# “Achieving balance…”

Professor Geoff Riley

# Is There A Problem?

Suicide – increased compared to general population and relevant professionals? (e.g. Vets, Dentists and lawyers?)

female > male

Depression – higher prevalence?

Substance abuse – higher prevalence?

Other morbidity – arguably no different, but expressed "Low morale, Stress and Burnout"

# Suicide research is fraught

Suicide is a rare event – Absolute numbers are low. So reliability of statistics is low

Suicide research is plagued with problems of recording, attribution and classification

Suicide is a complex phenomenon

Which statistic? Proportional Mortality Ratio vs. Rates

And so on….

# Suicide is a complex phenomenon

The risk factors for suicide are well known, including depression, alcohol and drug abuse, inherited factors, personality factors, and environmental factors including chronic major difficulties and undesirable life events such as separation and divorce.

Goldney 2005

# Suicide and psychiatric disorder

"Pre-existing psychiatric disorders were present in over 80% of doctors completing suicide, mainly depression and alcohol or drug dependence"

Hawton et al (2004)

# So, is There A Problem?

And if so, is it to do with the nature of the job or the nature of doctor's personalities?

# The Nature of the Job

# Occupational Health Psychology Concepts

Demand - Control Imbalance (Karasek 1978)

# Occupational Health Psychology Concepts

Demand - Control Imbalance (Karasek 1978)

Demand:

- Intensity
- Gravity
- Emotionality
- Threat

# Occupational Health Psychology Concepts

Demand - Control Imbalance (Karasek 1978)

Control:

Autonomy (decision authority)

Mastery (skill latitude)

# Occupational Health Psychology Concepts

Effort - Reward Imbalance **(Siegrist 1996)**

# Occupational Health Psychology Concepts

## Effort - Reward Imbalance (**Siegrist 1996)**

Effort:

'Extrinsic Effort': very much like the concept of demand

'Intrinsic Effort': relates to dispositional or personality contribution to perceived effort

# Occupational Health Psychology Concepts

## Effort - Reward Imbalance (**Siegrist 1996)**

Reward:

'Extrinsic Reward' : remuneration, recognition, respect, esteem, security (fame and / or money)

'Intrinsic Reward' : the satisfaction that inheres in doing a meaningful job well

# Occupational Health Psychology Concepts

Support:

# Occupational Health Psychology Concepts

Support: (Karasek and Theorell 1990)

'Instrumental support': having the right tools and environment to do the job

'Relational support':

1. being valued and appreciated by one's superior
2. having pleasant people to work with

# Occupational Health Psychology Concepts

- Key findings
  - Insufficient CONTROL
    - Autonomy – decision authority
  - Perceived extreme effort for insufficient reward
  - Perceived insufficient support and sense of being valued by hierarchy

# The Nature of Doctors

# Doctors' Personalities

Obsessional

Risks: Depression

Dependency

Risks: Depression, Boundary violation

Avoidant (Isolatory)

Risks: Depression, Substance abuse

Narcissistic

Risks: Disruptive, Boundary violation

# The job, the personality or mismatch?

Match

- Obsessional (anxious conscientious) people make great professionals – they are reliable, thoughtful, conscientious, and concerned

Mismatch

- Dependant, avoidant and narcissistic people don't! And if you're too obsessional the job may break you down

# Adverse Health Outcomes

Stress, burnout and reduced well being

Physical illness

Psychiatric illness eg. depression, alcohol abuse

Family and Marriage Breakdown

# “Burnout”

Maslach

- Physical exhaustion
- Emotional exhaustion
- Emotional withdrawal – “depersonalisation”, de-cathexis, anhedonia
- Reduced subjective personal accomplishment

# “Burnout”

Scott Meier

> “Lack of power (rank, status) to alter the absence of positive reward”

This is a behavioural definition of ‘Burnout’ which accords well with Karasek’s concept of

Demand - Control Imbalance

# Adverse Employment Outcomes

Loss of motivation, reduced performance, absenteeism, presenteeism, error, sanction

Leave the job – loss of highly skilled workers, ‘churn’, Loss of ‘corporate memory’

Leave town – loss of a service

Leave the Profession – “Such a waste”

# Contextual Issues

# Contextual Issues

- Medico-legal cases / trends
  - Rising indemnity premiums
  - Landmark civil cases
- Better informed & assertive patients/customers
- Complaints mechanisms more accessible (eg OHR)
- Tightening of resources/greater accountability
- JMS more questioning of traditional medical hierarchy
- Media++
- Publications on “Medical Errors” / iatrogenic injuries
  - Harvard Medical Practice Study (3 Jumbo Jets/2 days)
  - Quality of Australian HealthCare Study
- Push for “Clinical Governance”
- Bristol Royal Infirmary Inquiry (NHS)

# The Changing Compact

1. The Old Compact

What doctors give;

- Sacrifice early earnings and study hard and long
- See patients
- Provide good care as defined by the doctor

What they get in return;

- Reasonable remuneration
- Reasonable work / life balance
- Autonomy
- Job security
- Deference

Edwards et al. 2002

# The Changing Compact

2. The old promise and the new imperatives

Doctors promised;

- Reasonable remuneration
- Reasonable work / life balance
- Autonomy
- Job security
- Deference

New Imperatives;

- Greater accountability (eg. Guidelines), Culture of blame
- Patient centered care & personalized service
- Greater availability
- Work collectively with other professionals
- High quality Communication and Interpersonal skills

# Subjectively Reported Stressors

- Intensity of demand on doctors, time pressure and conflicting demands
- The gravity, emotional intensity and responsibility entailed in the job
- Medico-legal threat and unreasonable expectations and demands of patients
- Insufficient resources provided in the public sector
- Constraints and demands (“interference”) of various government (eg, Authority prescriptions)
- Requirements for ongoing accreditation and continuing professional development

# Subjectively Reported Stressors (Cont.)

Demanding, hostile and emotionally difficult patients and even actual violence

Maintaining amicable relationships with colleagues and staff within the work environment

Managing the demands of small business, finance and accounting

Loss of the traditional status of doctors, and negative media representation

After-hours and on-call work

Interference with family life

Poor remuneration (compared with expended effort)

Lack of appreciation

# Personal Solutions

1. Take Control - "Achieve balance"

   Take control at work (control, self determination)

   Take control of intensity of demand – diary

   Take control of unreasonable demand

   If necessary change role

   Protect key relationships (love) and talk and share – you don't have to do it all on your own

   Remember intrinsic reward (meaningful work)

# Personal Solutions

2. Self care

   Schedule down time

   Schedule holiday and recreation

   Schedule events (something to anticipate)

   stress management - exercise and relaxation

   - meditation

   Mindfulness, time to reflect

   get professional help if unhappy

# Personal Solutions

3. Decide to look after your health

   Attention to Diet

   Exercise – “2000 paces per day”

   Moderate alcohol – moderate generally, alcohol free days, monitor change in consumption

   “Your not still smoking!!”

   Regular medical checks and screen - birthday

# The Great Existential Themes

Meaning of life

- Love - Someone to care about
- Work - Something meaningful to do
- Hope - something to look forward too
- Freedom - autonomy, self-determination, control

# Systemic Solutions

- Control-enhancing opportunities
  - Participation in decisions the affect them
  - Particularly those relating to demand and reasonable autonomy
- Support
  - Respect and recognition, practical support, loyalty, advocacy and protection
  - Proper orientation of newcomers


ΔΡΕΨ ΜΙΣΔΟΝ

# Impairment and responding to impairment

# The Impaired Doctor

Definition

an individual whose competence or behaviour has fallen below acceptable standards as a result of illness.

Corollary – The appropriate intervention will be therapeutic rather than disciplinary notwithstanding the possible need for restriction on practice and monitoring

# “Diagnoses”

Characterised by Impaired judgement or insight

- Depression and Bipolar disorder
- Substance Abuse (Alcohol and Opiates)
- Personality Disorder and ‘Disruptive’ behaviour
- Dementia and organic brain disease
- Age, Frailty, Out of touch, Loss of skills & judgement
- Stress and Burnout (demand - control imbalance)
- Distress (marriage and family)
- “Sick”

# The “Disruptive” concept

Behaviours which impact adversely on others in the workplace or impair workplace effectiveness

Usually have their origin in personality disorder but if “uncharacteristic” may represent illness or life crisis

Provides for detailed description of unacceptable behaviours which expedites precise behavioural contract

# The “Disruptive” concept

The behaviours:

- Discriminatory Behaviour: Racism, sexism, ‘disability-ism’
- Bullying, intimidation, threat, abuse, deprecation, humiliation
- Throwing, slamming, smashing, hitting (something), shouting
- Foul language or offensive gesture
- Discourtesy, poor communication or no communication, unavailable on call, persistently late, unreliable, uncooperative

# Predictors of Risk of Impairment

Past history of psychiatric illness or substance abuse

Disposition or personality (obsessional, dependent, “Type A”, “loner”, “odd” )

Early career reports and observations (including Medical School)

Nature of the job or speciality?

Isolation

Women

# Predictors of Risk of Impairment

A Common Feature is ‘Isolation’

- Not having being locally trained
- Lacking a network of colleagues
- Not being involved in continuing professional development
- Coming from a non-English-speaking background
- Practicing in a rural area
- In solo practice
- Not being married
- Remember, a young doctor in a hospital setting may be extremely isolated

# ‘Red Flags’ for Impairment

Not coping with normal demands of job

Increasing incidence of complaints or concerns raised about a doctor

Uncharacteristic interpersonal and other behaviour including grooming (eg. rudeness, irritability)

Falling clinical standards and actual clinical errors

Avoidance and failure to keep abreast of administrative demands (eg, paperwork)

Lack of responsiveness when called. Not communicating

Worsening punctuality & ‘no shows’ (no prior advice)

Evasive and defensive when contacted

Overt signs or symptoms of psychiatric illness or substance misuse

# Other Sources of Raised Concern

- Audits
  - Mortality, Morbidity, Complications
- Clinical indicators
  - Sentinel events
- Concerned colleague
- Other discipline (Nursing, Allied health)
- “Whistleblower”

# Responding

# Principles of Responding

Do something! (Individual responsibility to act)

Hierarchical escalation

Informal and collegial contact at first, if possible, to minimise additional personal distress and further harm to reputation. Confidentiality

Issues

- Patient safety
- Act promptly (early intervention)
- Share concern
- Use advice and coaching as resource
- ?Formal report
- Does “patient” have insight
- Who will contact and how

# Principles of Responding

Systemic responding requires pathways and people

- First contact and triage
- Multiple Pathways – DHAS, Hospitals, Colleges, AMA, HODs, Government
- Flexible and potentially rapid
- Individuals in each administration who are informed about processes, preferably trained and rehearsed
- Identified psychiatrists and others who are accessible and available to take clinical responsibility
- Consistent with Principles of Human Resource Management and Natural Justice

# Options for Formal Responding

Immediate stand-down / Immediate leave / cooling off
Conciliation / mediation
Restrict clinical privileges
Behavioural contract, or
Unilateral imposition of conditions (eg behaviour)
Prescribing restrictions
Monitoring of conditions on practice (re competence)
Retraining / supervision / mentoring
Retirement / “Face saving”
Psychiatric referral for immediate treatment and monitoring of illness / fitness to practice

# Process Issues

Involve Medical Board or Council ?

Document the process

Consistent with Natural Justice

Consistent with HR Practices

Review:

- Address systems issues (don't endorse blame of individuals)
- Review process efficacy (harm, confidentiality etc.)

# Responding

## Specific Roles for Psychiatrists

- Provision of clinical care
  - Issues of treating doctors and family
- Advocacy
- Assessment for Regulatory Authority
- Monitoring fitness to practice

# Principles of Treating Colleagues

"Render them into ordinary patients"

Formalize arrangements, usual process and information gathering - no short cuts (no corridor consultations)

But, boundaries are not black and white so use discretion & judicious flexibility

# Prevention

Ethical Culture – Respect, Care, Justice

Culture of competence, high standards

Fair selection & credentialing processes

Culture of supportive transparency (vs. blame)

Systemic support structures in place (hospital, colleges, AMA)

Early intervention (vs. collusive denial – ‘we don’t diagnose anything we cant do anything about’ or don’t know what to do!)

No tolerance of disruptive behaviour or bullying – real response

Respect for diversity – no tolerance of sexism, racism and so on

Regular performance appraisals – fair process

Key role of leadership; Maintenance of standards, modeling

# Prevention

Ethical Culture;

Principles - Respect, justice, responsible care:

- Equity & Diversity, Natural Justice, Fair Process (HR)

Virtue Ethics - Prudence, Restraint, Integrity

- Humility, Constancy, Kindness

Communitarianism vs. Liberal Individualism


ΔΡΕΨ ΜΙΣΔΟΝ

# The Doctor-Patient Relationship – Preventing Violence in Clinical Practice

# Ethics and The Doctor - Patient Relationship

Basic Ethical Theory

The Social Contract, Authority and Trust

Beneficence Non-Maleficence, Respect for Persons, Fairness

Hippocratic Expectations and other ethical models

Applied / Clinical Ethics

Ethics in the Consultation

‘Therapeutic Abstinence’

Boundaries, Exploitation, Dual Relationships

# Communication and Consultations Skills

- Basic Communication Skills
  - Attention, Listening, Empathy, Probing
- Advanced Communication Skills
  - Listening for Meaning
- Basic Counselling Skills - Achieving Change in Patient Behaviors
  - Applied Communication Skills
- Consultation Skills
  - The ‘Standard Consultation’
  - Special Consultations – eg. Managing distress, breaking bad news

# Difficult Patient Behaviours and Difficult Consultations

- Mind and Body in Medicine
- Basic Psychiatric Diagnosis, Assessment and Management
- The ‘Difficult Patient’ (or the ‘difficult doctor’?)
  - Passive demanding; covert demanding; aggressive demanding
- Management of the Difficult Patient
  - “Shift to process”
- Management of the Angry, Threatening and Violent Patient
  - Safety, Communication Techniques, Achieving Control