Mentally and physically safe workplaces: the challenge of doctors' well-being

BY ERIC LEVI

Our ENT consultant colleague **Eric Levi** bravely tackles the very real elephant in the room of that stigma which is not really discussed until it is often too late.

It takes courage to tackle a difficult topic like doctors' mental health. Much easier to hide it under the carpet or refer the issue to someone else to be resolved. There is so much misunderstanding and stigma around mental illness that it is only natural for those of us who are not GPs or psychiatrists to shy away from this issue.

Mental health is an elephant in the room. If the recent Australian data on mental illness in doctors and medical students is reflective of our local context [1], then one in five of your colleagues or trainees at work today will have been diagnosed with, or treated for depression. Of more concern, one in four will have had thoughts of suicide. In your operating theatre, someone, perhaps you yourself, may have entertained suicidal thoughts. The rate of depression among doctors is comparable to the general population, but the rate of suicidality is statistically higher. If a debilitating disease affects 20-25% of the working population, it would be considered a public health catastrophe, but we keep this elephant hidden and it's almost certain that few of us have taken actions on mental illness.

Why? Because of stigma and misunderstanding. There is the stigma that a diagnosis of mental illness is equivalent to weakness. There is a risk that seeking help for mental illness may endanger employability. If we know of a colleague who suffers from diabetes, we would encourage them to take sugar checks and breaks during long operations and clinics, but we withdraw instead when we know of a colleague with a mental illness diagnosis. A doctor with mental illness is not necessarily an unsafe or weak doctor. A doctor with well-treated mental illness can provide the same effective and safe care as a doctor with well-managed diabetic illness.

There is also the additional misunderstanding that mental illness and burnout are the same thing, and that resilience training is the solution. Mental illness, such as depression, is a specific DSM-V and ICD-10 diagnostic category. Burnout is not. Burnout is defined as a psychological state characterised by emotional exhaustion, cynicism (or depersonalisation) and low work efficacy due to chronic occupational stress. The same Australian survey [1] reports that 47.5% of doctors are emotionally exhausted. For surgeons in particular, a study confirms that 40% of us meet the criteria for burnout [2]. Almost half of your typical surgical department is burned out, and therefore, ineffective. The causes are multifactorial. It is not just about work hours, it is the changing quality of work. The current administrative, technological, academic, legal and ethical demands on our work are not what they used to be. The world of surgery has changed as many jurisdictions have intruded on the doctor-patient relationship.

A previous *ENT News* article has described in great detail the prevalence of burnout specific to ENT surgeons [3]. As surveyed in 2005, burnout was prevalent across the entire academic hierarchy of otolaryngology – head and neck surgery in the US [4-6]. Levels were greatest in residents where an impressive 86% possessed either moderate (76%) or high (10%) burnout. Chairs were the next most affected, with 84% possessing moderate (81%) or high (3%) burnout. Academic faculty (measured through a cross-section of the American Society of University Otolaryngologists) were the least burned out, with 70% possessing moderate (66%) or high (4%) burnout. The survey was applied to UK otolaryngologists, but because of the modest participation level, concrete conclusions are difficult to make [3]. In general, UK academic otolaryngologists appeared to possess similar or higher levels than their American counterparts. Moderate or high levels of burnout were observed in 88% of those surveyed. This was higher than the 70% seen in American faculty and similar to the 84% seen in American chairs and 86% seen in American residents.

Burnout is the psychological sequelae of occupational stress. It is the symptoms and signs of poor institutional health which may ultimately affect individual mental health. We are complex beings and there are studies to tease out if depression and burnout are associative, causative or contemporaneous. Workplace factors, or institutional ill-health, are strong predictors for burnout. You may know a surgeon with no mental health diagnosis who is burned out and ineffective at work. You may also know a surgeon with a well-managed depression who is fully engaged in work providing key leadership.

Institutional health is the other elephant in the room. Dealing with this elephant requires more than shortening work hours or adding resilience training. Resilience training is a personal solution to an institutional problem. We need creative institutional solutions to institutional challenges. Improving the workplace culture will reduce risk factors associated with burnout [7], which ultimately means safer care for patients. It is not about softening the training programme or lowering expectations. It is about strengthening the safety and support for our trainees and colleagues.

Mental health is not a gender or

"Creating a mentally and physically safe workplace is critical, because our patients deserve fully engaged, competent and mentally healthy clinicians."

generational issue. Males and females, trainees and consultants suffer from mental illness. It takes courage to tackle the issue of mental health but the time is right. We have the momentum and the societal support. It is the natural extension of being an advocate for our patients and colleagues.

How do we engage in this arena? The first step would be awareness and acceptance of our colleagues with mental illness. By increasing awareness, we have the opportunity to shine a spotlight on the issue. Doctor wellbeing has become a topic that is regularly featured in grand rounds, conferences and medical publications. This is good. This will create an environment where it would be safe to talk about this matter.

However, awareness must lead to actions, otherwise it will lead to apathy. Collectively, as a medical community we have the obligation to improve the physical and mental safety around our workplaces. This will require creative solutions at personal, departmental, divisional, jurisdictional, national, legal and regulatory levels. It is more than mere 'resilience training'. This will involve multi-level changes from something as basic as roster safety to mandated national regulations. There are already champions in your unit who are willing to work together towards this. With good leadership and collaboration, we can catalyse this process. The solutions in your workplace will look different to the solutions in my workplace. Whatever they may be, we must understand that creating a mentally and physically safe workplace is critical, because our patients deserve fully engaged, competent and mentally healthy clinicians.

References

1. Beyond Blue. *National Mental Health Survey of Doctors and Medical Students*. October 2013. Available at: www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report_web Last accessed 17 July 2018.
2. Dimou FM, Eckelbarger D, Riall TS. Surgeon burnout: a systematic review. *J Am Coll Surg* 2016;**222(6)**:1230-9.
3. Ossoff RH, Golub JS, Johns III MM, Bradley PJ. Burnout in Academic Otolaryngology–Head and Neck Surgery. *ENT News* 2006;**15(4)**:84-86.
4. Golub JS, Johns III MM,Weiss PS, Ramesh AK, Ossoff RH. Burnout in academic faculty of otolaryngology–head and neck surgery. *Laryngoscope* 2008;**118(11)**:1951-6.
5. Golub JS,Weiss PS, Ramesh AK, Ossoff RH, Johns III MM. Burnout in residents of otolaryngology–head and neck surgery: a national inquiry into the health of residency training. *Acad Med* 2007;**82(6)**:596-601.
6. Johns III MM, Ossoff RH. Burnout in academic chairs of otolaryngology: head and neck surgery. *Laryngoscope* 2005;**115**:2056-61.
7. Shanafelt TD, Noseworthy JH. Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. *Mayo Clin Proc* 2017;**92(1)**:129-46.

AUTHOR

Eric Levi,
FRACS, MBBS (Melb), BSc,
PGDipSurgAnat, MPHTM,

Specialist Otolaryngologist, Head and Neck Surgeon
Paediatric ENT, Head and Neck, Airway Surgeon.

E: drericlevi@gmail.com
https://ericlevi.com
@DrEricLevi