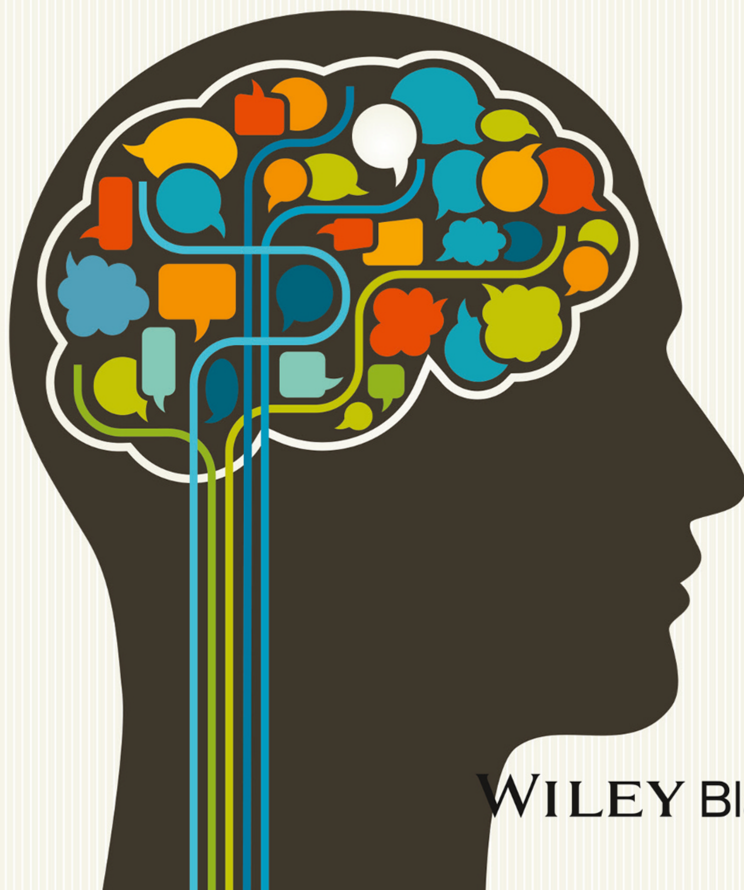
EDITED BY

ESTHER MURRAY AND JO BROWN

THE MENTAL HEALTH AND WELLBEING OF HEALTHCARE PRACTITIONERS

RESEARCH AND PRACTICE



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The Mental Health and Wellbeing of Healthcare Practitioners

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Research and Practice

Edited by

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She is a curriculum leader and designer, an examiner and an external examiner and has spent two years visiting medical schools in The Netherlands and Canada to explore different conceptualisations of medical education. She is an experienced mentor of teachers in higher education and runs courses on teaching and learning as part of professional staff development. She developed and delivers postgraduate courses for senior doctors on the practical application of clinical communication in everyday clinical practice. She is a member of the Association for the Study of Medical Education and is a Principal Fellow of the Higher Education Academy. Her research interests center on the movement of learning from classroom to clinical environment and the challenges to learning in the clinical workplace.

Dr Esther Murray CPsychol AFBPsS SFHEA Esther has been a health psychologist for 13 years, initially working in cardiac care both in service improvement and psychological interventions for patients, later going on to a career in academia. Her early research was in chronic pain and its effect on doctor–patient communication. Esther has previous experience in psychological intervention in cardiac care and training NHS staff in communication skills.

Esther is the first researcher in the UK to explore the concept of moral injury in medicine, and was invited to present on the topic at the Institute of Pre-hospital Care Performance Psychology in Medicine Symposium in June 2017. Esther has been invited to present at national and international conferences for healthcare professionals, educators and students. Esther also delivers training on the moral injury and psychological wellbeing to London Ambulance Service's Advanced Paramedic Practitioners, the Counter Terrorism Specialist Firearms Officers of the Metropolitan Police and is a regular contributor to London HEMS Clinical Governance Days.

Esther has recorded podcasts for WEM, St Emlyns, The College of Paramedics and for the London Advanced Paramedics and East of England Ambulance Service, she also delivers wellbeing workshops at the Royal London Hospital for staff in theatres and at the Royal College of Emergency Medicine and the Intensive Care Society.

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Introduction

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This book is the work of healthcare professionals and allied health professionals who have made the psychological wellbeing of their colleagues a part of their working lives. They are all, in one way or another, involved in the culture change which we know is needed in healthcare in order to keep staff safe and allow them to work in jobs that they love for as long as they want to. There are chapters written by psychologists, paramedics, general practitioners, anaesthetists and others; some are very personal stories of transformation, some are about interventions, some are traditional research and all focus on making spaces for those working in healthcare to be heard and find ways of managing the pressures of the job. Since starting work in a medical school it has become increasingly clear to me that there is a battle for the words to describe the experiences of staff as they deal with the trauma that they witness and also the day to day difficulties of understaffing, and the pressure to perform. There is certainly much more to say, and I see this book as the beginning, rather than the end, of the conversation.

I originally gave this book the title 'borrowed words' because I noticed how much words like resilience, burnout, compassion fatigue and so on were being used, all of which were developed in and borrowed from fields other than medicine. It has become increasingly common in medicine to borrow from other fields, probably the most well-known example is the borrowing of learning about human factors and safety from the field of aviation. Certainly this has been extremely useful in improving patient safety and developments in this area continue, always looking to develop more effective safety cultures in healthcare. (Chapter 13 of this book refers to such culture change.) Other borrowing is perhaps less useful, the wholesale dissemination of terms from other professional areas such as psychotherapy or social work will not apply in medicine and the uncritical adoption of these terms leads only to further resistance. The term resilience is an excellent example here. It originally describes the quality of materials to return to their original shape after being subjected to stressors such as bending or stretching, it was later applied in the field of child and developmental psychology in order to understand how children adapted to, and perhaps flourished despite, adversity. Its adoption in popular psychology has seen it applied in many

different areas, perhaps without appropriate rigour. In healthcare it came to be seen as an entirely individual feature, and there was an emphasis on intervening to create more resilient staff. Such an endeavour was bound to fail given that not all members of staff would have started from the same baseline of stress and distress, or with the same individual traits, and that healthcare is not a system based on individuals but on teams. In fact, the research on resilience states that while there are individual traits which might be useful, they hinge largely upon the ability to enlist appropriate support when things are hard. So, while the ability to regulate one's emotions is an aspect of resilience, seeking a friend or colleague to talk to is an excellent way to regulate emotions. Failing to engage in sufficient depth with psychological concepts which might have been useful has meant that some concepts, such as resilience, have become buzzwords for management failure to properly support staff, seeming only to put the burden of coping back in the shoulders of staff rather than providing appropriate support and commitment to structural change.

It is true that what is needed is both structural change, team training *and* a focus on individual support and wellbeing. The chapters in this book focus on the ways in which staff experiences can be understood, in order to inform intervention; and the ways in which individuals have come together to create grassroots change.

PART 1

RESEARCH

CHAPTER 1

Borrowed Words in Emergency Medicine

How 'Moral Injury' Makes Space for Talking

Esther Murray

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CONTEXT

In 2015 I started working at a medical school, it was an important move for me as I wanted to be a part of how doctors were trained, not only to ensure patients get the best possible care but also to understand how we can support doctors in practicing their profession without being harmed by it. I hadn't taken up a research post, but I had come along with a research idea, I wanted to know how it was that doctors (at this stage of my thinking) could practice for years, see terrible and upsetting things daily and not be affected by it. I had carried out some literature searches and found concepts like compassion fatigue and burnout, I had read reports of post-traumatic stress disorder in emergency responders, but what I had not seen was a systematic approach to understanding what was happening to doctors, and how we could combat it.

In my searches of 'doctor' and 'psychological' and 'trauma' I finally came across the writings of Jonathan Shay, a psychiatrist in the United States working with American war veterans in a VA hospital, this is a facility provided by the Veterans Health Association and serves veterans across the United States. His explanation of moral injury as one of the types of psychosocial harms that could be caused by repeated exposure to different types of traumatic events resonated powerfully with me. Although it did not seem to me that lots of doctors were suffering from

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diagnosable mental illness, it did seem that something was amiss. I could not really understand how it was that doctors were trained into, and then went on to practice their profession without the sort of regular supervision that psychologists are required to receive. I read about Balint groups, I heard about Schwartz rounds, but I could not find anything system-wide or systematic in the United Kingdom. What I did see was widespread discussions of burnout, equally widespread use of alcohol as a coping strategy, and a general sense that there was nothing to do but 'crack on'. This attitude that if you could not handle the pain then you should not be working in medicine at all was passed down to students and junior doctors.

Once I could pursue my area of interest at the medical school, I wanted to know if moral injury felt like a useful concept to doctors. I started my research with students in pre-hospital care, which is an area of medicine practiced by a variety of first responders such as doctors, nurses, paramedics, first aiders, remote medicine practitioners, voluntary aid workers, police, fire, and armed forces, it essentially covers any analytic, resuscitative, stabilising or preventative care given before the patient is admitted to hospital both at the scene of the incident and en route. The students I wanted to interview were all involved in either the Pre-hospital Care Programme (*PCP*) or the Intercalated Degree in Pre-hospital Medicine. The PCP is a student-led, staff supported programme in which students go out on shifts with the London Ambulance Service, mentored by specially trained paramedics. Students can join this programme from their second year at medical school. The intercalated degree (iBSc) in Pre-hospital Medicine is a year-long degree in the clinical, professional and psychosocial aspects of pre-hospital medicine for medical students. I was sure that pre-hospital care must be where the trouble lay since there was more evident trauma there than anywhere, with road traffic accidents, stabbings, shootings and suicide. The kind of medicine performed at the scene, the increasing likelihood of responding to terror attacks, and other kinds of mass casualties all seemed to suggest that pre-hospital care was where psychological trauma must occur. As time went on, it became clear that I was not quite right about what constitutes a 'traumatic event' for a doctor, and that doctors were only a small subsection of the people I should be thinking about, that no one was really thinking much about students and that no one had oversight of the situation or the degree of harm that had already been inflicted on healthcare professionals of all kinds.

Since I started out in 2015 the issue of the mental health of healthcare professionals has become more widely discussed. More and more work is being done at a national and local level to map the extent of the problem and there is recognition of the dearth of solid research that captures the experience of healthcare professionals, especially over time (General Medical Council (*GMC*), [1]). The terms usually used to describe the experience of being affected by healthcare work have often been borrowed from other areas of practice and it is worth tracing their various histories here.

Compassion Fatigue: Sinclair et al.'s [2] review of the use of the term compassion fatigue provides us with a useful frame for considering how we talk about the psychosocial effects of working in healthcare. Compassion fatigue refers to the gradual