What does ‘Wellbeing’ mean for Individual Anaesthetists and Organisations?

Dr. Robert Self

Wellbeing Seminar – 11 June 2019

@bobself_London

Declaration of Interest

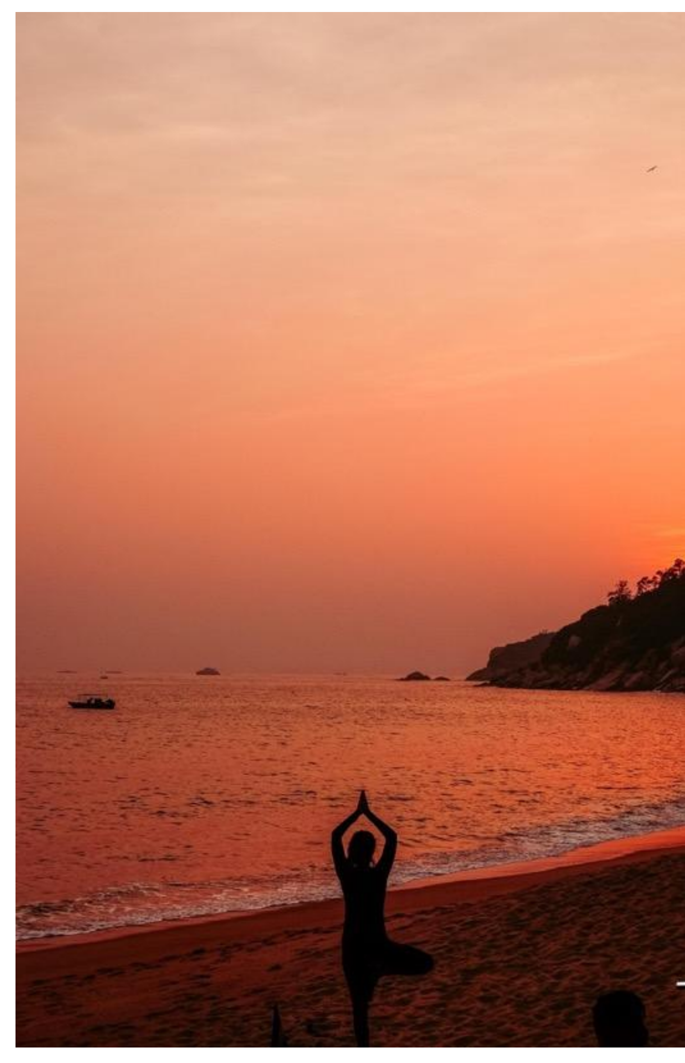
- 2007 Consultant Anaesthetist Royal Marsden Hospital
- 2016 RCOA College Tutor
- 2016 Association of Anaesthetists Mentoring Scheme
- 2018 Association of Anaesthetists Board / Council

Take Home Messages

- Wellbeing is important to anaesthetists at all career stages.
  - Trainees may be more susceptible to work stress & ‘burnout’ (SWeAT study)
- Anaesthetists face a number of specific challenges to their Wellbeing
- Improving Wellbeing / ‘Joy in Work’ is not ‘flaky’
- Improving Wellbeing needs BOTH Individual and Organisational Strategies
- Wellbeing overlaps with Patient Safety, Workplace Behaviours, (In)Civility and Patient Outcome

Why talk about Wellbeing?

Wellbeing?



RCoA responds to NHS Staff and Learners' Mental Wellbeing Commission report

Responding to Health Education England's publication of the report from the NHS Staff and Learners' Mental Wellbeing Commission, Dr Janice Fazackerley, Vice-President of the Royal College of Anaesthetists, said:

'Staff wellbeing and patient safety are intertwined….'

representing the single largest hospital specialty, we have worked with our 22,500 fellows and members to understand better the welfare challenges they face and have been successful in offering solutions to Government and NHS bodies. I am therefore pleased the Commission has recognised that NHS staff need to be better cared for, and has provided Government with a comprehensive plan to make the changes required to better support not only anaesthetists, but the entire NHS workforce.

"I am particularly pleased to see the Commission reference the College's report on the welfare and morale of anaesthetists in training[1]. Our 2017 report captured the views of more than half of all anaesthetists in training and highlighted the importance of basic provisions such as the availability of proper rest facilities and access to a hot and healthy meal when working late and unsocial shift patterns.

"The College is also pleased that the Commission's report recognises the need for capital funding to improve staff facilities in NHS workplaces. We hope that decisions at the upcoming government Spending Review acknowledge this recommendation and support the case for investing in those NHS staff who provide the care and treatment that keeps the country healthy and productive".

Why am I interested in Wellbeing?

- Personal experience – the ‘career lifeline’
- Being a mentor
- Trainee insight
    - Ex-trainee
    - College Tutor
- Recent publications

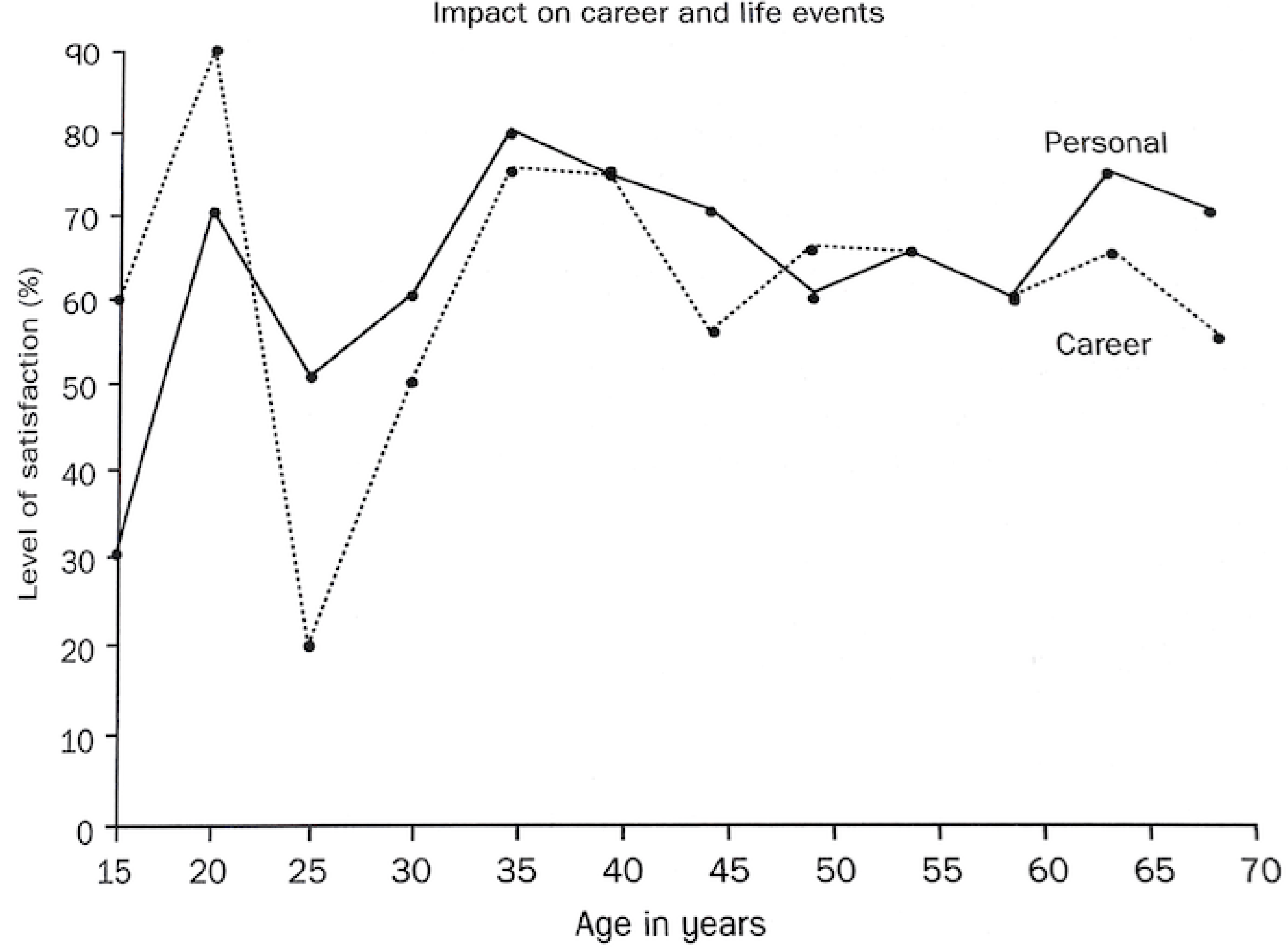
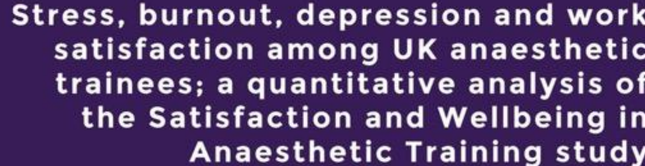


Figure 8.2 A career lifeline showing highs and lows across life stages

From 'Coaching And Mentoring At Work'
Connor & Pokora, 3rd Edition



Respondents included 397 out of 619 (64%) trainees from 29 UK anaesthetic departments.

37% of respondents reported a high level of psychological stress, which is consistent with estimates of moderate–high stress for trainee and trained anaesthetists worldwide.

Measures of depression risk were high, with 18% of respondents reporting symptoms indicative of a major depressive episode. This puts UK trainees towards the higher end of previous estimates (6–22%) for depressive episodes compared with anaesthetic trainees worldwide.

Almost half the respondents reported an imbalance in the ratio of occupational rewards compared with efforts. This is a concern, as effort-reward imbalance is associated with depression and lower quality patient care.

25% had a high burnout risk. A substantial proportion of respondents reported major adverse associations between stress exposure and a high risk of burnout and depression.

Female sex, weekly exercise of ≤ 1 h and > 7.5 hours per week of non-clinical work were independently predictive of high perceived stress.

A non-clinical work-load of > 7.5 hours per week was associated with an almost two-fold increase in the likelihood of high stress.

Taking > 3 days of sickness absence in the previous year, having no children and male sex were independently associated with high burnout risk.

Respondents in all high-risk groups were significantly more likely to complete the survey anonymously and were, therefore, less likely to take part in the confidential interview phase of the study.

This work supports recent calls for UK anaesthetic departments to provide work schedules that facilitate personal and professional development, including consideration of allocating supporting professional activities time for trainees.

Looseley A, Wainwright E, Cook TM et al. Stress, burnout, depression and work satisfaction among UK anaesthetic trainees; a quantitative analysis of the Satisfaction and Wellbeing in Anaesthetic Training study. *Anaesthesia* 2019.

https://onlinelibrary.wiley.com/doi/full/10.1111/anae.14681

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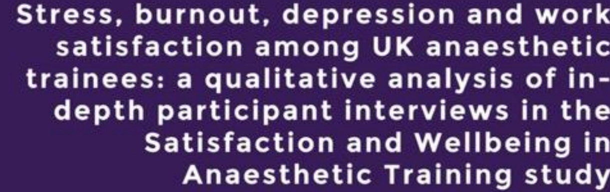

Key themes from interviews included: factors enabling work satisfaction; stressors of being an anaesthetic trainee; and suggestions for improving working conditions.

Although protective factors against work stress were highly valued, they did not mitigate negative effects greatly.

There was love for clinical aspects, but the immense overall pressure and feeling 'on the edge' relate to the concept of burnout, since there was evidence of trainees feeling emotionally exhausted, with a sense of reduced personal accomplishment.

Almost all trainees found elements of professional satisfaction. Most discussed feeling supported by consultants in their learning, often more so than in other specialties. Most valued doctor–patient relationships and enjoyed learning technical skills.

Participants did not offer solutions to their perceived problem of worsening societal views of doctors, but concentrated on improving issues specific to anaesthetic training and did discuss changing the culture within medicine, so trainees can freely seek help if needed.

Trainees want more time within training for essential non-clinical work. This was the single biggest issue arising, in terms of the number of participants mentioning it (all) and the impact it had on their working lives.

It is vital that trainees are competent. Confidence issues are a separate problem, but if trainees are competent and also feel confidence in their competence, this should reduce the feelings of 'running on empty' and exhaustion that trainees described.

No participant spontaneously mentioned Professional Support Units, despite many describing exhaustion and issues of burnout. Awareness of Professional Support Units could be increased at times outside induction.

This work gives insights from anaesthetic trainees about the manageability of their work-load and training and provides a firm foundation for the positive organisational and cultural changes that are obviously required.

Suggestions included: contracted hours for non-clinical work; individuals taking responsibility for self-care in and out of work; cultural acceptance that doctors can struggle; and embedding wellbeing support more deeply in the speciality. Supervisors should be trained and skilled at identifying significant problems.

Wainwright E, Looseley A, Mouton R, O'Connor M, Taylor G, Cook TM. Stress, burnout, depression and work satisfaction among UK anaesthetic trainees: a qualitative analysis of in-depth participant interviews in the Satisfaction and Wellbeing in Anaesthetic Training study. *Anaesthesia* 2019

https://onlinelibrary.wiley.com/doi/full/10.1111/anae.14694

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A report on the welfare, morale and experiences of anaesthetists in training: the need to listen

December 2017

Welfare:

On the edge of a black hole

It was quite simply the single most terrifying moment of my life. It was a Wednesday in August almost three years ago. I had finished my morning list and was walking back to the operating theatres after lunch. I stopped - I could neither go forwards or backwards - it was as if I was frozen to the spot. Suddenly, I realised that I could not carry on and do the list. I didn't know at that moment why I could not carry on; all I knew was that I could not. I seemed to stand there for minutes completely immobile. It was as if I were standing at the edge of an infinitely dark and deep abyss that lay right before me – a sort of black hole that would swallow me up if I lost my balance – and my legs were shaking more and more as I imagined the consequences of falling into the black hole. Eventually, I turned and managed to walk to the car park, get in my car and drive home. As I got back to the house, it felt as if my head was going to explode, I felt utterly exhausted and I was terrified that my illness – or whatever it was – would end my career and harm my family. If I could not work, what was the point of carrying on? I felt thoroughly wretched and totally confused. Two days later, I was to go on holiday for three weeks, so I 'phoned the department and told them a bad night – not only because it was busy but also because we lost a young patient on the operating table. It was no one's fault but we all felt pretty bad about it. Then I was on call for the weekend, which was busy, but not unusually so. Monday was a day of compensatory rest after being on call, so I went to play a round of golf. I recall driving up to the golf club not feeling quite right and thinking rather angrily that I shouldn't have to do on-call at my advanced age! I expected that a day's golf would "blow away the cobwebs", and after a good night's sleep I would be fit for work the next day. I worked on the Tuesday but felt unwell, with a headache, some 'flu-like symptoms and also feeling generally "strange" – I couldn't really explain it. I didn't feel right the next morning, the Wednesday, but I felt okay to do my list - or so I thought. That was the day I arrived at the edge of my own personal black hole. What was happening to me?

It slowly dawned on me that what I was going through was a manifestation of some sort of stress that had been building within me for some months and even years, and had been brought to a head by the emotional challenge of the death of a young patient and by the tiredness of a couple of

Board of ESRA, which at the time was going through a political maelstrom. As the person charged with the responsibility of rewriting the society's constitution, I was in the very middle of this storm, and had been the subject of some very typical mainland European wrangling and politicking. I had not had a terribly easy time but I was blithely ignorant of what my lifestyle was doing to me right up to the moment that the black hole opened up in front of me. Stress – isn't that what happens to other people – the weak, disorganised or inadequate? Surely, stress doesn't affect people like me, I thought. How wrong I was.

Stress-related illness is an increasingly common occurrence. It has a significant impact on the individual, on their place of work and on the organisation that employs them. It is estimated that about 1 : 6 workers is affected. Most doctors are aware of this but few think it could happen to them, me included! This is most certainly not the case. In fact, doctors are more likely to be affected than almost any other group of professionals. There seems to be a spectrum, ranging from a minor event to a full-blown illness requiring significant

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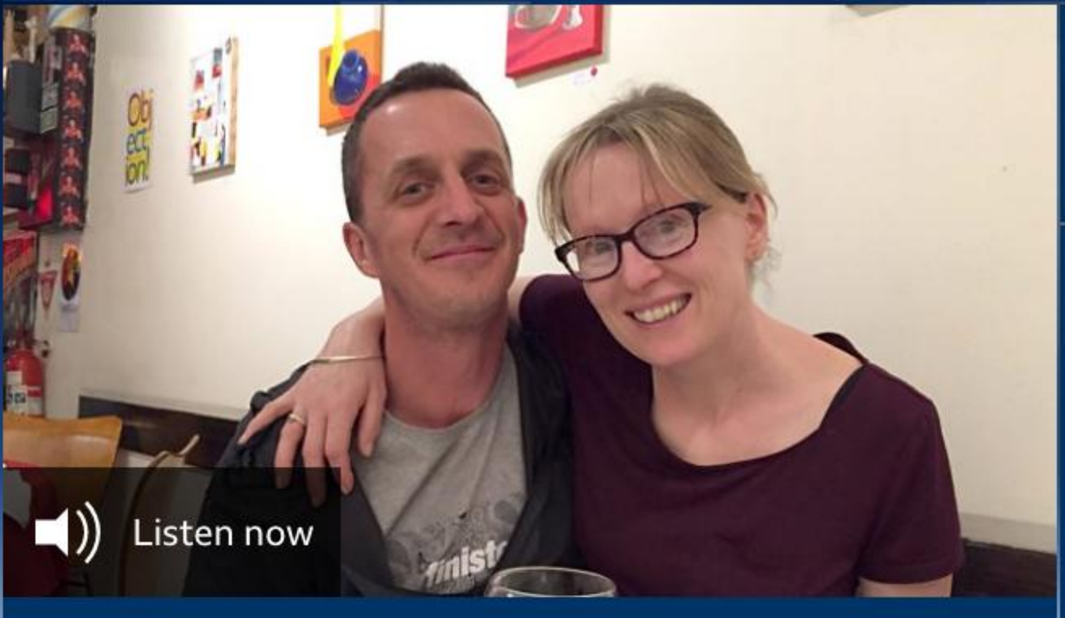

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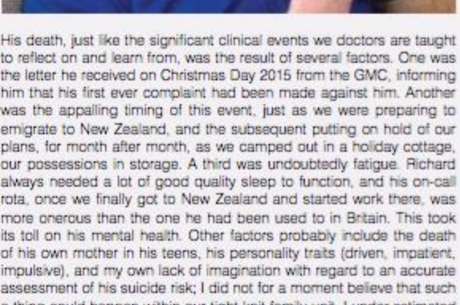
Why we need to talk about suicide

Last year, I was widowed. My husband, a consultant anaesthetist and intensivist, took his own life on 23 October 2017. He was 47. He was a bright, talented doctor who had a reputation for excellent clinical judgment, and a warm and friendly rapport with his patients, who appreciated his directness and honesty. Richard always liked to say it like it is, and, here in Herefordshire, a rural county with a high proportion of farmers among his patients, this went down well. He enjoyed the back and forth banter of the operating theatre, and was a keen contributor to their home baking rota. He was also an enthusiastic internet shopper, which explains the considerable reduction in our outgoings since his death!

He is an enormous loss not only to myself, our two children and his wider family, friends and colleagues, but also to his patients.

That he felt there was no alternative to taking his own life, in the middle of the afternoon, while our son was in the house, and I was out on a walk with our daughter, still seems incredible to me. I have no doubt that the final significant factor in his death was his profession. He had easy access to the lethal drugs that enabled him to make his exit swiftly and, I assume, painlessly. It is well-known that anaesthetists are at particular risk of suicide for this reason.

We are now slowly adjusting to our new life without him, and have returned to the UK from our beachside home in Northland, New Zealand, leaving behind an environment so beautiful that it makes my heart ache to remember it. My children are my main focus, and how to raise them alone; I worry about them endlessly, but am very proud of the way they are coping with this hitherto unimaginable tragedy thus far.



His death, just like the significant clinical events we doctors are taught to reflect on and learn from, was the result of several factors. One was the letter he received on Christmas Day 2015 from the GMC, informing him that his first ever complaint had been made against him. Another was the appalling timing of this event, just as we were preparing to emigrate to New Zealand, and the subsequent putting on hold of our plans, for month after month, as we camped out in a holiday cottage, our possessions in storage. A third was undoubtedly fatigue. Richard always needed a lot of good quality sleep to function, and his on-call rota, once we finally got to New Zealand and started work there, was more onerous than the one he had been used to in Britain. This took its toll on his mental health. Other factors probably include the death of his own mother in his teens, his personality traits (driven, impatient, impulsive), and my own lack of imagination with regard to an accurate assessment of his suicide risk; I did not for a moment believe that such a thing could happen within our tight-knit family unit. I under-estimated how ill Richard had become, and how disordered his thinking.

It will come as no surprise to learn that my husband suffered from a significant depression during the final months of his life. He had had his first episode in his early twenties, and was recovering from this when I first met him. He had no recurrence of the condition for well over 20 years until after his GMC complaint and our move across the globe. He was taking medication when he died, but it was – in retrospect – the wrong medication, and had probably contributed to an agitation which I had not seen in him before, and which became increasingly prominent. He was three days away from his first appointment with a psychiatrist when he died.

I have recently been asked to join the Association's Working Party on Suicide and was honoured to accept this request. A survey is currently being prepared, and will be sent out to members in the autumn of this year. We would be really grateful for your help in completing it. The purpose of the survey is to produce guidance to help Trusts and anaesthetic departments become more 'suicide aware', possibly mitigating the risk to individual clinicians, and to provide help in the aftermath of a suicide should this occur. I am sure that most anaesthetists would agree that these are important and worthwhile objectives. Each suicide leaves such devastation in its wake, and, rightly or wrongly, Richard's feels to me like it could have been prevented.

Kate Harding

Wellbeing

- ‘An optimal state of physical, mental and social wellbeing, and not merely the absence of burnout.’

- NEJM Catalyst August 7, 2017
  - Bryan Bohman MD et al
  - Physician Well-Being: The Reciprocity of Practice Efficiency, Culture of Wellness, and Personal Resilience

Burnout

- 'A syndrome characterised by depersonalisation, emotional exhaustion and loss of sense of achievement.'
  - Wong and Olusanya; BJA Education 2017
  - Often attributed to Christine Maslach in 1981
- Emotional condition with mental & physical fatigue, frustration & disengagement
- The Four C's – callousness, cutting corners, cynicism, contempt
  - PG Brindley, JICS 2017
- 'You know when it's happening to you.'
  - Dr. Abigail Zuger, Wounded Healer Conference, London 2018

- ‘Do you feel burnt out because of your work?’
- Numbers not that different in Anaesthetic Trainers and Trainees
- ‘Very High / High degree’ about 20%
- If include ‘Somewhat’ -50 to 60%

WHO Burn-out: International Classification of Diseases (ICD-11)

- Occupational Phenomenon
- NOT classified as a Medical Condition
- ICD-11 definition:
- ‘Burn-out is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions:
  - Feelings of energy depletion or exhaustion
  - Increased mental distance from one’s job, or feelings of negativism or cynicism related to one’s job; and
  - Reduced professional efficacy’
  - Refers to phenomena in occupational context only

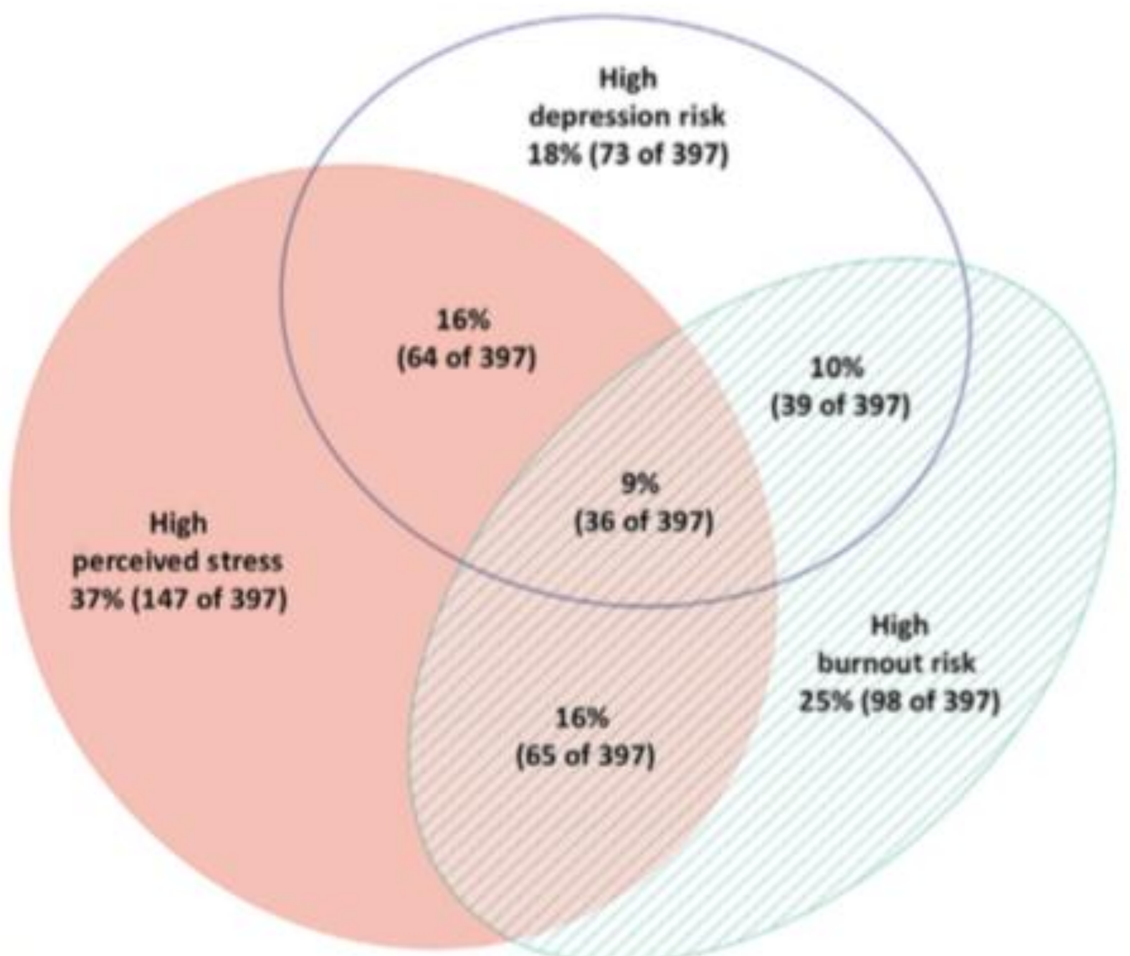


Figure 1 Euler diagram displaying the proportion of all respondents categorised with high perceived stress, high burnout risk and high depression risk, and the co-existence of these issues.

‘Burnout’ or ‘Moral Injury’

- Moral Injury (Abi Rimmer, BMJ April 2019)
  - Originally used to describe soldiers’ response to actions in war
  - Burnout = Not a failure of individual
  - Moral Injury puts onus back on the system

BMJ 2019;365:l2375 doi: 10.1136/bmj.l2375 (Published 3 June 2019)

MORAL INJURY

Physician burnout: moral injury is a questionable term

Michael J Asken *director*

Provider Wellbeing, UPMC Pinnacle Health Hospitals, Harrisburg, PA 17101, USA

- Inappropriate term
- Comparison of experience of warriors vs healthcare workers
- Mistaken belief that resilience cannot be taught or developed
- E.g. military, police, firefighting

Burnout, bad sandwiches and becoming old

I have just finished my third year of being a consultant anaesthetist. I have another 31 years ahead of me. Over this period of time many things will change: advances in the field of anaesthesia, the health care demands of the population, my own health care demands and, probably most importantly, my social situation (at the time of writing I'm engaged and have no children).

Figure 1: Resilience is not a one-player game

- Dr. Benjamin Fox, Anaesthesia News – November 2018

- ‘Likewise, it’s not good enough to simply be ‘not burnt out’. Instead we should be striving to achieve a mental state of excellence. This is known as flourishing….’

What are (some of) the Challenges to Wellbeing in Anaesthetists?

Challenges to Wellbeing (1)

Anaesthetists have specific challenges:

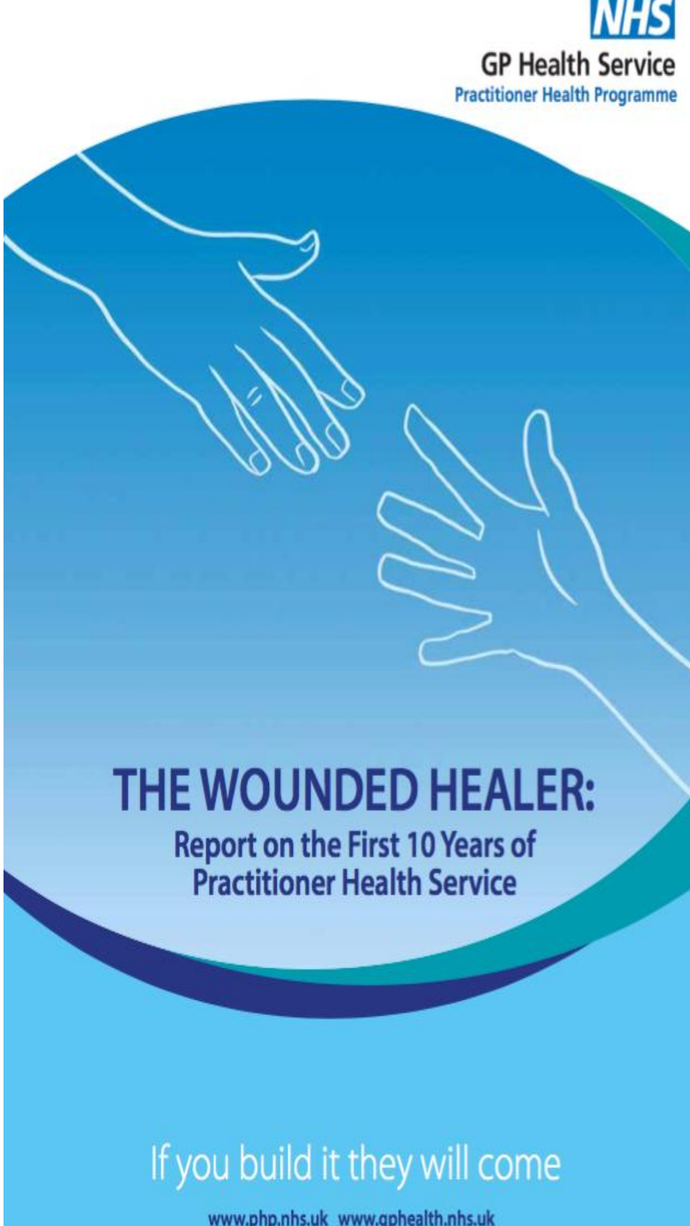
- Lack of control & Unpredictability of work
- Perceived overextension
  - e.g. Time constraints, Work Overload, Production Pressure
- Clinical factors
  - e.g. Complex clinical tasks, responsibility, fear of harming patient
- Access to (and knowledge of) potent drugs in the working environment

Haleh Saadat & Zeev Kain, Current Opinion Anesthesiology 2018
'Wellness interventions for anesthesiologists'

Challenges to Wellbeing (2)

- Fatigue
- Complaints / GMC investigation
- Computers
- Workplace Culture / Behaviours
- Communication difficulties
- Mixing family life with professional duties

Haleh Saadat & Zeev Kain, Current Opinion Anesthesiology 2018
'Wellness interventions for anesthesiologists'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Fatigue

The Faculty of
Intensive Care Medicine

Joint statement: tackling the effects of fatigue on the NHS workforce

Following the tragic death of an anaesthetic trainee who fell asleep at the wheel while driving home after a night shift, the Association of Anaesthetists of Great Britain and Ireland (AAGBI), the Royal College of Anaesthetists (RCoA) and the Faculty of Intensive Care Medicine (FICM) have come together to launch an agenda for action to address the impact of fatigue and shift working on the NHS workforce.

Evidence about the issue

Anaesthesia is the single largest hospital-based medical specialty. Issues raised by both anaesthetists and intensivists are indicative of the challenges facing the profession, and the wider NHS. A recent national survey of anaesthetic trainees published in the scientific journal Anaesthesia found:

- Nearly three quarters of respondents reported that fatigue had a negative effect on their physical health or psychological well-being
- 84% had felt too tired to drive home safely after a night shift
- 57% had experienced an accident or near miss when driving home after a night shift.

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A survey of fatigue amongst consultants in anaesthesia and paediatric intensive care medicine in the UK and Ireland

L. McClelland[1], R. McCrossan[2], F. Corcoran[3], N. Redfern[2], J. Fraser[4], C. Gildersleve[5], K. Ferguson[6] and E. Plunkett[7]

[1]Morriston Hospital, [2]Royal Victoria Infirmary, Newcastle upon Tyne, [3]The Dudley Group of Hospitals NHS Trust, [4]Bristol Royal Hospital for Children, [5]Noah's Ark Children's Hospital for Wales, [6]Aberdeen Royal Infirmary, [7]University Hospitals Birmingham and Birmingham Women's Hospital

Awareness of fatigue in anaesthesia is increasing following the Association of Anaesthetists' #FightFatigue campaign and the publication of a survey of fatigue amongst trainee anaesthetists [1]. This study assesses workplace fatigue amongst consultants.

Methods

We undertook an online survey of consultant members of the Association of Anaesthetists, the Royal College of Anaesthetists, the Association of Paediatric Anaesthetists and the Paediatric Intensive Care Society. The survey (administered by Enventure Research) was open from 25 June to 6 August 2018 and promoted through the communication networks of these organisations.

Results

We received 3847 responses from a total of 10,549 members, representing a 36% response rate. There were responses from 316 acute hospitals in the UK and Ireland. The majority of consultants (84%) contributed to an overnight on-call rota. Work related fatigue was reported by 91% of respondents. Over a quarter undertake continuous work periods lasting up to 72 h. Nearly half said they receive two to three phone calls per night on-call, with most taking up to an hour to go back to sleep after being disturbed. Seventeen per cent reported never achieving the legal requirement of 11 h rest between on-call and normal duties. Sixty per cent describe a departmental arrangement for colleagues to cover the next day after a busy night, if required. One third had access to a private rest area with a bed when on-call. Most (79%) commute by car and 48% admitted driving despite feeling too tired to do so. Forty-five per

Health Effects of Complaints / GMC Investigation

Open Access — Research

BMJ Open

The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey

Tom Bourne,[1,2,3] Laure Wynants,[4,5] Mike Peters,[6] Chantal Van Audenhove,[7] Dirk Timmerman,[2,3] Ben Van Calster,[2] Maria Jalmbrant[8]

https://php.nhs.uk/resources/complaints

NHS Practitioner Health Programme

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Complaints

Complaints

Patients are encouraged to complain about the service they get from their doctor and for many doctors this can seem to be personal, an attack on their core sense of self and on their vocational values.

A doctor's response to a complaint is often similar to the stages of bereavement or similar to receiving a diagnosis of a terminal disease. Others, that the complaint is felt with such force that they literally feel a heavy weight on their chest wall.

But complaints are common. Most complaints are handled informally and even those which are not have good outcomes. Whilst complaints hurt, they do get resolved (even if the resolution is not entirely to your satisfaction).

What should you do when the complaint lands on your desk?

1. First and foremost, do nothing. Do not respond, do not fire off an email or write a letter to the patient, even if pressurised by your employer/trainer or colleague.
2. Do not rant and rave (not publicly anyway).
3. If you can, take the rest of the day off. If not, organise to meet someone you trust, soon. There are deadlines to meet, processes to follow but they can wait till tomorrow

For confidential advice please contact 020 3049 4505

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Facing a disciplinary process or investigation

Facing a disciplinary process or investigation

As a team, we have built up considerable understanding and expertise around the interface between disciplinary processes and ill health. We are able to help doctors along the whole disciplinary pathway; from initial complaint to any contact with the GMC/GDC or Performers List/Organisational investigation. We have also built good relationships with all of the major medical defence organisations and barristers who are able to offer free or low-cost advice and, through our patient user group, we are developing a guide for doctors attending the GMC/GDC.

Over the last ten years we have worked with the GMC to help improve the experience of doctors with mental health problems passing through their processes. We have helped the GMC redraft their correspondence to doctors and to improve how the GMC communicate.

Doctors who are undergoing disciplinary processes are often traumatised and highly stressed. They may be entering an unknown territory over which they have no control. At PHS we consider any doctor with a complaint or referral for further investigation as high risk and in need of support, more so if the doctor is also suspended from work

For confidential advice please contact 020 3049 4505

Email us

DRAFT FOR COMMENT

Code of Practice for Complaints for NHS staff

This draft document has been prepared by the Practitioner Health Service to try and minimise the harm caused by an already stressful complaints process. It would also ensure that there is a timely and fair response for all parties, and a balance between the rights of patients and those of doctors. If you have any comments do let us know: email – gp.health@nhs.net

A Code of Conduct for Complaints should include

1. **Clarity as to what the complaint is, what is it about, who has made it and who else, if anyone, is involved.**
2. This also includes standardization of who within the organization sends the complaint to the doctor. Ideally, a member from the Human Resource department should lead on all complaints, including being the point of contact for the doctor receiving the complaint and other internal or external stakeholders.
3. **A right to have the terms of reference or the parameters of the complaint made**

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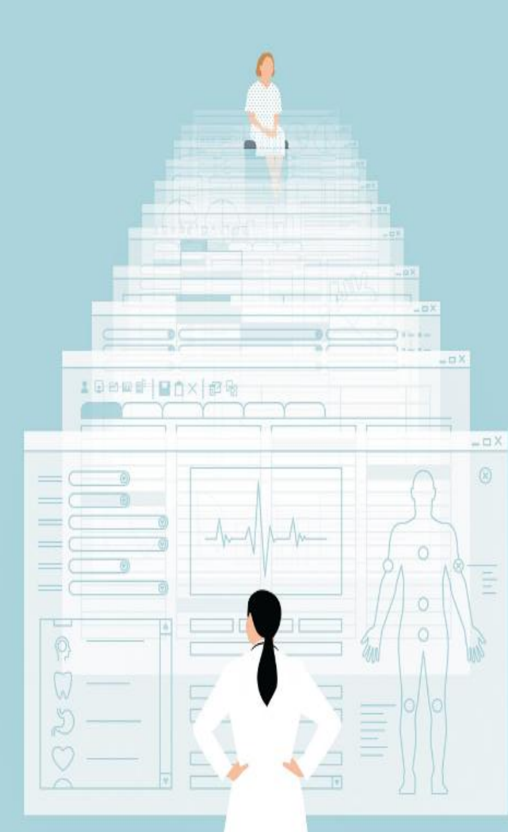
ANNALS OF MEDICINE NOVEMBER 12, 2018 ISSUE

WHY DOCTORS HATE THEIR COMPUTERS

Digitization promises to make medical care easier and more efficient. But are screens coming between doctors and patients?

By Atul Gawande



Poor Behaviours in Healthcare @neilspenceley

EVOLUTION

OF INCIVILITY

A civil clinician → External stressors → A permissive environment → An incivil clinician

Evolution of incivility

It only takes a few simple steps

What can be done to Improve Wellbeing in Anaesthetists?

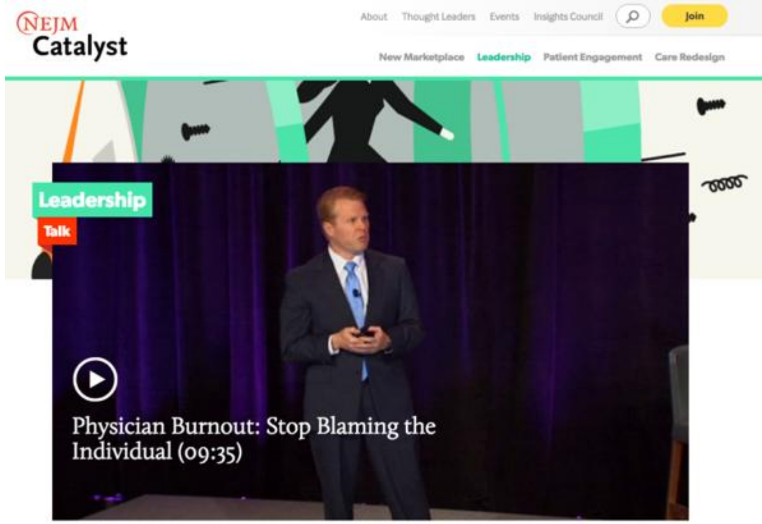
Sleep, Granola & Yoga?

‘We tell physicians to get more sleep, eat more granola, do more yoga, and take more care of yourself. These efforts are well intentioned.

The message to physicians, however, is that you are the problem, and you need to toughen up.

We need to stop blaming individuals and treat physician burnout as a system issue.’

Dr. Tait Shanafelt
Chief Wellness Officer, Stanford Medicine



Physician Resilience – a Stronger Canary is Never Enough

Posted by Dike Drummond MD

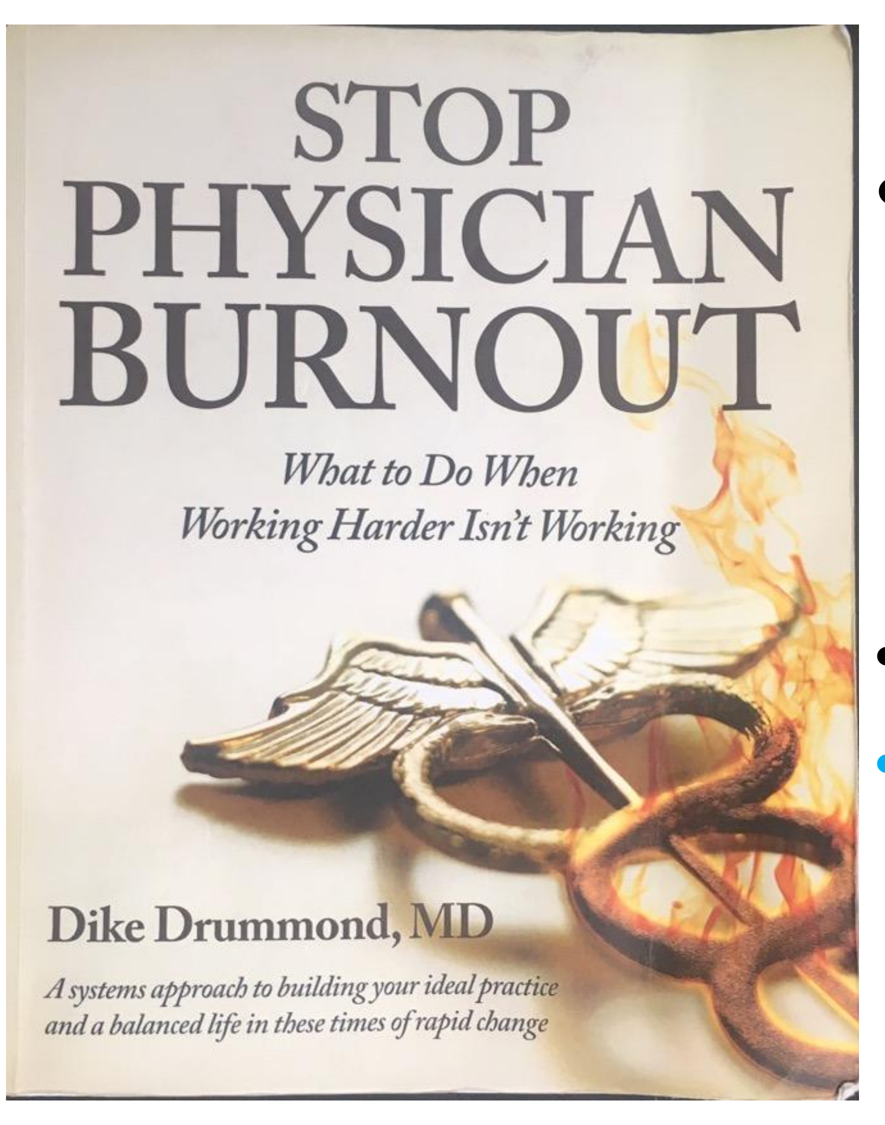
Physician Resilience – a stronger canary is never enough

In my work with thousands of over-stressed physicians and over 140 healthcare organizations, I have learned one lesson over and over -

Resilience training alone is not sufficient to rein in the epidemic of physician burnout.

If you believe like I do that physicians are the canary in the coal mine of medicine.

Then it is clear the epidemic of physician burnout is an indictment of the conditions of the mine, not the resilience of the canary.



- 'Burnout is NOT a Problem. It is a Dilemma – a perpetual balancing act.'

- Dr. Dike Drummond www.TheHappyMD.com
- @TheHappyMD

The Happy MD Burnout Prevention Matrix

Reduce Personal Stress	**Increase Personal Recharge**
Reduce Organisational Stress	Increase Organisational Recharge

Lessons from Emergency Medicine..........

EM-POWER: A Wellness Compendium for EM

Emergency
Medicine
Positivity
Opportunity
Wellbeing
Engagement
Retainment

Published: April 2019

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Long Lives,
Healthy Workplaces

A TOOLKIT FOR ANAESTHETIC DEPARTMENTS

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Australian Society of Anaesthetists

Evidence-based resource

NHS Staff and Learners' Mental Wellbeing Commission

February 2019

www.hee.nhs.uk

- 33 recommendations
  - 1. NHS Workforce Wellbeing Guardian
  - 2. NHS Workplace Wellbeing Leader
  - Four recommendations relating to Suicide in Healthcare workers
  - 33. Bullying

WHITE PAPER

IHI Framework for Improving Joy in Work

AN IHI RESOURCE

20 University Road, Cambridge, MA 02138 • ihi.org

How to Cite This Paper: Perlo J, Balik B, Swensen S, Kabcenell A, Landsman J, Feeley D. *IHI Framework for Improving Joy in Work.* IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017. (Available at ihi.org)

Foreword

Okay, I admit it. "Joy in work" sounds flaky. That was the reaction a friend of mine had when I suggested a couple of years ago that she add that to the strategic goals she was exploring with her team on a day-long management retreat. She did try, and her report back to me was this: "They hated it. They said, 'Get real! That's not possible.'"

Sad to say, I suspect that may still be the response of all too many workgroups and leaders, both inside and outside health care. "Hunkering down," "getting through the day," "riding out the storm" – these are much more familiar attitudes in inevitably stressed work environments, as truly good people try hard to cope with systems that don't serve them well, facing demands they can, at best, barely meet. The closest most organizations come to "joy" is "TGIF" parties – "Thank goodness it's Friday. I made it through another week."

It has long seemed a paradox to me that such depletion of joy in work can pervade as noble and meaningful an enterprise as health care. What we in the healing professions and its support roles get to do every day touches the highest aspirations of a compassionate civilization. We have chosen a calling that invites people who are worried and suffering to share their stories and allow us to help. If any work ought to give spiritual satisfaction to the workers, this is it. "Joy," not "burnout," ought to rule the day.

In our work in health care, joy is not just humane; it's instrumental. As my colleague Maureen Bisognano has reminded us, "You cannot give what you do not have." The gifts of hope, confidence, and safety that health care should offer patients and families can only come from a workforce that feels hopeful, confident, and safe. Joy in work is an essential resource for the enterprise of healing.

Good news! Joy is possible. We know it is possible, not only from intuition, but also from science. This IHI White Paper summarizes a surprisingly large literature on theory and evidence about factors, such as management behaviors, system designs, communication patterns, operating values, and technical supports, that seem associated with better or worse morale, burnout, and satisfaction in work. It also cites a growing number of health care organizations that are innovating in pursuit of joy in work, and often getting significant, measurable results. (One of those organizations is IHI, itself, whose local projects are worth studying.)

Since joy in work is a consequence of systems, quality improvement methods and tools have a role in its pursuit. That is to say: organizations and leaders that want to improve joy can do so using the same methods of aim setting, tests of change, and measurement that they use in the more familiar terrain of clinical and operational process improvement.

So, listen up! "Joy in work" is not flaky, I promise you. Improving joy in work is possible, important, and effective in pursuit of the Triple Aim. This IHI White Paper will help you get started. And you might well find that the joy it helps uncover is, in large part, your own.

Donald M. Berwick, MD
President Emeritus and Senior Fellow
Institute for Healthcare Improvement

WHITE PAPER

IHI F

Impr

AN IHI RESOURCE

20 University Road, C

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‘So, listen up! “Joy in work” is not flaky, I promise you.
Improving joy in work is possible, important and effective in pursuit of the Triple Aim.’ (hope, confidence and safety in healthcare).

Donald M. Berwick MD
IHI

- Individual
- Anaesthetic Department
- Theatre Suite
- Directorate
- Hospital
- School of Anaesthesia
- Regional
- National

- ’Pebbles in Shoes’
- ’Boulders’

Individual Strategies

- ‘What Matters To You?’
- Reduce Personal Stress & Increase Personal Recharge
  - @TheHappyMD
- A Wellbeing SOAR™ (Strengths, Opportunities, Aspirations, Resources)
  - www.appreciatingpeople.co.uk
  - @AppreciatingP
- Baker’s Dozen (Dr. Mark Stacey)
- Meditation

Downward-Facing Dog?

Review

The Use of Yoga to Manage Stress and Burnout in Healthcare Workers: A Systematic Review

Rosario Andrea Cocchiara [1], Margherita Peruzzo [2], Alice Mannocci [1], Livia Ottolenghi [2], Paolo Villari [1], Antonella Polimeni [2], Fabrizio Guerra [2] and Giuseppe La Torre [1,*]

1 Department of Public Health and Infectious Diseases, Sapienza University, 00185 Rome, Italy; rosario.cocchiara@uniroma1.it (R.A.C.); alice.mannocci@uniroma1.it (A.M.); paolo.villari@uniroma1.it (P.V.)
2 Department of Oral and Maxillofacial Sciences, Sapienza University, 00161 Rome, Italy; margherita.peruzzo@gmail.com (M.P.); livia.ottolenghi@uniroma1.it (L.O.); antonella.polimeni@uniroma1.it (A.P.); fabrizio.guerra@uniroma1.it (F.G.)
* Correspondence: giuseppe.latorre@uniroma1.it; Tel.: +39-064-9694-308

Received: 22 January 2019; Accepted: 22 February 2019; Published: 26 February 2019

‘You should sit in meditation for 20 minutes every day – unless you’re too busy; then you should sit for an hour.’ – Zen adage

‘The Vital Signs’
A guide for doctors seeking help and advice
RMBF

Departmental Strategies

- Wellbeing on Agenda at Trainee / Consultant meetings
- Wellbeing Board / signpost Resources
- Computers (the broken keyboard in theatre etc..)
- Strategies for solo working / sickness
- Support for those facing complaints / investigation. The ‘Second Victim’ of Medical error
- Signposting Support Resources
  - http://www.aomrc.org.uk/supportfordoctors/
  - Practitioner Health Programme now open to all in England
- Assessment Tool from ‘Long lives Healthy Workplaces’

Schools of Anaesthesia

01.02.2019

A training day dedicated to the wellbeing of anaesthetic & critical care doctors & practitioners.

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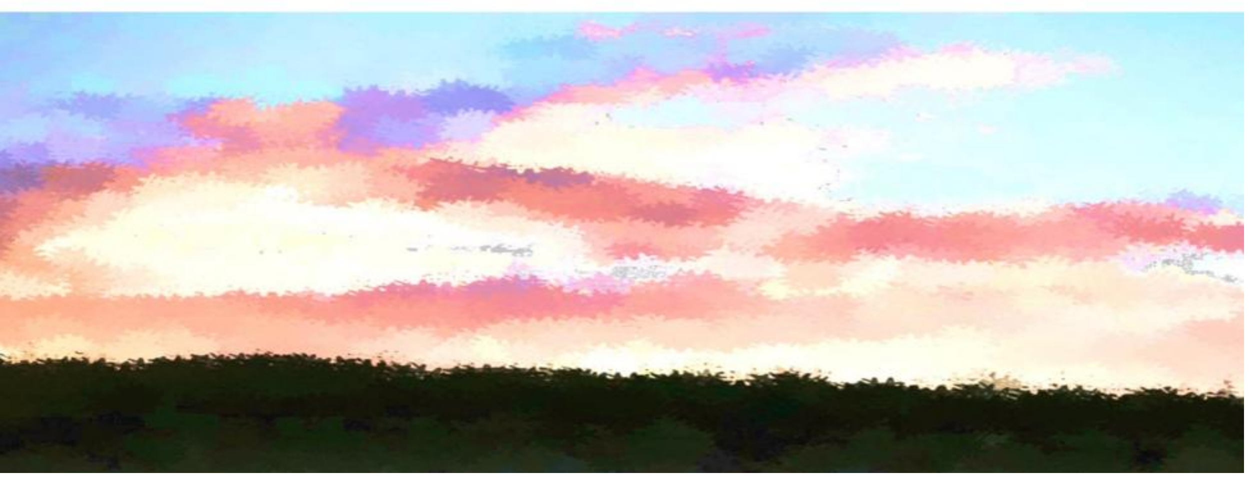


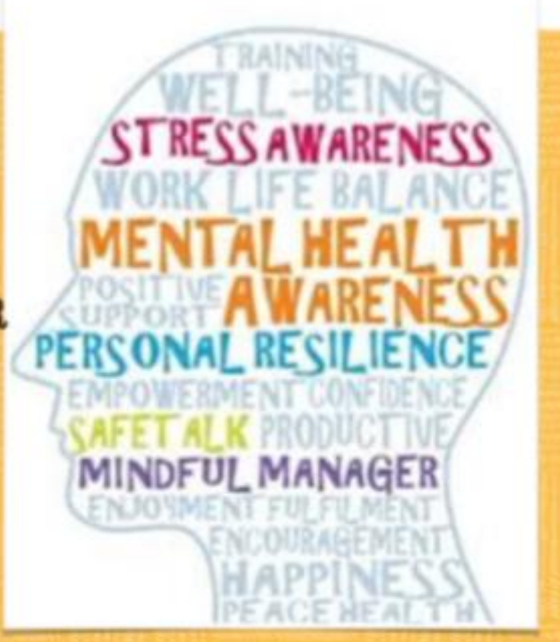
MARCH

28

CHELSEA AND WESTMINSTER HOSPITAL.

GLEESON LECTURES THEATRE.

5PM ONWARDS



IMPERIAL SCHOOL OF ANAESTHESIA

WORK WELL-WELL BEING EVENT

Tickets are free and available at EVENTBRITE. https://www.eventbrite.co.uk/e/isa-work-wellwell-being-event-tickets-55150502638

Speakers include
AAGBI's Dr Nancy Redfern; Comedian John Salmon; Dr Al-Najjar, Professional Support Unit, Prof Chris Williams, NHS Mood zone & Laura Fischer on PTSD.

Contact: y_samaroo@yahoo.co.uk, j.elliott6@nhs.net, terri.stewart@nhs.net

Bullying

Tackling Undermining and Bullying in the NHS

Royal College of Surgeons of Edinburgh and Royal College of Obstetricians and Gynaecologists

Thursday 4 April 2019 9.30 – 17.00
Venue: RCOG, London

Learning from Excellence

LfE highlights success in an environment where the prevailing approach to learning is to highlight failure

Dr. Adrian Plunkett

https://learningfromexcellence.com/

No Blame Learning Environment- RCOA endorsed

Recommendation 4

All employers should support a cultural shift towards a no-blame learning environment that prioritises the safety of patients and the development of staff

There should be structured and meaningful feedback from reported adverse incidents, to ensure that these are used for learning and improvement. The outcomes from investigations into reported adverse incidents should be communicated promptly to mitigate any associated anxiety for all involved.

Good practice example

The Safe Anaesthesia Liaison Group (SALG) (www.rcoa.ac.uk/salg) was set up by RCoA, AAGBI and NHS bodies to review anaesthesia-specific adverse incidents. SALG also evaluates anaesthetic safety reports for further investigation through research or audit, and for dissemination to the wider anaesthesia community via quarterly reports and its network of over 800 patient safety leads. Hospitals should work with the patient safety leads to address incidents in a safe environment.

Recommendation 4a: Methods for excellence reporting should be implemented to support a positive workplace culture

Good practice example

Learning from Excellence[7] and GREATix[8] are locally-developed initiatives which are gaining national recognition. They are based on learning from episodes of peer-reported excellence. Both initiatives have reported significant improvements in staff morale and patient experience across all professions and a positive cultural shift. Learning from excellence is equally as valuable as reflecting on failure.

British Journal of Anaesthesia 115 (5): 645–7 (2015)
Advance Access publication 14 July 2015 · doi:10.1093/bja/aev216

A new view of safety: Safety 2

D. R. Ball[1] and C. Frerk[2,*]

[1] Department of Anaesthesia, Dumfries and Galloway Royal Infirmary, Bankend Road, Dumfries DG1 4AP, UK, and
[2] Department of Anaesthesia, Northampton General Hospital, Billing Road, Northampton NN1 5BD, UK

*Corresponding author. E-mail: chris.frerk@ngh.nhs.uk

Primum non nocere (first do no harm) is a priority for our practice, and nowadays safety is under constant scrutiny by patients, politicians, and the press. This is increasingly recognized by our profession, and articles with a focus on risk and safety are starting to appear in UK anaesthetic journals.[1 2]

Safety is a concept that we intuitively believe we understand but is difficult to define. A suitable definition might be 'the control of recognized hazards to achieve an acceptable level of risk'. A system is evidently not safe when an episode of harm has occurred (e.g. wrong-site surgery), but a system cannot be deemed to be safe simply because an adverse event has not occurred recently. The longer a team, department, organization, or service goes without anything going

Established models of accident investigation are generally based on cascade or domino models of the serial, sequential worsening of an incident into an accident. Heinrich[4] first presented this notion in his book '*Industrial Accident Prevention*' in 1931, with five falling dominoes, one being 'human error'. James Reason's popular and influential 'Swiss cheese model' of accident evolution invokes a similar idea, with the concept of breaches in various defences (cultural, organizational, and personal) allowing propagation of an incident into an accident.[5 6] These are essentially linear narratives, based on what Hollnagel calls a 'causality credo'.[7 8] The main assumption in these analyses is that the event under review occurred in a system that is capable of deconstruction to its composite parts, and that it is describable

Leading article

Learning from excellence in healthcare: a new approach to incident reporting

Nicola Kelly,[1] Simon Blake,[1,2] Adrian Plunkett[1]

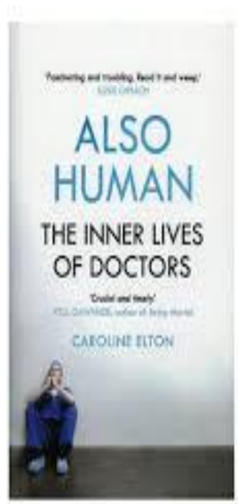
- 'Safety-I'
  - Reactive
  - Incident reporting / 'Root cause analysis'
  - Potential impact on 'Second Victim'
- 'Safety-II'
  - Noting everyday examples of good practice and learning from adjustment required for successful outcome in variable conditions
  - 'Resilience engineering'
  - Used in other industries e.g. air traffic control

'Work as Imagined'

'Work as Done'

- ‘Perhaps in 150 years’ time, the attention given to doctors’ emotional well-being will match that given currently to infection control. Perhaps historians looking back at how we treated doctors in 2018 will regard our medical systems with the same horror that we experience when we read about surgeons in Lister’s day refusing to wash their hands between patients.’

- Caroline Elton ‘Also Human’



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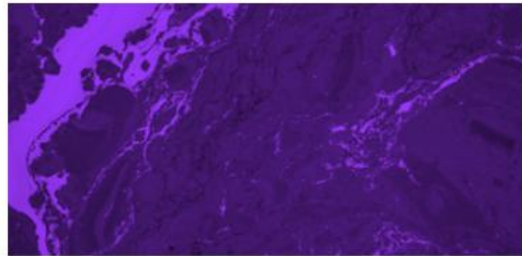


Emergency contacts

Experiencing problems with drugs or alcohol? Or your mental or physical health? These organisations can help.

Mental wellbeing

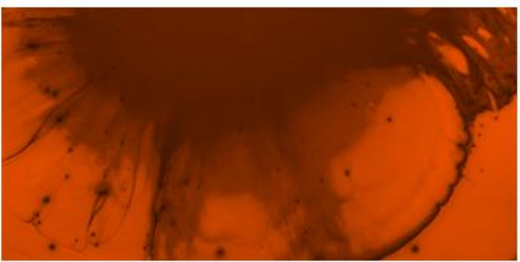
Advice on achieving a work/life balance, managing stress, dealing with bullying and avoiding anxiety and burnout.

Physical health

Find out how to take care of your physical health, from working with a disability or an allergy to dealing with ageing.

Fatigue

It's time to change the culture of fatigue. Find out more about our ongoing campaign to #fightfatigue



Suicide prevention

Find useful resources on suicide prevention and the results of our in-depth report on suicide among anaesthetists.

Mentoring

Find out more about mentoring, sign up for our mentoring scheme or learn how to become a mentor.

Career support

From training to retirement, from LTFT to A Day in the Life of...series: we have advice for every stage of your career.

Networks

Discover more about our networks including Linkman and Trainee Network Leads (TNLs).

www.anaesthetists.org

Mentoring

What is mentoring?

There are many definitions of mentoring, from 'a learning relationship', to 'helping someone become better at helping themselves'.

In truth mentors have several roles, including sounding board, critical friend, facilitator, networker, coach, and even role model. Each mentoring relationship is different. Some are intense and last over time; others are brief and related to a specific situation.

Mentoring is not about offering advice and sharing experiences. It's about helping someone else become effective at developing their opportunities and resources, and managing their problems, helping them to become better at helping themselves.

Why use a mentor?

Association mentoring scheme

Become a mentor

Take Home Messages

- Wellbeing is important to anaesthetists at all career stages.
    - Trainees may be more susceptible to work stress & ‘burnout’ (SWeAT study)
- Anaesthetists face a number of specific challenges to their Wellbeing
- Improving Wellbeing / ‘Joy in Work’ is not ‘flaky’
- Improving Wellbeing needs BOTH Individual and Organisational Strategies
- Wellbeing overlaps with Patient Safety, Workplace Behaviours, (In)Civility and Patient Outcome

EDITORIAL

Physician Burnout—A Serious Symptom, But of What?

Thomas L. Schwenk, MD; Katherine J. Gold, MD, MSW, MS

A patient complains of intermittent wheezing. He cannot characterize the wheezing further with regard to timing, precipitating events, or how it affects his health. A physician makes a diagnosis of asthma without further evaluation, gives the patient several recommendations regarding lifestyle modification and potential precipitants, and prescribes an inhaled long-acting β-agonist and corticosteroid.

Related articles pages 1114 and 1131

The reported range of burnout prevalence was 0% to 80.5% (ie, no one to nearly everyone included in the studies experienced burnout). Similar results were found for the 3 domains of the MBI with a range of 0% to 86.2% for emotional exhaustion, 0% to 89.9% for depersonalization, and 0% to 87.1% for feelings of low personal accomplishment. The high level of heterogeneity again precluded further analyses of the demographic correlates of prevalence.

In the second study, Dyrbye and colleagues[4] had access to a sample of 49 medical schools and 8594 first-year medical

[Burnout: Prevention and Recovery]

Dr Jon Smith, Consultant in Paediatric Cardiothoracic Anaesthesia and Intensive Care, Newcastle Upon Tyne NHS Foundation Trust.

1H02, 1I02, 1I03, 1I05, | Domain 1: Knowledge, skills and performance, Domain 2: Safety and quality

[Stress in the Workplace]

Dr Hamish McLure, Consultant Anaesthetist, Leeds Teaching Hospitals NHS Trust.

1L02, 1L03 | Domain 2: Safety and quality, Domain 3: Communication, partnership and teamwork

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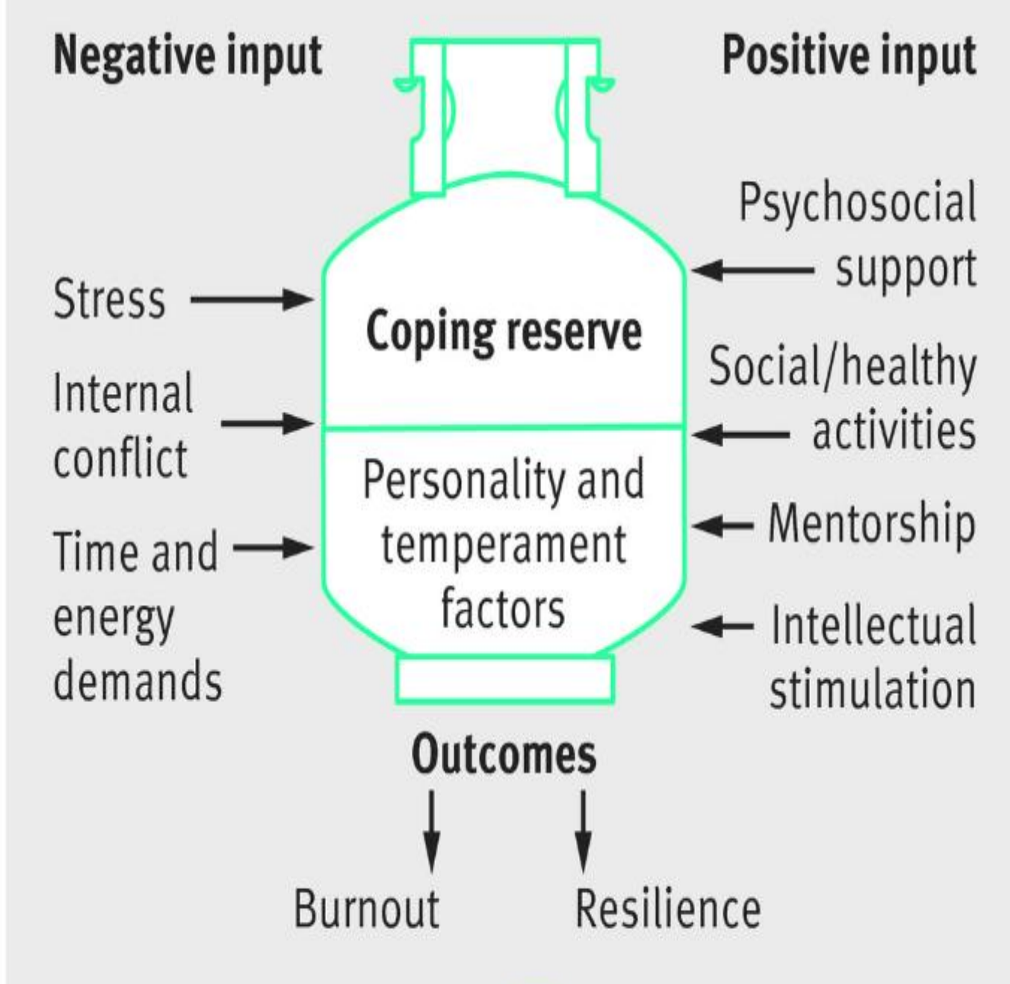
Doctors need to be supported, not trained in resilience

Authors: Eleanor Balme, Clare Gerada, Lisa Page

Publication date: 15 Sep 2015



A conceptual model of medical student wellbeing[25]

The model is a good one and can be used beyond medical school to the lifelong career of a doctor. However, as a model it is incomplete, because it omits the importance of organisational and sociocultural issues, including a stable structure; removal of the culture of blame, name, and shame; and open door policies for line managers. If these issues are not considered, we risk placing the locus of disturbance on to the individual and investing resources in sticking plasters when the necessary treatment is a major operation.

National Strategies

- Civility Saves Lives
  - https://www.civilitysaveslives.com
- Learning from Excellence
  - https://learningfromexcellence.com
- Sign Up to Safety
  - https://www.signuptosafety.org.uk

RCoA responds to NHS Staff and Learners' Mental Wellbeing Commission report

Responding to Health Education England's publication of the report from the NHS Staff and Learners' Mental Wellbeing Commission, Dr Janice Fazackerley, Vice-President of the Royal College of Anaesthetists, said:

"Staff wellbeing and patient safety are intertwined and it's been clear for a long time that more needs to be done to care for NHS professionals who have chosen a career caring for others.

"The Commission's report provides a fair and honest assessment of the shortfalls in staff support and rest facilities. As a College representing the single largest hospital specialty, we have worked with our 22,500 fellows and members to understand better the welfare challenges they face and have been successful in offering solutions to Government and NHS bodies. I am therefore pleased the Commission has recognised that NHS staff need to be better cared for, and has provided Government with a comprehensive plan to make the changes required to better support not only anaesthetists, but the entire NHS workforce.

"I am particularly pleased to see the Commission reference the College's report on the welfare and morale of anaesthetists in training[1]. Our 2017 report captured the views of more than half of all anaesthetists in training and highlighted the importance of basic provisions such as the availability of proper rest facilities and access to a hot and healthy meal when working late and unsocial shift patterns.

"The College is also pleased that the Commission's report recognises the need for capital funding to improve staff facilities in NHS workplaces. We hope that decisions at the upcoming government Spending Review acknowledge this recommendation and support the case for investing in those NHS staff who provide the care and treatment that keeps the country healthy and productive".