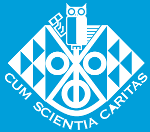
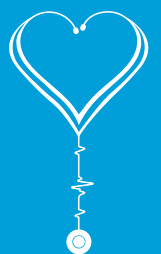


The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

Self Care.

Caring for yourself and your colleagues



GP
Heart of the community
Kāinga Tupu

Acknowledgements

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Introduction

Why self-care?

As doctors, we encourage people every day to care for themselves: exercise more, eat the right things, drink less alcohol, quit smoking, get enough sleep, have a holiday, make time with friends and develop interests outside work. We also care for people when these things start to unravel. This unravelling usually starts with a single thread that comes loose but, if left unattended, can progress to involve the whole garment of our lives. Do you have any loose threads in your life?

Knowing what we should do **does not mean we always do it.**[1] Self-care requires us to recognise when we are not self-caring. It takes reflection and time.

When did you last take time to reflect on how you are? When was your last holiday/time out? Was it hard to get away and did you feel guilty? Did the cost outweigh the benefits? Was it exhausting?

The answer should be no, but sometimes we are trapped into thinking that other people's wellbeing is more important than our own. Doctors are well known for going to work when they are not physically well.[2,3] How often does this occur when we are not mentally at full capacity?[4,5,6]

We go to great pains to explain to our depressed, anxious and stressed patients that their condition did not turn up overnight. Conditions sneak up on us, so we often do not realise how low our mood is until it is overwhelming. How often do health professionals ignore the signs? Is depression more common amongst physicians? And do we get more depressed than our patients before we notice? Research suggests the answer to all of these questions is yes[1,4,7] and for a variety of reasons.[5,8]

There is no doubt the role of a doctor has many stressors. These include excessive workloads, organisational changes, poor management and insufficient resources, as well as dealing with mistakes, complaints and litigation, and patient suffering. These are not unique to medicine. The uniqueness is that we have to lead teams, adhere to higher standards of regulation and put patients' needs ahead of our own.

It is not only the nature of the work that increases a doctor's risk of depression. The personality traits of many medical professionals, such as perfectionism, can lead to individuals becoming increasingly self-critical. Unhelpful coping strategies, such as emotional distancing, an excessive sense of responsibility, a desire to please everyone, guilt for things outside of one's control, self-doubt and obsession, all contribute to the risk.[9,10]

We often cope with a busy professional life, but our lives outside the practice can be as complex as those of the patients we treat. We forget that we may also be parents, partners, friends, sons, and daughters. And all the life events that patients experience might come our way too.

"Self-care enables me to be a better doctor. If I am not taking care of myself, it is difficult to have patience with, sensitivity to or empathy for my patients."

Of course, our self-care is as essential to our health and wellbeing as it is for our patients.

Doctors are more susceptible to drug use and addiction,[11] relationship break-ups/divorce, significant mental health issues and suicide[12,13,14,15] than the general population. The incidence of these issues amongst New Zealand doctors is similar to our counterparts in the UK, Canada and the US.[16]

The six-year review of the NHS Practitioner Health Programme[17] showed that the average age of those engaging with the service was 30–39 years for female health practitioners and 40–49 years for males. Eighty percent of presentations are for mental health issues and 20 percent are addiction related. Similarly the experience of the Medical Council of New Zealand's (MCNZ's) Health Committee shows that the majority of doctors receiving support from the Committee have either psychiatric or substance dependence problems.

> "The secret to survival boils down to having the humility to recognise that we are all vulnerable and fallible, and the wisdom to recognise when we need help and accept it."
>
> – Dr Joanna MacDonald, former Chair of the MCNZ's Health Committee, personal communication, 2016.

This resource contains some ideas on how to manage your own self-care. It identifies when we are more at risk and when, therefore, self-care is essential and also shares stories from fellow doctors. In addition, it suggests assessment tools and resources that may be helpful in sustaining you in your important and demanding role as a doctor.

"When the kids were little I felt like the juggle did my head in. I would not quite finish all the tasks in the practice, rush out the door, pick up the kids, go to after-school activities and be 'on' for whatever the kids wanted – then I had to respond intelligently to my partner at the end of an untidy day. I often felt that I was on a zooming escalator and would just like to step to one side for a moment and let it all rush past me. Then I could pat myself down and see if I was still in one piece."

Caring for colleagues

Many of us have seen a colleague who is not performing at their best or are not providing the best care for their patients.[18] They could be considered to be a 'disruptive' doctor,[19,20] a stressed doctor or an unwell doctor. Providing support to these colleagues can be difficult. Doctors are masters at hiding their vulnerability. In addition, doctors are not very good at treating other doctors.[10,21] We often don't take our colleagues' advice.[1] Sometimes we believe that someone else will take action, that 'nothing will happen if I report a colleague' or there may be fear of retribution.[18] Inflammatory terms like 'whistleblower'[22] and 'dobbing in' are used. The privacy issues and complexity of treating a fellow doctor as a patient are not straightforward.[16]

Any underperforming health professional may put patient care at risk. Poor patient care causes harm and can engender complaints. Although a complaint may be seen as less important than harm caused to a patient, complaints can have devastating effects on the doctor involved. In the UK, the suicide of depressed doctors under investigation for complaints has resulted in the development of several practitioner health programmes.[15] With this in mind, early recognition of health-related deterioration in the performance of colleagues or ourselves is preferable. Terms like 'burnout'[23,24] are often used, and there are recognised causes of burnout in all employment situations. There are also other **everyday risk factors** for deterioration in performance.

How do we approach a colleague we are worried about?

The MCNZ has several **guidance documents**[25] and states that **raising a concern is about support, education and/or rehabilitation** (Appendix 1) rather than administering discipline. Under **Section 45**[26] of the Health Practitioners Competence Assurance Act 2003 (HPCAA), doctors, their colleagues and their employers **must** advise the MCNZ if they have reasonable belief that a doctor or other health professional has a mental or physical condition that could affect their performance. For the most part, early referral to the MCNZ's Health Committee means that many practitioners can resolve their issues while remaining at work.[16,17] In any situation, approaching the individual is the first step. If the individual lacks insight into their condition, it may be necessary to involve a higher authority.

Apart from everyday colleague-to-colleague interactions, there are two other formalised interactions where we may become concerned about another doctor. These are when the doctor is our student or our patient.

As an educator

As a teacher, supervisor or mentor, it is important to be aware not only of the clinical skills of the trainee but also their general wellbeing. Most trainees will experience times when they feel disempowered, overworked, unsure of

themselves or even bullied.[7,27] Providing opportunities during the educational programme, mentoring sessions or in quiet moments to discuss a student's wellbeing is essential to reveal any potential issues. This will enable appropriate strategies and changes to be put in place to help.

Many of the presentations in the NHS Practitioner Health Programme are for those aged 30–39 years old.[17] This is often a time in our career when we are transitioning into a vocation or gaining Fellowship. Commonly, these transition periods are when difficulties occur,[28] and it is critical to take care, to observe or support doctors during these times.

As a doctor's doctor

There is much written about being a doctor for other doctors. The reason for this is because it can be tricky. However, for all of us, having our own general practitioner (GP) is essential. We should avoid treating our own family or ourselves, except in emergency situations, as we cannot be objective and it interrupts continuity of care.[29] Many practitioner health programmes provide specific training for those providing care to fellow doctors. There are also **conferences**[30] and guidance available on the subject.[12,16,31]

> "If a doctor is doctoring a doctor
> Does the doctor doing the doctoring
> Doctor the doctor being doctored
> The way the doctor being doctored
> Wants to be doctored,
> Or does the doctor doctoring the doctor
> Doctor the doctor being doctored
> The way the doctoring doctor usually doctors?"[31]
>
> *Courtesy of Dr Clare Gerada, Medical Director*
> *NHS Practitioner Health Programme*

"I noticed that one of my colleagues was not doing so well. I tried to talk with them about it, but was not in such a good place myself. Both of us had workplace and home life stressors. Somehow, I managed to get through. He left his job and may not come back. That is a sad outcome for him and the medical profession."

Things that put our self-care at risk

If an athlete is gearing up for a big race, they will train harder and focus most of their activities around that race while also maintaining their wellbeing. They will eat better, exercise more, sleep regularly, use their time wisely, listen to their coach, take advice, and maybe have a massage. They know the challenges and hurdles they face.

When we are dealing with (or about to deal with) things that are more stressful/ intense than usual, we also need to be more focused. Recognising when these challenges might come about can allow us to put things in place that will help us get through a difficult time without jeopardising our health or the care of our patients. It also helps if we recognise situations when we may need to provide more support for our colleagues.

It is commonly accepted that about two percent of health professionals will have a health issue that compromises their performance.[32] Burnout is even more common.[33] Outside the nature of the job, the following are common demographics for those who are at risk:[12]

- Male >50 years
- Female >45 years
- Divorced, single or in relationship break-up
- Depressed
- History of risk taking
- Chronic pain or illness
- Change in financial or occupational status.

"Deal with chronic stress in your non-work relationships because it will impact on your work."

There are some life-changing events that may have an impact on anyone – whether they work in the health profession or not. They include buying a house, the death of a loved one, having children, changing jobs, moving to another city or country, ageing parents, or children leaving home. When several of these 'everyday occurrences' happen at the same time, it can increase the burden of an already burdensome occupation.

Complaints

It is said that we will all have a complaint made against us during our career as a health professional. Whether we are resigned to this or not, it is still **a distressing and difficult process** (Appendix 2) to go through, no matter how well the situation is managed.[14,15,21] Having support[34] throughout a complaint process is important, but many of us tend to keep complaints to ourselves. This is unhelpful and definitely unhealthy. How many of us have found out after the fact that our colleague has gone through a complaint?

Workplace factors

The majority of us work in some form of institution, whether it is a small practice or a large tertiary hospital. Structures, resources, policies and politics can all have their impact on us. Colleagues and team dynamics can either make our work easier or harder.[35] Compliance issues, bureaucracy and clinical or governmental demands extend our work beyond patient contact alone. **Bullying** (Appendix 3) and sexual harassment could also cause significant harm.[36]

Leadership brings its own challenges. As we progress through our careers, we may take on responsibilities beyond patient care. Apart from developing our own personal skills, working with others, managing services, improving services and setting the direction of a practice or workplace can also create stressors.[37]

Living in New Zealand, we all know **people who have had their practice disrupted** (Appendix 4) or who have been caught up in an emergency. Stories from people involved in natural disasters don't tend to show disastrous outcomes. For the most part, people tend to pull together, support each other and make do, rebuilding as soon as possible and restoring normality.[38] Despite this, such situations can put us under unexpected stress[39] that we need to stop and recognise.

> "I am lucky enough to have some great work partners. They know me well enough to know when I am feeling stressed and care enough to check. They do not need to say anything, but the fact that they are asking is enough for me to reflect on where I am at. It emphasises the importance of working closely with a caring team – it is not a job we can do alone."

What can I do about self-care?

There are various tools available for self-assessment. Some we are familiar with, others have been used in research. An objective assessment is often valuable for gauging how we are managing. As mentioned before, doctors are expert at hiding how they are[5] or what habits they have adopted.[40] It is time for some honest evaluation.

How resilient are you? Studies have shown that resilience is associated with a personality trait pattern that is mature, responsible, optimistic, persevering and cooperative.[9,41] There has been some debate recently in the UK about doctors needing resilience training – like soldiers – but in fact most of us are quite resilient. Try this **test**[42] (there are also other websites that have similar assessments). If you do register low on resilience, then Dennis Charney's **resilience prescription**[43] may be helpful.

Have you ever talked through the Kessler 10 or PHQ-9 with a depressed patient and felt that you could tick the same boxes? These are valid tests and provide a good indication of function deterioration.[44] If you think you are at a low ebb but not actually depressed, then a burnout assessment could be useful. There are many burnout questionnaires available. The British Medical Association has a **burnout questionnaire** in its 'Doctors for doctors' area.[45] Our own New Zealand Medical Association has a **one-page list of signs of burnout/anxiety/depression and substance abuse**.[46] A quick look on the internet will bring up an overwhelming array of questionnaires. Websites such as **Mindgarden**,[47] which is aimed at professionals, uses the Maslach Burnout Inventory and various other validated measures.

Take action

In every international article about self-care and doctors' wellbeing, the first step is to appoint yourself a GP/family physician. As William Osler said "The physician who treats himself has a fool for a patient".[48]

There are essential everyday things that are important – such as food, exercise and sleep. Then there are the other beneficial assets and activities, such as family, friends, holidays and interests outside of work. Osler also said, "The young doctor should look about early for an avocation, a pastime, that will take him away from patients, pills, and potions…"[49]

The old adage 'work hard, play hard' makes sense sometimes, but if our work is getting stressful, we need to put more energy into the things that make us feel uplifted – the 'play' in our lives – to balance things out.

"Of course we all need to practise what we preach. It is good for us when we go to our colleagues to try and learn to be in a patient role, as it gives us valuable insight…"

Reading can increase your knowledge and skills in this area. At a recent seminar on developing resilience in our workforce, there were several book suggestions:

- *Inside-out: the practice of resilience* – Sven Hansen
- *Flourish* – Martin Seligman
- *The seven habits of highly effective people* – Stephen Covey
- *Thinking fast and slow* – Daniel Kahneman
- *Time to think* – Nancy Kline
- *Rainy brain, sunny brain* – Elaine Fox
- *What doctors feel* – Danielle Ofri
- *The chimp paradox* – Dr Steve Peters.

As a mentor, supervisor or teacher, it is worth developing our skills in aiding our colleagues, as suggested by Hilton Koppe.[16] Scheduling time into educational programmes to enable discussion on health and wellbeing, stress, burnout and illness and their effects on performance is essential. Articles such as *Top ten tips for flourishing in residency*[50] may be worth discussing in a small group situation. The Council of Medical Colleges also provides **guidance on dealing with inappropriate behaviour** (Appendix 3).

"I spend time with my young family, read, go to movies, pursue other interests and spend time with pets. I try to make my free time completely separate from medicine, so that the two worlds don't collide."

Finding help

There is free counselling available for doctors who are Medical Protection Society or Medical Assurance Society members.[51] This is confidential counselling and psychological support and has been well utilised since its inception.[52] Online counselling services such as **Big White Wall**[53] are targeted to health professionals. A survey of character strengths[54] or mindfulness training[55] can also be beneficial. **The University of Auckland** and **Penn State University** both have free-access online tools and resources aimed at managing stress and depression and developing resilience. There are a large variety of alcohol and drug assessment tools available online.[56,57] Formally assessing how you are is useful, but seeking help and taking action is more important.

Supervision is commonplace for social workers, psychologists and counsellors, but not so common amongst doctors. A study undertaken by Hamish Wilson looking at supervision concluded that "supervision had a positive impact on the participant's style and philosophy of practice. It helped to counter the stresses of long-term work as a helping professional."[58]

Supervision assists GPs to resolve personal and professional work-related issues, it helps GPs become more aware of the self in the work environment, and it provides insight into the doctor–patient relationship.[58]

APPENDIX 1

Supporting doctors to take care of themselves

Mr Andrew Connolly
Chairman, Medical Council of New Zealand

Other people's health is something we all think about every day as doctors, but what about taking care of our own health?

Get yourself a GP if you don't have one

The old aphorism 'a doctor who treats herself or himself has a fool for a doctor and an idiot for a patient' strikes a chord with me. I genuinely believe that we all should have our own GP. I certainly do. We are better served by an objective and informed evaluation of any symptoms we have and advice on our health generally.

Supporting rehabilitation of doctors back into the workforce

As doctors, we are constantly exposed to stresses and hazards that can impair our relationships and ourselves: working long hours, fatigue, sleep deprivation, patient demands, secondary traumatic stress, consequences of mistakes, debt, demands of external bodies (including the MCNZ and colleges), fear of complaints and litigation, and infectious diseases. In addition, we are, of course, vulnerable to the same illnesses as the rest of the population. Anecdotal comments suggest there may be a reluctance by some doctors to notify health concerns about colleagues or themselves to the MCNZ because of the possible impact on a doctor's career and ability to practise.

The MCNZ has an important role in assessing and supporting the treatment of doctors with health problems affecting their practice, through the work of its Health Committee. The Committee's key objective is to ensure public health and safety. We believe that, with appropriate treatment, management and monitoring, doctors who have health problems can often continue to practise medicine safely. We see ourselves as having a role in promoting the rehabilitation of doctors back into the workforce.

The reward of managing ill doctors

The reward is that most of the doctors who come to the Committee are helped to continue working or to return to work in some capacity, by being helped to manage their illness in a way that allows them to practise safely. This obviously benefits the public and the doctors. Few doctors would remain under its supervision for longer than five years, and most for less than that length of time.

Despite their initial reactions to involvement with the Committee, which are often of fear or anger, many doctors express gratitude for the help they have received when they reach the point of no longer being under its supervision. And some choose to stay under its supervision, albeit at arm's length, as a form of safety net.

Getting help

If you need help with a health-related issue, your GP should be high on the list of people you talk to. Some colleges, like The Royal New Zealand College of General Practitioners, have their own early warning systems and programmes. Support is also available from indemnity organisations and groups such as the Association of Salaried Medical Specialists and the New Zealand Resident Doctors' Association.

Quick links

These quick links will take you to websites that offer support and understanding to ill doctors.

- **Australian Doctors in Recovery (ADR)**
- **Medical Council of New Zealand – Supporting doctors' health**
- **Medical Protection Society**
- **New Zealand Resident Doctors' Association**
- **The Association of Salaried Medical Specialists (ASMS)**
- **The Doctors' Health Advisory Service**
- **The Royal New Zealand College of General Practitioners – Self-care**

APPENDIX 2

Recovering from a serious medical error

Dr Brett Mann 2011

A registrar recently asked a medical teacher, "How can I be a confident general practitioner after making a serious mistake resulting in injury to a patient?" I was asked to respond to this important question.

Doctors know that sudden sick feeling of anxiety and dread when hearing that a patient they have looked after has experienced a serious adverse event – usually one the doctor did not consider. For the reporting year of 2007/08 district health boards reported 258 people treated in New Zealand hospitals who were involved in serious preventable adverse clinical events.[59] Some of these resulted in major disability or death.

When the patient is disabled or dies, it is easy to understand the doctor's severe self-recrimination, painful rumination, feelings of inferiority and loss of confidence. Fear of medicolegal consequences and the often protracted and sometimes injurious nature of complaint procedures[60] may make return to emotional equilibrium especially difficult. I think there are a number of issues to grapple with that help doctors recover from these situations. Dealing with any one issue is unlikely to be sufficient in itself, and sometimes keeping four or five things in mind will be necessary to find greater psychological stability.

The wider social context

Doctors should remember that they are not the only group in our society regularly facing the risk of responsibility for mistakes that result in serious injury or death – others such as police, fire fighters, the armed forces and some politicians do too. It is vital for the good of society that individual members are willing to serve society by stepping into these roles and part of that service is living with the risk of being seriously criticised and occasionally having to grapple with the burden of personal guilt resulting from one's human imperfection. This service and willingness deserves the community's appreciation and respect. Most doctors are motivated by altruism and will be responsible for improving and extending the lives of many patients. This perspective sets medical errors within a wider positive context, and doctors and the community they serve should not lose sight of this during the intense focus on a single medical error.

Society and its doctors also have to accept that there is a limit to what doctors can learn from books and other formal educational activities. These activities can never fully prepare doctors for the myriad complexities of clinical practice. It is a painful and unpalatable reality that some things will only be learned in the crucible of ongoing clinical experience.

It is a painful and unpalatable reality that some things will only be learned in the crucible of ongoing clinical experience.

Who or what is responsible?

The doctor immediately involved in a medical error is an easy target for blame. It is easy for the doctor to be over-burdened with blame even though much or all of the responsibility may lie elsewhere. Regardless of who is being blamed, it is important to stand back and look at exactly what happened and consider carefully how much is the fault of the doctor, the fault of the patient, inadequate supervision, system errors or gaps in medical education. Of course, sometimes there is no fault. Sometimes poor outcomes are simply part of the unpredictability of life; for example, the person who turns out to have an undiagnosed life-threatening pulmonary embolus despite the doctor following best practice guidelines.

Doctor psychodynamics

Unrealistic personal expectations

On one hand doctors must do all they can to avoid mistakes, and learn as much as possible from those that happen. On the other, human imperfection must be acknowledged and integrated into doctors' understanding of themselves and their colleagues. While this difficult process of integration is probably never fully achieved, unrealistic expectations contribute to excessively harsh self-judgments or judgment of colleagues and surely contribute to a lack of openness about mistakes in the profession.

Splitting

Splitting is the psychological process of 'all or nothing' thinking, dividing assessment of events into good or bad, black or white, with little, if any, psychological space between. If the doctor bears some responsibility for the error, it is important to avoid 'splitting' in which the doctor passes wide-ranging judgment upon him or herself as 'bad', 'incompetent' or 'a failure'. It is important for a doctor not to automatically assume that he or she is less competent, less professional, less of a 'good' doctor than other colleagues. Mostly, it will mean the doctor is human, imperfect, just like every other doctor.

Parent–child dynamics

Our earliest deeply imprinted painful experiences of criticism usually arise from parents during childhood, and thoughts and feelings associated with these experiences are easily activated by a complaint. Introspection will commonly identify that the doctor feels like the 'powerless child' criticised by 'the powerful parent'. This 'parent–child' dynamic is very disempowering and makes it much harder for the doctor to 'stand up on the inside' and defend against the criticisers. Simply recognising the presence of this dynamic can be very helpful as the doctor recognises the interactions should be 'adult to adult' on a much more equal footing. The criticisers are not all powerful but rather fallible, imperfect human beings who can make big mistakes just like everyone else, and the doctor has the right and the capacity to stand up and appropriately defend him or herself.

Patient psychodynamics

The natural response of most patients to suffering caused by a medical error is anger, usually directed towards the doctor most closely involved. Justified anger may be exacerbated by two additional dynamics of anger, and recognising these can mitigate an excessive sense of responsibility generated by patient anger.

Human imperfection must be acknowledged and integrated into doctors' understanding of themselves and their colleagues.

Projected anger

Projection is the unconscious denial of one's own unacceptable attributes, thoughts, and emotions, which are then ascribed to another. Some of the anger towards doctors from patients or patients' families may result from their lack of acceptance of their own imperfections and ultimate mortality. Part of the patient's anger may be a projection of these unresolved issues. While it is difficult to know how much this is present in a specific case, awareness of this dynamic may help doctors take less personal responsibility for some of the anger directed their way, particularly when it seems to be excessive.

Displaced anger

Some of the anger towards a doctor may be displaced anger from a patient's previous negative experience. I remember a complaint for an alleged medical error against a colleague made by a very angry patient. The complaint was largely motivated by the patient's unresolved anger relating to a previous doctor's handling of his wife's cancer. The patient believed the previous doctor had been too late in diagnosing his wife's cancer and displaced this anger onto the next available doctor when an opportunity presented.

> The natural response of most patients to suffering caused by a medical error is anger, usually directed towards the doctor most closely involved.

Inadequate supervision

I remember as a first-year house surgeon making a diagnosis of biliary colic in a patient who turned out to have a ruptured duodenal ulcer. The patient ended up in intensive care with adult respiratory distress syndrome. I had discussed the case with the surgeon on call, but despite this, the surgical registrar was harshly critical of my diagnosis the next day. I was disturbed but not devastated by the error, realising that the problem was more lack of adequate supervision of an inexperienced junior doctor.

Gaps in medical education

As a young practitioner, I 'failed' to diagnose a scaphoid fracture. I was taught that this fracture was caused by a fall on an outstretched hand. The patient played as goalkeeper in a soccer team and his scaphoid was fractured while diving through the air to fend off the ball in full flight. I had not been taught that scaphoid fractures are actually avulsion fractures caused by wrist hyperextension. A fall on an outstretched hand was simply the most common mechanism of injury. The patient needed a bone graft and still has a chronically stiff wrist.

I well remember another patient, also a doctor, who did not realise an otherwise benign looking lesion on his toe could be an amelanotic melanoma. It had been present for two years by the time it was excised, and the doctor died within 12 months, leaving behind a wife and young family. On reflection, as with the scaphoid fracture, it seemed the fault was less that of the doctor and more of the gaps in his medical education. How often do general practitioners blame themselves or are they blamed by others for mistakes that are more accurately recognised as imperfections of medical education? Nevertheless, while striving to improve medical education, it is important to accept that it also will never be perfect.

Systems error

It is well recognised that many other causes of error could be avoided by better systems; systems reducing the likelihood of human imperfection leading to patient harm. Programmes like CORNERSTONE® can help to improve our systems and processes. In addition to the current drug interaction alerts, further

reductions in general practice error will require development of information technology regarding problems to beware of with particular illnesses, and interactions of medications with specific illnesses. Medicine is increasingly complicated and no doctor can remember everything relevant to their scope of practice, so better systems are even more important. Again, it must be acknowledged that these systems will never be perfect either.

Self-care

Once a complaint occurs, emotional support is essential and can be sought from a spouse, trusted friends and colleagues. An understanding, empathic colleague can 'join' the doctor through relating his or her own experiences, leaving the doctor feeling less isolated and alone.

Maintaining healthy dietary, sleep, and exercise patterns is very important. Consideration should be given to reducing workload until emotional equilibrium and confidence improves. Using distraction and making sure there are enjoyable activities outside of work to look forward to each week will help provide relief from the stress of the complaint.

Doctors of all people should not be reluctant to seek psychological help but it seems they often are. They should be quick to see their own GPs regarding stress and mood issues and avoid any temptations to self-medicate. In addition, the Medical Protection Society and Medical Assurance Society offer a well-received, jointly funded counselling service for stressed doctors.[61] Psychotherapy and/or cognitive behavioural therapy is likely to be very useful in addressing thinking patterns that exacerbate the doctor's suffering, for example, unrealistic expectations, splitting, perfectionism, 'what if' thinking, over-generalisation, catastrophising, excessive focus on the negative, rumination and other more complex psychodynamics.

It is imperative to consider seeking medicolegal advice early in a complaint process irrespective of whether the Health and Disability Commissioner or the Medical Council is involved. Medicolegal advice will provide perspective on how to approach the patient or the patient's family and other potential legal issues and help the doctor avoid falling into unforeseen traps at a time of great stress and when their thinking processes may be less reliable.

Conclusion

Doctors provide a vital service to their communities and ease the suffering and save the lives of many people. Doctors need to address unrealistic expectations and better integrate the knowledge that doctors and the systems they work in are imperfect and that the complexities of the human condition can exceed the ability of doctors to get it right every time.

Recovery for the doctor may be complex and detailed consideration of who or what is responsible for the error is essential. Avoiding splitting, parent–child dynamics, awareness of the psychodynamics of patient anger and receiving comprehensive psychological support can markedly reduce suffering. Good self-care and early medicolegal advice is vital.

In the end, it is important to take the long-term perspective, realising that one day the intensity of the current situation will be over. The doctor will be wiser for the experience and will have paid the emotional price that most doctors pay as members of this demanding but very rewarding profession.

APPENDIX 3

A framework for dealing with inappropriate behaviour in the medical profession

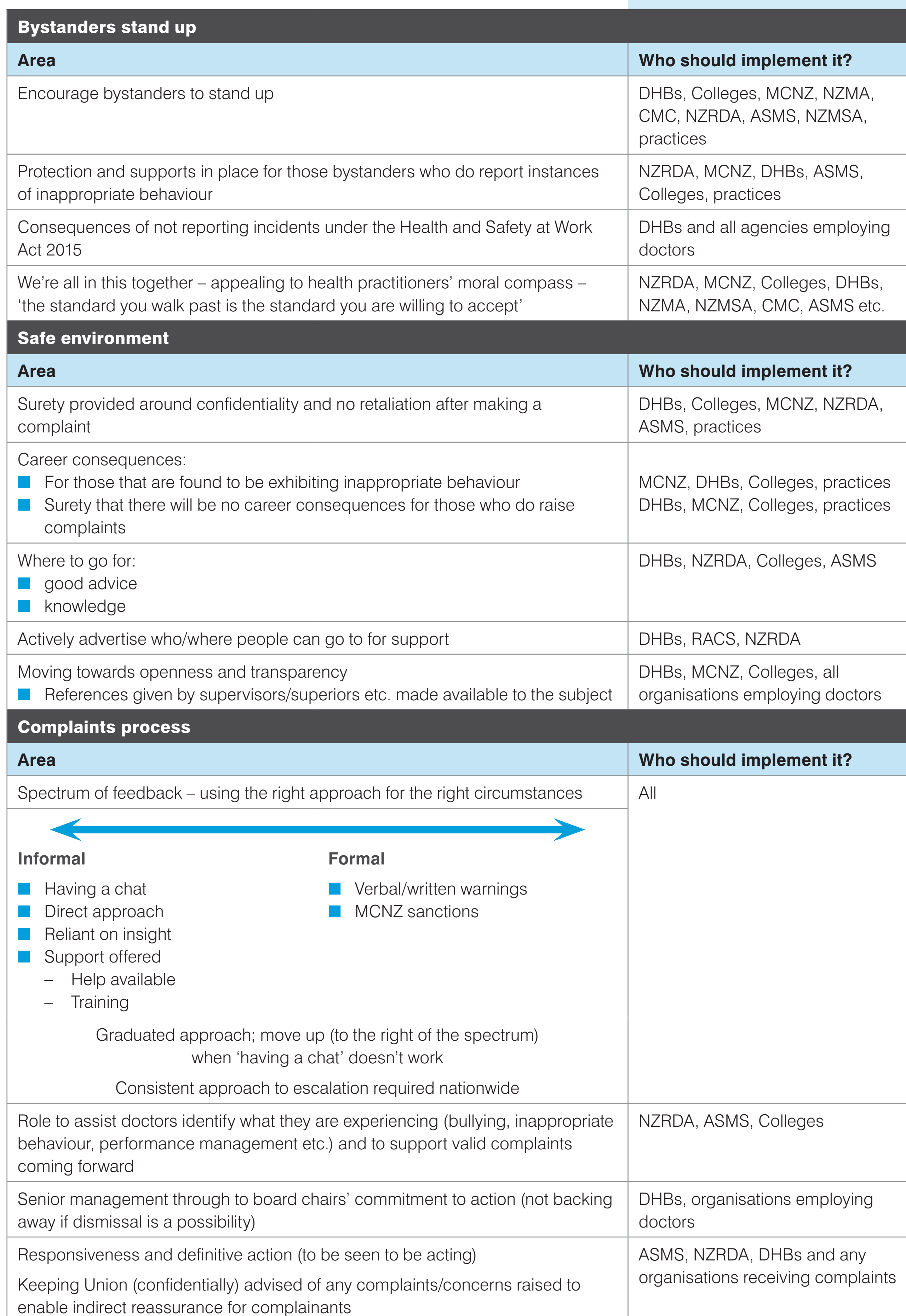
Adapted from a **Council of Medical Colleges in New Zealand** document

Underlying principles

1. Commitment by leadership of the organisation
2. Mission/goals/values of the organisation support respectful workplace behaviours
3. Tools in place to monitor and provide reports on behaviours in clinical and educational areas
4. Processes in place to review those reports
5. Graduated scale of interventions
6. Training and education available
7. Resources available to address inappropriate behaviour (for the person exhibiting the behaviour)
8. Resources available to support those affected (the complainant/bystanders)

Culture

Area	Who should implement it?
Behavioural competence – everyone at all levels ■ What is/isn't acceptable ■ What is above the line/below the line: Above the line behaviours (what is acceptable) **Respect, collegiality, teamwork** Below the line behaviours (what is unacceptable)	Medical professionals and their employers, MCNZ, Colleges
Accreditation	MCNZ, Colleges
Specific training in: ■ how to teach adults ■ adult learning ■ teach the teacher ■ 360° feedback ■ difficult conversations	Colleges, DHBs, MCNZ
Building and maintaining a positive team culture	DHBs, practices
Appointments process – transparent and unbiased	DHBs, MCNZ, Colleges (note: for selection of trainees, training supervisors etc.), GP and urgent care practices



Bystanders stand up	
Area	**Who should implement it?**
Encourage bystanders to stand up	DHBs, Colleges, MCNZ, NZMA, CMC, NZRDA, ASMS, NZMSA, practices
Protection and supports in place for those bystanders who do report instances of inappropriate behaviour	NZRDA, MCNZ, DHBs, ASMS, Colleges, practices
Consequences of not reporting incidents under the Health and Safety at Work Act 2015	DHBs and all agencies employing doctors
We're all in this together – appealing to health practitioners' moral compass – 'the standard you walk past is the standard you are willing to accept'	NZRDA, MCNZ, Colleges, DHBs, NZMA, NZMSA, CMC, ASMS etc.
Safe environment	
Area	**Who should implement it?**
Surety provided around confidentiality and no retaliation after making a complaint	DHBs, Colleges, MCNZ, NZRDA, ASMS, practices
Career consequences: ■ For those that are found to be exhibiting inappropriate behaviour ■ Surety that there will be no career consequences for those who do raise complaints	 MCNZ, DHBs, Colleges, practices DHBs, MCNZ, Colleges, practices
Where to go for: ■ good advice ■ knowledge	DHBs, NZRDA, Colleges, ASMS
Actively advertise who/where people can go to for support	DHBs, RACS, NZRDA
Moving towards openness and transparency ■ References given by supervisors/superiors etc. made available to the subject	DHBs, MCNZ, Colleges, all organisations employing doctors
Complaints process	
Area	**Who should implement it?**
Spectrum of feedback – using the right approach for the right circumstances	All
←→ **Informal** ■ Having a chat ■ Direct approach ■ Reliant on insight ■ Support offered – Help available – Training **Formal** ■ Verbal/written warnings ■ MCNZ sanctions Graduated approach; move up (to the right of the spectrum) when 'having a chat' doesn't work Consistent approach to escalation required nationwide	
Role to assist doctors identify what they are experiencing (bullying, inappropriate behaviour, performance management etc.) and to support valid complaints coming forward	NZRDA, ASMS, Colleges
Senior management through to board chairs' commitment to action (not backing away if dismissal is a possibility)	DHBs, organisations employing doctors
Responsiveness and definitive action (to be seen to be acting) Keeping Union (confidentially) advised of any complaints/concerns raised to enable indirect reassurance for complainants	ASMS, NZRDA, DHBs and any organisations receiving complaints

APPENDIX 4

Surviving the South Dunedin floods

Jill McIlraith
Aurora Health Centre

No matter how well prepared you think are, you can never be too prepared for a natural disaster.

This was brought home to Aurora Health Centre in June 2016 when large swathes of South Dunedin were flooded, resulting in thousands being evacuated, hundreds of business affected – and our health centre inundated with sewage-contaminated flood waters.

The first day, while standing calf deep in freezing dirty water in what became our standard attire – gumboots and old clothes – we realised taking care of ourselves, our staff and our most vulnerable patients was the priority.

Staying calm, reassuring staff that no one would lose their jobs, and by being positive, pragmatic and organised, we could survive this while still meeting our duty of care to a badly affected community in the middle of a Dunedin winter.

Self-care in the midst of such upheaval came down to caring for each other, recognising that everyone had families they still needed to care for, being patient with each other and communicating well.

Several things made this easier:

- Holding regular but short meetings of all staff every day for the first few weeks, so we could check everyone was okay and tasks could be allocated
- Setting up a large white board to keep track of prioritised tasks
- Encouraging staff to step up and solve problems, and praising them when they came up with solutions (and thanking afterwards with a bonus)
- Delegating and trusting each other to get on and do the job
- Keeping a sense of humour and perspective (no one had died, our database was secure even if we didn't have computers for five days, we were fully insured, we had emergency plans, we got on well with our landlord, the PHO offered practical help, etc.)
- Making sure everyone took breaks and had access to somewhere dry and warm away from the cold and chaos (we hired a cabin on wheels, parked it outside the back door and equipped it with a new fridge, heaters, tea, coffee and biscuits)
- Asking for help from colleagues, friends, family and experts, for example, decontamination experts and accountants to keep track of insurance claims

"Self-care in the midst of such upheaval came down to caring for each other, recognising that everyone had families they still needed to care for, being patient with each other and communicating well."

- Accepting that the practice would work differently while in crisis and rebuilding mode, for example, once the phones were operating later the first day, a doctor and nurse were allocated to do phone triage, repeat scripts, contact our most vulnerable patients, arrange house visits and refer patients to the Dunedin Urgent Doctors; all routine reviews and recalls were suspended and lots more was done by phone, such as WINZ work capacity certificates
- Taking the long view, not getting anxious over small things and thinking how we could end up with a better practice, for example, redesigning the utility room and converting the record room into an clinical admin room.

While it certainly wasn't fun for the several months it took to rebuild the practice, and we worked in limited space, moving around to accommodate builders, it did have positives: it built team spirit, everyone contributed, it cost less in the end than we had anticipated (thank goodness for good insurance and meticulous accountants) and the consulting rooms ended up with better furniture and equipment.

References and resources

1. Doctors don't take advice they give to patients [Internet]. British Medical Association; 2015 Dec 15 [updated 2016 Oct 24]. http://www.bma.org.uk/support-at-work/doctors-well-being/not-taking-care
2. Szymczak JE, Smathers S, Hoegg C, et al. Reasons why physicians and advanced practice clinicians work while sick: a mixed-methods analysis. JAMA Pediatr. 2015;169(9):815–21.
3. Bracewell LM, Campbell, DI, Faure PR, Giblin ER, Morris TA, et al. Sickness presenteeism in a New Zealand hospital. N Z Med J. 2010;123(1314):31–42.
4. Singh D. NHS criticised over suicide of mentally ill doctor. BMJ. 2003;327(7422):1008.
5. Department of Health. Mental health and ill health in doctors. UK: Department of Health; 2008. Available from: http://www.em-online.com/download/medical_article/36516_DH_083090%5B1%5D.pdf
6. Health and Safety Executive. Self-reported work-related illness (SWI) and workplace injuries: results from the Labour Force Survey (LFS). Table STROCC2—2011/12: Estimated prevalence and rates of self-reported stress, depression or anxiety caused or made worse by current or most recent job, by occupation, for people working in the last 12 months, 2011/12.
7. Beyond blue. National mental health survey of doctors and medical students; October 2013 [cited 2016 March 2]. Available from: https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report_web
8. Riley GJ. Understanding the stresses and strains of being a doctor. Med J Aust. 2004;181:350–3.
9. Eley DS, Cloninger CR, Walters L, et al. The relationship between resilience and personality traits in doctors: implications for enhancing well being. PeerJ. 2013;1:e216. doi:10.7717/peerj.216
10. NHS Practitioner Health Programme. The first five years of the NHS Practitioner Health Programme 2008–2013. Available from: http://php.nhs.uk/wp-content/uploads/sites/26/2014/05/Five-Year-Report.pdf
11. Merlo LJ, Singhakant S, Cummings SM, Cottler LB. Reasons for misuse of prescription medication among physicians undergoing monitoring by a physician health program. J Addict Med. 2013;7(5):349–53.
12. Silverman M. Physicians and suicide. In: The handbook of physician health: essential guide to understanding the health care needs of physicians. Goldman LS, Myers M, Dickstein LJ, editors. Chicago, IL: American Medical Association; 2000. p.95–117.
13. Andrew LB, Physician suicide [Internet]. Updated 2016 Oct 3 [cited 2016 Mar 2]. Available from: http://emedicine.medscape.com/article/806779-overview
14. Bright RP, Krahn L. Depression and suicide among physicians [Internet]. Current Psychiatry. 2011;10(4):16–30. Available from: http://www.currentpsychiatry.com/home/article/depression-and-suicide-among-physicians/b1d152751a0bb7bf9e4c2b5aeb2a416e.html
15. General Medical Council. Doctors who commit suicide while under GMC fitness to practise investigation. Internal review; 2014 Dec 14. Available from: http://cms.pulsetoday.co.uk/uploads/2014/12/18/a/s/r/Internal-review-into-suicide-in-FTP-processes----FINAL-EMBARGOED.pdf
16. Medical Council of New Zealand. Medical Council News. Issue 46 Dec 2008. Available from: https://www.mcnz.org.nz/assets/News-and-Publications/Newsletter/DEC08.pdf

17. NHS Practitioner Health Programme. Annual Report 2013/2014. Available from: http://php.nhs.uk/wp-content/uploads/sites/26/2012/04/Six-Year-Report.pdf
18. DesRoches CM, Rao SR, Fromson JA, et al. Physician perceptions and preparedness for reporting, and experience related to impaired and incompetent colleagues. JAMA. 2010;304(2):187–93. [cited 2016 Mar 2]. Available from: http://jama.jamanetwork.com/issue.aspx?journalid=67&issueid=4520
19. Molea J. When behavior disrupts the physician-healer. Available from: http://www.medscape.com/viewarticle/521971
20. Davies M, Dinwoodie M. The disruptive doctor [Internet]. 2015 Oct 20. Available from: http://careers.bmj.com/careers/advice/The_disruptive_doctor
21. Brooks SK, Gerada C, Chalder T. Review of the literature on the mental health of doctors; are specialist services needed? J Ment Health. 2011;20(2):146–56.
22. General Medical Council. GMC policy on whistleblowing. Available from: http://www.gmc-uk.org/DC5900_Whistleblowing_guidance.pdf_57107304.pdf
23. Paterson R, Adams J. Professional burnout – a regulatory perspective. N Z Med J. 2011;124(1332). Available from: https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2011/vol-124-no-1333/view-paterson
24. Clark S. From burnout to resilience: a general practice perspective. N Z Med J. 2011;124(134). Available from: http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2011/vol-124-no-1341/letter-clark
25. MCNZ. Supporting doctors' health [Internet]. Available from: https://www.mcnz.org.nz/support-for-doctors/supporting-doctors-health/
26. Health Practitioners Competence Assurance Act 2003. Available from: http://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203826.html
27. Larkin SL, Spillman M, Vanlint VW, et al. Stress, personal and educational problems in vocational training. A prospective cohort study. Aust Fam Physician. 2003;32(6)473–5,480.
28. Peters M, Hasan O, Puddester D, et al. Doctors' health: taking the lifecycle approach. BMJ. 2013;347:f7086. Available from: http://www.bmj.com/content/347/bmj.f7086
29. MCNZ. Statement on providing care to yourself and those close to you. Wellington: Medical Council of New Zealand; 2013. Available from: https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Statement-on-providing-care-to-yourself-and-those-close-to-you.pdf
30. International Conference on Physician Health™ Theme: Increasing joy in medicine. 2016 September 18–20. Renaissance Boston Waterfront Hotel 606 Congress St., Boston, MA, 02210 USA.
31. Guidance and competencies for the provision of services using practitioners with special interest; Health for Health Professionals NHS (unpublished document, quoted with permission)
32. MCNZ. Doctors' health. Wellington: Medical Council of New Zealand; 2004. Available from: https://www.mcnz.org.nz/assets/News-and-Publications/Booklets/doctors-health.pdf
33. Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work life balance among US physicians relative to the general US population. Arch Intern Med. 2012;172(18):1377–1385. Available from: http://archinte.jamanetwork.com/article.aspx?articleid=1351351
34. General Medical Council. A guide for doctors referred to the GMC [Internet]. Available from: http://www.gmc-uk.org/concerns/doctors_under_investigation/a_guide_for_referred_doctors.asp
35. BMA. Promoting a positive working environment [Internet]. 2015 Aug 12 [updated 2016 Oct 25]. Available from: http://www.bma.org.uk/support-at-work/doctors-well-being/promoting-a-positive-working-environment
36. Tonini S, Lanfranco A, Dellabianca A et al. Work related stress and bullying: gender differences and forensic medicine issues in the diagnostic procedure. J Occup Med Toxicol. 2011;6:29. doi: 10.1186/1745-6673-6-29
37. NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges. Medical leadership competency framework: enhancing engagement in medical leadership. 3rd ed. UK: NHS Institute for Innovation and Improvement; 2010. Available from: http://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Leadership-Framework-Medical-Leadership-Competency-Framework-3rd-ed.pdf

38. Jacob B, Mawson AR, Payton M, et al. Disaster mythology and fact: hurricane Katrina and social attachment. Public Health Rep. 2008;123(5):555–566. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2496928/
39. Forbes D, Alkemade N, Waters E, et al. The role of anger and ongoing stressors in mental health following a natural disaster. Aust N Z J Psychiatry. 2015;49(8):706–13.
40. Reese S. Drug and alcohol abuse: why doctors become hooked. Medscape Business of Medicine. 2015 May 06. Available from: http://www.medscape.com/viewarticle/843758.
41. Jensen PM, Trollope-Kumar K, Waters H, et al. Building physician resilience. Can Fam Physician. 2008;54(5):722–9. Available from: http://www.ncbi.nlm.nih.gov/pubmed/18474706
42. PsychTests Test Yourself. Resiliency test [Internet]. Available from: http://testyourself.psychtests.com/testid/2121
43. Charney D. The resilience prescription [Internet]. Available from: https://icahn.mssm.edu/files/ISMMS/Assets/Files/Resilience-Prescription-Promotion.pdf
44. Kroenke K, Spitzer RL, Williams JB. The PHQ-9. Validity of a brief depression severity measure. J Gen Intern Med. 2001;16(9):606–613. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495268/
45. BMA. Doctors for doctors: burnout questionnaire [Internet]. Available from: https://web2.bma.org.uk/drs4drsburn.nsf/quest?OpenForm
46. NZMA. Signs of burnout/anxiety/depression/substance abuse [Internet]. Available from: https://www.nzma.org.nz/about-nzma/nzma-structure-and-representatives/councils/dit-council/are-you-ok/warning-signs-And-support/warning-signs
47. Mind Garden. Available from: http://www.mindgarden.com
48. Bean WB, editor. Sir William Osler aphorisms from his bedside teachings and writings. Springfield, Illinois: Charles C Thomas; 1961.
49. Osler W. The medical library in post-graduate work. BMJ. 1909;2:925–8.
50. Skakum K, Katz LY, Fleisher W. Top ten tips for flourishing in residency. Acad Psychiatry. 2015;39(4):492–3.
51. Medical Protection. Counseling services [Internet]. Available from: http://www.medicalprotection.org/newzealand/help-advice/counselling-service
52. Cunningham W, Cookson T. Addressing stress-related impairment in doctors. A survey of providers' and doctors' experiences of a funded counselling service in New Zealand. N Z Med J. 2009; 122(1300):19–28.
53. Big White Wall. Available from: https://www.bigwhitewall.com/landing-pages/defaultnz.aspx?ReturnUrl=%2f
54. University of Pennsylvania. Authentic Happiness. VIA survey of character strengths [Internet]. Available from: https://www.authentichappiness.sas.upenn.edu
55. Mental Health Foundation of New Zealand. Mindfulness [Internet]. Available from: http://www.mentalhealth.org.nz/home/our-work/category/21/mindfulness
56. National Institute on Drug Abuse. Chart of evidence-based screening tools for adults and adolescents [Internet]. Updated 2015 Sept. Available from: https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/screening-assessment-drug-testing-resources/chart-evidence-based-screening-tools-adults
57. Alcohol.org.nz. Interactive tools [Internet]. Available from: http://alcohol.org.nz/resources-research/alcohol-resources/interactive-tools
58. Wilson H. Self-care for GPs: the role of supervision. N Z Fam Phys. 2000;27(5)51–57.
59. Quality Improvement Committee. Sentinel and serious events in New Zealand hospitals 2007–2008. Wellington: Quality Improvement Committee; 2009. Available from: https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/SSE-report-2007-08.pdf
60. Cunningham W, Dovey S. The effect on medical practice of disciplinary complaints: potentially negative for patient care. N Z Med J. 2000;113:464–7.
61. Cunningham W, Cookson T. Addressing stress-related impairment in doctors. A survey of providers' and doctors' experiences of a funded counselling service in New Zealand. N Z Med J. 2009;122(1300):19–28.

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