambiguity and the interpersonal difficulty because actually you're having a different story for what the patient and you are saying from each other. And once you start having those dialogues, I think that's actually a much safer interaction to have as well.

Louise Stone (44:28):

I think one of the things I've learned from the research I'm doing with young people is that when they're presenting for something, they might be going to ED because they don't feel safe and they want to be admitted, they rehearse. It's an audition, and I was so sad to hear about one of my gender diverse participants, they actually have a costume that they wear. It's the pink shirt, so they look like a girl. And I

just thought, oh my goodness. It's a performance that you rehearse on TikTok or wherever it is that you rehearse so that you can get what you need. And I don't think that's different to anyone else. We know that 85% of the time people sitting in the waiting room and rehearsing what they're going to say to the doctor so that they don't look stupid in inverted because they're trying to look authentic, they're trying to look worthy. I find that really sad and we like to think that we are authentic and that we meet them authentically. But the reality is, as we all know, when we think about when we're sitting at the doctors, we are rehearsing what we're going to say so we don't look stupid. It's what you're do.

May Su (45:40):

And every interaction is the weight of that, isn't it?

Louise Stone (45:43):

Once you accept that this is a performance, that a person is giving you to tell you something, I think it helps so much better to understand what's going on. And if you meet them authentically, they will show more and they'll show more. But often the young ones will throw out something and if you don't hit the mark with them, they'll just disengage. I was surprised in my study to have people talking about years and years and years ago when, oh, I love this psychologist. She told me she had a cat, or she told me that she got anxious when she was young. They don't want to know your life story, but they want to know that you are meeting them. As a respectful human,

May Su (46:25):

We often talk about the relational stuff, and part of the relational stuff is sometimes thinking that the other person in the room is the same as you, but that's not the case. Everyone's got their own stories and their stories get harder and harder to share. The more and more different that they feel or stigmatised that they feel, and there's a hierarchy of stigma isn't there, about what things are harder and harder to uncover. So I am conscious that we've just had this wonderful, wonderful discussion. Thank you, Louise and Hester for sharing this conversation with me. I hope that you enjoyed listening to this episode of The Mental Health Professionals Network Presents A Conversation About Health in its complexity. You've being listening to me, Dr. May Su, and my co-host, Associate Professor Louise Stone and the wonderful Dr. Hester Wilson, who's joined us as a guest today. We hope you enjoyed this conversation as much as we have where we've discussed health in its complexity, in the context of what if scratches are moral code.

(47:35):

If you want to hear more about or learn more about us, your hosts, or if you want access to the resources to which we've referred, go to this episode's landing page and follow the hyperlinks. Mental Health Professionals Network values, your feedback. 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 but provide comments and suggestions about how Mental Health Professionals Network might better meet your listener needs. And if you haven't listened to the previous two episodes of A Conversation About Health in its Complexity, you can do so by searching for Mental Health Professionals Network Presents on your preferred podcast streaming platform. Thank you for taking the time to reflect on your work and how you mitigate some of the challenges that may present. We know it's not always easy. Thank you everyone for listening.

Host (48:27):

Visit mhpn.org.au to find out more about our online professional programme, including podcasts, webinars, as well as our face-to-face interdisciplinary mental health networks across Australia.