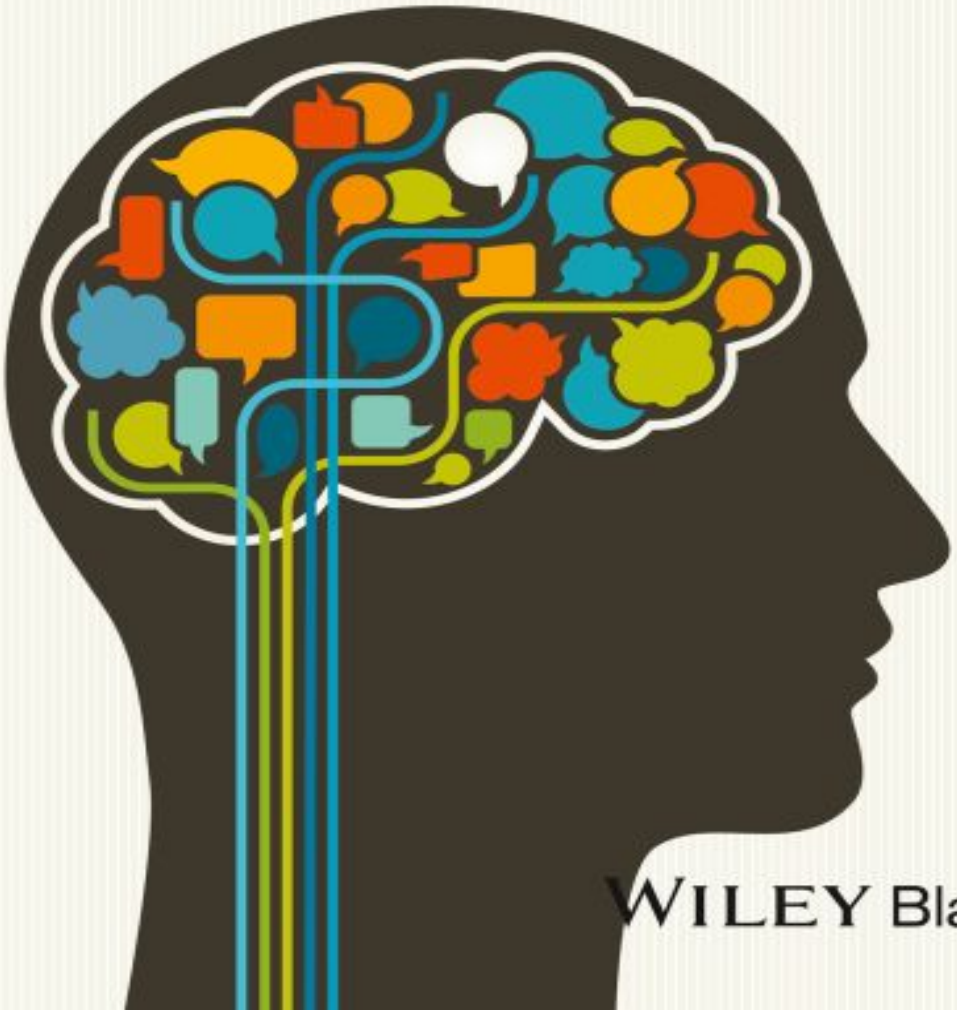
EDITED BY

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

Research and Practice

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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.

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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

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

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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 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 erosion of compassionate feelings towards, for example, patients, because of the high demands and stressful nature of the job. The point that Sinclair and colleagues are trying to make, though, is that the term

‘compassion fatigue’ like many similar terms in healthcare, is used without due care or appropriate rigour. Ledoux [3] points out that rather than trying to connote a lessening of compassion, as if compassion were a finite resource running in only one direction, it could be worth noting that much of the difficulty in maintaining compassionate attitudes is related to those things which thwart the expression of compassion such as long working hours, too few staff for too many patients, lack of rest for staff or opportunities to offload concerns. This conceptualisation is much closer to that of moral distress which has also been extensively explored in nurses and which is discussed below. Interesting observations can be made about those factors which might explain how they occur, it may be that some caring strategies are simply more prone than others to result in compassion fatigue, for example, a tendency to have a ‘rescuing’ style of caring will result in difficult feelings if the patient cannot be ‘rescued’; a sense that perhaps the patient's illness is in part self-inflicted will interfere with compassionate feelings; difficult or disrupted patient interactions might mean that satisfaction cannot so easily be gained from the encounter and thus the good feelings which might offset the difficult or depleting feelings cannot necessarily be accessed.

An alternative conceptualisation of compassion fatigue is proposed by Charles Figley in his 1995 book ‘Compassion Fatigue: Coping with Secondary Stress Disorder in Those Who Treat the Traumatised’ in which compassion fatigue is a form of distress which arises from being exposed to the traumatic experiences of others’. The book focuses on the experiences of psychotherapists, trauma counsellors and others in the business of addressing the psychological needs of people who have undergone trauma. The term ‘compassion fatigue’ itself was borrowed from psychotherapists' experiences, as many of the terms used

in understanding the emotional experiences of healthcare professionals have been borrowed. References to compassion fatigue as conceptualised by Figley, appear in papers about healthcare workers having been lifted wholesale and without further explanation in the text (see, for example, [4]). This is by no means a strange occurrence, in fact, in healthcare, the borrowing of learning from other industries is commonplace, with probably the most well-known example being the borrowing of safety and quality assurance techniques such as checklists, and learning on human factors from aviation. The learning from organisational psychology or other systems-based work, though, reminds us that it is not usually effective to take a concept wholesale from one area and apply it to another. It would be wiser to verify the appropriateness of the concept first. I have often wondered if the scientific background of much of medical practice has done it a disservice, in the end, meaning that concepts from social science do not look so credible as those from the physical sciences and are thus appropriated without much rigour, seeming ‘good enough’ or maybe ‘harmless enough’.

Burnout: The concept of burnout was described by Christine Maslach in 1981 [5], as ‘a psychological syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishment’ which can be the result of work demands which are principally relational in nature and where there is no opportunity to recharge. The term was developed to capture the experience of any person who worked ‘in an intense involvement’ with others, rather than those specifically in helping professions, this includes the criminal justice system and education. The result for workers is the sense that they are unable to do a good job, but also a disengagement from the people they had set out to serve, meaning that they are unable to access the potential good feelings which could be part of working with

people. The concept is now very widely used in healthcare, a Google Scholar search in September 2020 of ‘burnout healthcare professionals’ returns 330 000 results.

Moral Distress: this concept was outlined by Jameton in 1984 in his book ‘Nursing Practice: the ethical issues’ [6] and refers to the effects of knowing what should be done for a patient, but being unable to do it because of situational and organisational constraints such as lack of time, staff or equipment. Most of the research in moral distress relates to nursing practice. The concept is of interest in this chapter since it highlights the relationship between organisational issues and personal, moral issues. This allows us to think of the healthcare professional's own agency in the workplace. Later work shows that to thrive at work, people need a sense of autonomy, belonging and competence and that this is as true for healthcare workers as for anyone else [7].

Secondary Trauma: refers to the stress experienced by helping those who have been traumatised. It is now listed in the Diagnostic and Statistical Manual of the American Psychiatric Association 5th Edition (DSM-5) as a potential aetiology for post-traumatic stress disorder (*PTSD*) (see below). This is an important development because it shows that there is a recognition of the powerful negative effects of helping work now. It would produce symptoms like hyperarousal, avoidance, intrusive thoughts and depression and anxiety type symptoms [8] and its effects have been explored in various professions, including healthcare.

Vicarious Trauma: describes the trauma that occurs from hearing the traumatic events that another has suffered, or in other ways being exposed to this trauma, including, one might assume, treating their physical injuries [8].

Note: The terms ‘vicarious trauma’ and ‘secondary trauma’ tend to be used exclusively from one another, sometimes

the term secondary trauma is used to describe the after-effects of a primary trauma, for example, the loss of employment or relationship subsequent to primary trauma (such as domestic violence, violent crime, terrorism etc.).

Post-traumatic stress disorder (PTSD): this is a mental disorder that results from exposure to traumatic events that threaten the self or others [9]. The disorder is listed in the DSM-5 [10] and the symptoms include: intrusive memories and flashbacks, sleep disturbance, avoidance of places, people or things which remind the person of the event, possible dissociative symptoms, irritability, self-destructive behaviour and so forth. These symptoms need to have lasted for a month or more in order to meet diagnostic criteria. The inclusion, in the DSM-5, of PTSD caused by threats to others as well as self, recognises the effects of working as, for example, an emergency responder or in other areas where there is exposure to accidents and acts of violence, while not necessarily being the target of these acts of violence. The revised definition also recognises that one of the symptoms of PTSD will be persistent negative appraisals of the world, the self and the future [11].

Post-traumatic Growth: the idea that people can grow and develop as a result of adverse circumstances is not a new one and much has been written on the topic, especially by positive psychologists such as Maslow, Caplan and Csikszentmihalyi. Since the 1980s and 1990s much more research has been undertaken to explore this idea in a variety of areas such a bereavement, illness and accidents [12]. It describes profound transformative changes in relation to quite serious trauma, not just a resilience to these or maintenance of baseline wellbeing. It is an important consideration in a book about the mental health and wellbeing of healthcare practitioners given the

likelihood of their exposure to traumatic events is so much greater.

Moral Injury: Moral injury, then, has been described in two ways, firstly, by Jonathan Shay as: the betrayal of what's right by someone who holds legitimate authority, in a high stakes situation [13] and as the result of: 'perpetrating, failing to prevent, bearing witness to or learning about acts that transgress deeply held moral beliefs or expectations' [14]. Shay's observations of veterans recovering from their experiences in the theatre of war highlighted the tenacious nature of the emotional reactions to these experiences. He spoke of their struggles to recover from the events which had rocked their view of themselves and of the world; even though they had undergone effective, evidence-based treatments for PTSD. Processing of events that he came to understand as morally injurious could only take place in peer groups where experiences among veterans were similar. Shay recognises his role as an outsider, conceptualising himself only as a facilitator of these discussions between people 'who know'.

The morally injurious event might take many forms, and indeed there is ongoing research to understand exactly what might constitute a morally injurious event (Journal of Traumatic Stress Special Issue June 2019), certainly the people I spoke to about my research had their own ideas about what was morally injurious for them. The resultant symptoms tend to follow a pattern, though, and this revolves mostly around shame and guilt, with their concomitant withdrawal from social networks. There are parallels with some of the aspects of guilt and disruption to world view which are now described in the latest iteration of the PTSD criterion and symptoms in the DSM-5 but in moral injury the source of this guilt and shame is different. Cognitive models of PTSD conceptualise the symptoms as the result of the interactions of the mind with extreme fear,

that is, the world is appraised as an unsafe place in which terrible things can happen, the concept of moral injury suggests that the mechanism of action might be more closely related to feelings and thoughts about shame and guilt, that is, the world is a *wrong* place, in which terrible things are *allowed* to happen. The guilt and shame felt as a result of moral injury will not automatically extinguish over time if emotions are not effectively processed, researchers point out [15].

It may be that morally injurious events disrupt our individual worlds such that our attempts at meaning making fail and we are unable to resolve the cognitive dissonance we experience. Of course, assimilating events is part of our maturation as humans, but it seems that some events cannot be ‘squared away’ as easily as others. Possibly the painful realisation of the wrongness of the world, and maybe ourselves in it, is extremely isolating. Certainly, feelings of guilt and shame tend to make us close off from our feelings, maybe by numbing them with food, drugs, alcohol or work, maybe by intellectualising our experience to the point where emotion is no longer present, but also by blaming others, by expressing anger (in lieu of sadness) all of these mean that we do not allow ourselves to access our individual experience of pain, sorrow and regret and thus do not move through it. As well as our individual experiences, we have our relationships with others which are also disrupted by moral injury.

In a special issue on Moral Injury in the Journal of Traumatic Stress, Litz and Kerig also point out that there are important cultural and individual factors to take into consideration with regard to understanding what might be morally injurious to any individual [16]. It is important to recognise a potentially bio-psycho-social-spiritual aspect to the practice of medicine, especially when healthcare practitioners work in teams, often in under-resourced

settings and with little time or space to debrief, or benefit from peer support. Given the explosion of research into the psychosocial distress experienced by healthcare professionals and the urgent need to both explore and map the extent of the problem and to address the causes and consider the remedies, now may be the time to review and clarify the terms we might find useful to do that. In Canada, at the Canadian Institute for Public Safety Research and Treatment, the term ‘Post-Traumatic Stress Injury’ (www.cipsrt-icrtsp.ca) is preferred to PTSD because it recognises that the harms resulting from exposure to traumatic events may manifest as very significant symptoms but that these might not meet the diagnostic criteria for PTSD; equally to talk of injury rather than disorder calls to mind physical injuries, which can help remove some of the stigma which is often attached to mental health conditions. It is not unusual for workplace injuries to occur in medicine, and models like this one suggest that psychological or psychosocial injuries are as usual as needle sticks or injuries resulting from manual handling. Nor is it necessarily ‘disordered’ to experience strong and lasting psychological difficulty from traumatic situations.

Understanding the psychological harms of the workplace through a social psychological lens means that moral injury can be understood as happening to an individual but affecting the team, and the shared meanings in teams and work settings. It is important to remember that in many areas of medicine there is no long tradition of debriefing, or formal peer support whether after major incidents or even relatively routine incidents. Older physicians often talk to me about the erosion of safe spaces such as the doctors' mess, where cases could be discussed without fear of being overheard. Shift patterns have changed in many services now, resulting in long, 12-hour shifts with short handovers,

there is increased lone working in pre-hospital care so that opportunities for peer support and rapid, informal, and timely debrief are eroded. There is no equivocation in the literature around these various topics; social support is extremely useful in mitigating the psychosocial impact of working in healthcare ([17], for example).

In Shay's initial understanding of moral injury, he discusses the role of leadership, how bad decisions by leaders left subordinates at risk. In any organisation, the actions of leaders and management affect the staff but as we have seen in the recent novel coronavirus pandemic, these actions can leave staff vulnerable to serious disease, disability and even death. This is probably as stark an example of the role of failures in leadership as that faced by Shay's Vietnam veterans. But even on a more average day, decisions at the highest level leave healthcare professionals vulnerable because of understaffing, inadequate hospital estates, insufficient equipment. The powerful hierarchies which exist in the National Health Service (*NHS*) and the services of allied health professionals often mean that staff have no recourse and feel that they cannot raise concerns in ways that will actually see them addressed. When leaders do not protect and defend the safety of their staff, they leave them emotionally and physically vulnerable. Since the NHS is an organisation which holds a particular place in the hearts of much of the nation, staff members find themselves in a constant position of dissonance. They are called on to provide a service for all but are insufficiently equipped to do so, which results in their being unable to offer a standard of care they can feel proud of and are constantly exhausted by demands they cannot meet. This means that their sense of self is under constant threat because ‘who I am’ and ‘who we are’ is not ‘who we should be’ but nor is it within their gift to change that.

DESCRIPTION

The initial research I undertook, alongside my colleagues Charlotte Krahe and Danë Goodsman explored the questions:

- Does the way in which medical students talk about their experiences in emergency medicine and pre-hospital care resonate with the concept of moral injury?
- If social support can be protective, to what degree do students feel they have access to this support and want to use it?

The study was envisaged as an exploratory study, and simply the first of a series across professional groups, exploring the lived experience of providing emergency medicine pre-hospital care, through the theoretical lens of moral injury. The focus group/interview schedule was adapted for healthcare populations from previous research on moral injury in military populations [18]. I conducted interviews and focus groups with students who were either on the intercalated degree in pre-hospital care, or involved in the pre-hospital care programme at the medical school, both of which would mean that they had exposure to traumatic incidents. The students knew me, as they had seen me attend symposia and so on in pre-hospital care. The students were offered the opportunity to amend transcripts but declined, nor did they take up the opportunity to review the findings. Questions were designed to be minimally distressing for students while exploring moral injurious experiences and symptoms resulting from moral injury, potential protective factors were also explored.

The data was analysed with thematic analysis (Braun and Clarke), through the theoretical lens of moral injury and

there were themes which did indeed resonate with the concept of moral injury. Participants spoke of the ways in which the mechanism of injury affected how they felt about the job:

> *'it's always the ones with the violent connotations which are the hardest to process afterwards… when it's a violent attack there's an air about it of 'God, someone else has done this and it's up to us to reverse it'.*

Sometimes a lack of resources caused problems:

> *'the paramedic had used up all his morphine… I felt so bad for this kid… he was in lots of pain and just basically lying on the floor and we couldn't do anything. I felt bad'.*

In line with cognitive processing models, they found the clinical debrief to be useful, whether with a paramedic or physician who had also been on the scene:

> *'They know exactly what happened and you can say, well why did we decide to do this…then suddenly there is some kind of scientific underpinning, understanding that helps you process what's happened'.*

Equally, they also talked about the need for emotional processing, 'Just sit down and understand and go, yeah, that's crap… talk me through it. Get everything out'. even when this was hard to do: 'You've got to make the effort, I find I have to make the effort. If I'm going to talk about it, I need to talk about it properly'.

Interestingly, this population did not talk about failures of leadership, or poor decisions made by leaders, but had unstinting admiration for their seniors and their extensive experience:

> *‘he (the doctor) was like, okay, let's look for injury patterns because that's quite useful. I just remember thinking, oh my God … Obviously I was feeling a lot more than he was but that's just by virtue of him having – that's his job and that's his life’.*

It was not until I started talking to other groups that I began to understand the issues that were arising with leadership, and also, that I had actually begun my exploration of moral injury in healthcare in the wrong place.

The research I undertook with students in pre-hospital care was meant to be the first step in a series of studies about whether moral injury was a concept that resonated with healthcare professionals. Once it was complete, I presented it with my collaborator, Charlotte Krahe, at a symposium in June 2017, two weeks after the fire at Grenfell Tower. I was overwhelmed by the response. I had thought there would be some interest in the topic, but I had not anticipated the number of people who would want to talk to me about their experiences, and their concern for themselves and their colleagues. It was this event that meant that I began to understand the extent of distress in paramedics and other ambulance staff, and in specialties such as intensive care, critical care, and, of course, emergency department staff.

Those who had not spoken to me at the time often wrote to me later, many were educators who wanted to know how to protect the students in their care: