President's Blog

October- November 2018

The elephant in the room

I recently returned from the National Scientific Congress in Adelaide. As always, a very enjoyable meeting from the ASA. The "euboxic" term of my blog title comes from William Harrop-Griffiths, a former AAGBI President, very clever man, entertaining presenter and regional anaesthesia enthusiast. He tried to convince the audience that not only does regional anaesthesia have better outcomes than general anaesthesia but also cures cancer. It was extremely entertaining and informative. The real message was about balance and conscientious practice. This theme was also picked up by another former President (ASA), Guy Christie-Taylor. The background here is the systematic disadvantaging of female applicants to Tokyo Medical University. Since 2006 the university has been subtracting points from all exam scores, then adding up to 20 points to those of male applicants, with the explicit goal of reducing the percentage of women entering medical school. Guy very humbly admitted to his many biases, and then referred to a recent article in the Harvard Business review. (1)

You had better sit down for this.

"Allowing things to continue as they have for women in medicine is accepting a system where potentially higher-quality care is denied to patients due to sexism and bad practices. In fact, the difference in patient mortality observed in studies of male and female physicians is approximately the same magnitude as the improvement in mortality that can be attributed to the last decade of scientific improvement in patient care. This means that excluding female physicians in the healthcare system sets our society back not only in gender equality but also in terms of the progress we should be making in medical care. "
Wow!! Interestingly, Joyce Wahr, Professor and Medical Director Perioperative Assessment Centre, University of Minnesota also commented on gender balance. I will return to this topic at the end of the blog.

This is my last blog as president; I trust you've enjoyed reading them and that you've found them useful. It has, at times felt like a relentless task but it has helped me to collect my thoughts. We have covered many topics including: disruptive behaviour, the #metoo movement, gender balance, standardisation, errors and drug errors in particular, incident reporting, the HDC, specialty name change, personality types, and welfare.

Looking back over my term, the experiences I have had, the conversations and topics discussed, there are two themes that particularly stand out. One, that the NZSA is foremost about the individual anaesthesiologist and two, the emotional dichotomy we live as medical practitioners. These two came together for me over the last 12 months; the catalyst being the death of Whangarei colleague Richard Harding. Many of us will have lost friends and colleagues to an untimely death. Two of my trainee contemporaries have also taken their lives. I watched a TED talk recently delivered by Pamela Wible who founded the Ideal Medical Care Movement, which is a trend back to relationship driven medicine currently very popular in the United States. This talk highlighted the high prevalence of mental ill health and suicide in the medical profession. Pam asked the room of doctors if any had lost close medical friends to suicide; 50% put their hands up. She then asked if anyone present had ever thought about suicide, and another 50% of hands. As doctors we will go to extraordinary lengths to help patients but are often very poor at looking after ourselves. The elephant in the room. Why is this and what can we do about it? Difficult questions, but probably related to culture and values. We are starting to address the elephant. There are a

number of positive concepts and interventions being developed. One that I think will be extremely useful and which I'm hopeful will underpin this whole topic as we move forward is *Long Lives Healthy Workplaces*, a tool kit for Anaesthetic Departments, which you can access at https://asa.org.au/welfare-of-anaesthetists/ The tool kit is an initiative of the Welfare SIG and EveryMind, an Australian Institute dedicated to mental wellness. It is of very high quality and I encourage you to visit the site to view the resources.

At the risk of over saturating you on welfare, I would like to devote my last blog to this topic and especially the concept of peer support or a buddy system for colleagues undergoing a medico-legal process.

The background:
I have previously written about the concept of the "second victim." More recently I came across the concept of "moral injury" which I think is less pretentious, more sensitive and superior overall. The term comes from a military context where in essence the job involves breaking our normal moral code, or knowingly doing what we know is not right. i.e. intentionally causing harm to other humans. In our profession we aim to relieve distress yet daily we may do the opposite; delivering bad news, causing unintentional harm making difficult decisions with significant consequence on behalf of others, So, to some extent we break a moral code also. These actions are not without spiritual or emotional repercussions – hence the term, moral injury. I have struggled to find literature on moral injury in relation to the medical profession, but I would suggest that if not dealt with, moral injury is cumulative.

The American Airforce has potential answers

We can learn from the military and police; somewhat paradoxically they are miles ahead of us in recognising the importance of protective and aggravating factors in mental and emotional health. Robust peer, social and leadership support are well recognised as ameliorating the "injury." Conversely lack of support and poor leadership may lead to post traumatic stress. Some authors focus on resilience while others argue that resilience is not a helpful concept as it puts the onus back on the victim. The US Airforce struggled with a high suicide rate amongst their airmen in the early 1990s. To address this, an eleven-point plan was implemented which led to a 75% reduction in death rates. Although the Airforce plan is not directly applicable in a civilian setting, the principles are. The *Long Lives Healthy Workplaces* project mentioned earlier incorporates these principles.

The Airforce data suggests that 30% of deaths occurred in relation to a judicial or complaint process. So, clearly this is a high risk group. How do we support this group? I have discussed this with several organisations: HDC, Medical Council, Medical Protection Society, and the Welfare SIG. There is no simple answer and a number of internal and external barriers (privacy, confidentiality etc). Point eleven of the Air force plan is in essence a buddy system. In my mind this would be a trusted colleague who has been through the process and can walk beside, guide and support the "buddy." The role is NOT that of a counsellor.

The buddy system

How would this buddy system look and run? An obvious initial contact point for those undergoing complaint is the MPS. In the last 12 months, 59 anaesthesiologists have contacted MPS requesting guidance. The MPS could suggest that they contact the buddy system. That is the easy bit, from here on it gets complicated and there are two main barriers.

Barrier One, or the emotional dichotomy I mentioned above. As a group we struggle to ask for help. I have recently experienced this phenomenon. To cut a long story short I had to terminate a relationship with a pain patient. For a number of reasons, the trust relationship

between us broke down and it become clear to me that I could no longer provide a robust therapeutic role. I therefore followed the Medical Council process and exited the relationship. Even though I am sure this was the correct course of action I felt a significant degree of failure and guilt – to the patient, the colleagues to whom I handed on the patient, and myself. The Air force has recognised this problem; 30% of airmen who took their lives had never asked for help. The Air force circumvented this issue and provided compulsory support to all personnel undergoing a judicial or complaint procedure. This option is not of course acceptable in civilian life, despite the same barriers and risks. So, the support process never begins. After some reflection and discussion, I think normalising the process is probably our best bet. The reality is most will experience several complaints throughout the course of their career; we could run seminars on "surviving a complaint."

Some departments run peer-review groups – small groups which meet regularly to discuss difficult cases and issues (the activity is included in CPD) and encourages colleagues to establish their own buddy relationships in advance of a judicial or complaint process. The role of MPS could simply be to check that the doctor has a support system in place and if not, refer them to avenues for support such as a "buddy system."

Barrier two: Developing the buddy system and deciding who should be the "buddy" and what, if any training should they have? My initial thoughts are that the buddies need to be peers, have some experience of the complaint process and be compatible. Do we have a pool of names that people can choose from? Do we need to offer support for the "buddy?" I am discussing these issues with the Welfare SIG and other passionate colleagues. Your feedback would be most useful. These issues need to be addressed as while I suspect (and hope) that many have an informal support system of peers, the evidence suggests that a significant proportion do not.

Back to Joyce Wahr and gender balance. She referred me to an observational study of social behaviour in operating rooms. (2) Some interesting observations and thoughts from this study:

1) Like it or not, operating rooms are hierarchical. So, although we might prefer an egalitarian approach it is not realistic.
2) In this paper, the role of the Anaesthesia provider was seen as "intermediate."
3) Conflict is inevitable but also a constructive part of cooperation. All organisations need to find a balance between conflict and cooperation. Successful marriages are marked by a "magic" 5:1 ratio between positive and negative interactions, a ratio that also appears to mark successful cooperation in other primates.
4) The study was surprised by the frequency of handoffs during a case and could not quantify everyone's attendance. As previously noted, team membership in the OR is intermittent and ad hoc at best. The constant shifting of clinicians challenges the assumption that "a team" exists as an entity and complicates the establishment of familiarity and the formation of shared goals.

All food for thought.

As always, may the force be with you.

Feel free to email me at president@anaesthesia.nz (although not for much longer) with your comments.

David

Reference:

1) How Discrimination Against Female Doctors Hurts Patients,m Christopher G. Myers, Kathleen M. Sutcliffe, August 30, 2018 Harvard Business Review.
2) Ethological observations of social behaviour in the operating room, Laura K.Jones, Bonnie Mowinski Jennings, Melinda Higgins, and Frans B.M de Waala www.pnas.org/cgi/doi/10.1073/pnas.1716883115