Providing Support to Doctors working in Intensive Care

Abstract:

â Jadingâ is a process of exhaustion in which apathy and cynicism replace the drive to be responsive and caring. â Burnoutâ a term first coined in the psychology literature in 1974 was based on Graham Greeneâ s novel â A Burnt-Out Case[1]. It is the umbrella description for disengagement in the workplace setting characterised by withdrawal, denial and inefficiency. There is an alienation from the pressures of work. Marshall and Kasman[2] defined it as â the loss of motivation for creative thoughtâ . It is the opposite of engagement which is associated with energy and optimism. People who experience all 3 symptoms- emotional exhaustion, negative attitude towards patients, reduced sense of personal accomplishment- have the greatest degree of burnout. It doesnâ t get better by being ignored. These processes have serious consequences for the individual involved and the hospital that they work in. The doctor underperforms and the Unit becomes dysfunctional There is decreased quality of care, increased absenteeism, and high staff turnover. There is an inability to make decisions and a failure to set priorities.

Doctors working in intensive care units are particularly vulnerable to these types of psychological stresses. Matters are compounded by long hours, little spare time and continual peer and patient pressure. There is the need for sustained vigilance and the challenge of demanding interpersonal relations. There are frequent difficult ethical dilemmas to be confronted over prolongation of life in patients with little hope of recovery. There is the challenge of keeping up to date with this rapidly advancing specialty. The bright lights, flashing monitors, distinctive smells and constant background noise are by their very nature stressful. Fatigue is commonly encountered. High intensity medical care leads to traumatisation among the attending medical staff. Working in close contact with tense grieving families can be emotionally draining. Trainee doctors are placed in the frontline of intensive care at an early stage in their career. It represents a considerable level of responsibility for someone in their mid to late twenties. The seeds of apathy and vulnerability can become engrained even at this early stage. The worry is that the process can derail a promising career.

It must be appreciated that organisations cause burnout and individuals suffer from it. It is prevalent in some hospitals and not in others. Units get it wrong when there is a disproportionate amount of work, poor governance and a lack of clearly defined attainable values. The workforce is treated as a commodity rather than as valued individuals. Certain personalities are more prone to burnout. They tend to be ambitious achievers. They feel a need to constantly prove themselves. They fail to make a distinction between their work and their own individual needs. The job becomes their identity and if it starts to go badly it can be devastating for them.

Intensive care is a specialty with a high rate of attrition. It is a stressful environment involving complex therapies and frequent deaths. Coomber et al[3] found that one third of ICU doctors were stressed. The stressful aspects of the work included being overstretched, compromising standards when resources were short, bed allocation, too much responsibility, making the right decision alone, effects on personal life, and lack of recognition by others. A study of neonatal intensive care unit rank order of stressors found that the top 5 items were sudden death or relapse of an infant, personal life versus work, doctor nurse conflict, insecurity regarding competence, understaffing and overwork. Doctors are more likely to come to work when sick compared with other workers. A Finish study found that one third of doctors keep working when unwell. This â presenteeismâ can compound problems when the individual is working in a stressful intensive care setting[4].

Job related stress can have serious or tragic consequences for doctors. It may lead to alcohol or drug abuse. Suicide is a rare but well documented consequence. One study examining 29 cases of suicide among doctors found that 25 of them had work related problems compounded by a background of depression[5]. A metanalysis of previously published papers[6] found that when compared with the general population male doctors had a moderately increased rate 1.4 and female doctors had a higher rate 2.3. It is postulated that doctors are more critical and are more likely to blame themselves for their own illnesses.
Brierley and Pierce[7] have recently described the role of a pastoral care consultant in interacting with intensive care trainees. The individual performing the role is one of the existing consultants. The trainee can self-referral or be referred by one of the team. The interaction is confidential and covers a wide range of problems such as stress, lack of clinical confidence, emotional trauma following a difficult case, bullying or harassment. A buddy system in which the trainee is allocated a senior member of the nursing staff is frequently employed. The traineeâ s on call and other duties may be temporarily modified until solutions are found. Regular meetings and discussions between the trainee and the nurse take place. Group sessions with the psychologist are arranged for the trainees.

Predicting and preventing burnout in intensive care units should be a priority. Professional relationships and working conditions must be constantly monitored and any deviations quickly amended. The senior staff must accept that one of their roles is to enhance the capacity of workers to cope with the demands of their jobs. For trainee doctors the ready availability of skilled assistance and support is one of the most important factors in reducing stress. The quality of the relationships between doctors and nurses in the tense setting of intensive care is of central importance. Doctors and nurses differ in their perception of teamwork. Thomas et al[8] found that 73% of doctors rated communication with nurses as high. In contrast only 33% of nurses rated doctor-nurse communication as high. The 2 disciplines view collaboration differently. Nurses commonly report that their input is frequently not well received and disagreements are not properly resolved. Intensive care is a vital and costly service. National policies are needed to ensure that staff well-being is being optimally protected.

JFA Murphy
Editor

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Comments: