CHAPTER 1

Why resilience? Why now?

Anna Frain[1], *Sue Murphy*[2], *and John Frain*[3]

[1] University of Nottingham, Graduate Entry Medical School, Derby Speciality Training Programme for General Practice, Nottingham, UK
[2] Faculty of Medicine, Department of Physical Therapy, University of British Columbia, Vancouver Campus, Canada
[3] Division of Medical Sciences and Graduate Entry Medicine, University of Nottingham, UK

OVERVIEW

- Those entering healthcare professions are motivated by the potential 'joy of practice'.
- Healthcare practitioners are being harmed by the impact of the systems in which they work.
- *Burnout* is an occupational hazard for all healthcare workers and increases the risks of both major and minor errors in caring for patients.
- Equality and inclusion in healthcare are not only morally right but enables all to fulfil their potential to improve patient outcomes and maintain practitioner well-being.
- The Covid-19 pandemic has brought into sharper focus the impact and current challenges of the working environment upon healthcare workers.
- Organisations have a duty of care to protect patient safety by supporting healthcare workers with intelligent kindness.

Introduction

Healthcare workers are human beings trying to help other human beings. This invariably leads to a discussion of human frailty and shortcomings. Yet, the skills and abilities of practitioners are awesome, and we often have an insufficient sense of awe regarding them – to listen and to understand the effects of suffering on patients, to use our senses to examine and to diagnose, to provide comfort and support, to restore to health, to witness both the greatest joys in patients' lives as well as their darkest moments. Undoubtedly, this work requires the full use of our talents and is rewarded by the joy of practice.

Alongside this, advances in treatments across the multidisciplinary spectrum of healthcare in the past century enables us to do more and achieve more for patients and to genuinely feel we are making a difference to peoples' lives. Those entering healthcare training should be confident they are entering an occupation at the cutting edge of human endeavour and characterised by the sense of the well-being and resilience of those working in it.

Yet, the reality for many practitioners is very different. Confronted by the uncertainties and ambiguities of practice as well as the stresses of the healthcare environment, new entrants to the professions show increased reluctance to undertake specialty training, deciding to take career breaks or leave the profession completely (Figure 1.1). This established problem is so significant and widespread that it must be considered to genuinely threaten the future sustainability of modern healthcare. *Resilience* implies an ability to 'bounce back', to regain our well-being after a distorting experience. The data suggests we are not bouncing back as well as perhaps we once did. This is impacting patient care and providing immeasurable harm to healthcare providers.

'First, do no harm'

For UK healthcare professions, the past decade is bookended by two events. First, a private citizen's Freedom of Information request in 2012 led to the publication of an internal review by the General Medical Council (GMC) which revealed that, during the 2005–2013 period, 28 doctors had committed suicide whilst undergoing the GMC's fitness-to-practice (FTP) investigations (Horsfall, 2014). Casey and Choong argued that these deaths were preventable and the GMC has a duty of care towards doctors under investigation (Casey and Choong, 2016) (Box 1.1).

Practitioner suicide and distress is not unique to the UK, nor is it confined to doctors (Hofmann, 2018). Nonetheless, these healthcare professionals likely entered training with the same aspirations and hopes as their peers. In their deaths, they left behind people who loved and needed them. A healthcare culture which seemingly leaves people viewing suicide as their only alternative should concern us all – as John Dunne said, 'Any man's death diminishes me, because I am involved in Mankind'.

Second, the initial phase in the UK of the Covid-19 pandemic was characterised by shortages of personal protective equipment (PPE), with the result that staff felt they were being required either to place themselves at risk without adequate protection, or to decline to care for patients and risk disciplinary action. This

ABC of Clinical Resilience, First Edition. Edited by Anna Frain, Sue Murphy, and John Frain.

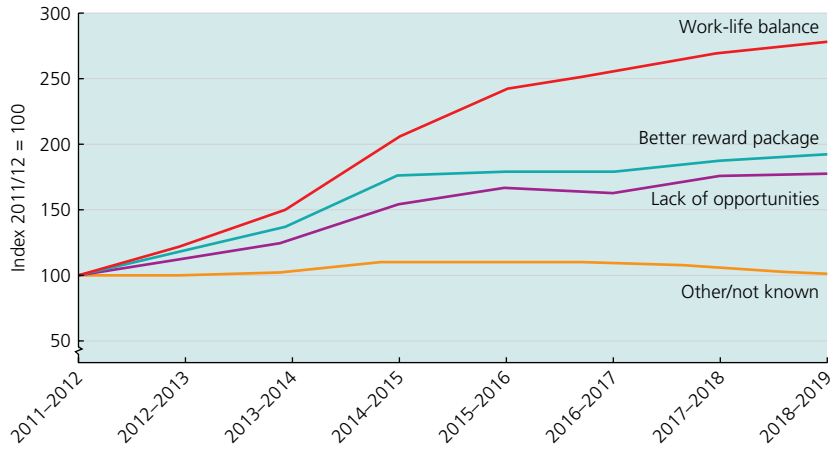

Figure 1.1 Change in reason for leaving given by staff (for voluntary resignations), 2011–2012 to 2018–2019 (Index at 2011/2012 = 100). Source: The Health Foundation (2019). © 2019, The Health Foundation.

impression of a lack of concern for healthcare staff reached its apotheosis when a prominent UK politician suggested that shortages of PPE were occurring due to wasteful usage by healthcare staff (see Chapter 6). Subsequently, reports emerged of higher-risk staff feeling unable to request the PPE *to which they were entitled*.

On a more mundane level, healthcare staff report day-to-day shortages in their work in terms of access to food, rest breaks and adequate on-call facilities, such that these provisions are not in step with employment law (GMC, 2019). Even a cursory look at Maslow's triangle (Chapter 3) suggests that meeting a practitioner's basic psychological and physical needs is required to safeguard and provide support for the high-level problem-solving necessary in clinical decision-making; it is unlikely that depriving people of food, drink and adequate rest improves patient safety. When we consider clinical resilience, it is important that we do not impose on practitioners yet another burden of fearing failure. Rather, it is about enabling clinicians to optimise their cognitive performance, be the best they can be and recover the joy of practice. In this, organisations have a particular responsibility (Chapter 8). With resilience, our recurring theme is kindness. Kind health systems and organisations will more greatly facilitate the potential of their teams and the safety of patients.

Box 1.1 **Suicide whilst under GMC's fitness to practise investigation: were those deaths preventable?**

In their review of suicides whilst under the GMC's FTP procedures, Casey and Choong argued that the GMC has a duty of care towards its members and that these suicides were preventable. Coroners were also identified as having a duty to report these suicides as preventable to the GMC. However, Casey and Choong could not identify that these deaths had been reported in line with established legislation. They also commented: 'The high prevalence of suicide among physicians in general should not obscure the fact that suicide whilst under the GMC's FTP investigations is sufficiently unique and deserves special attention. It is thereby a matter of profound regret that it had to take a random FOI request by an independent party to eventually highlight just how serious and extensive the problem is. That FTP investigation has never, prior to that, been isolated and identified as a distinct risk factor for physician suicide meant that practically nothing has been done to avert such deaths'.

Source: Based on Casey and Choong (2016).

Increasing patient expectations, complaints and litigation

Zuzsanna Jakab (WHO) emphasises that peoples' expectations of healthcare have changed, and that they wish for greater involvement in their healthcare, including in making decisions about treatment (Jakab, 2011). However, many health inequalities still exist and indicate a need for patient empowerment. Patients may not have the material, educational or political means to access health, now considered a basic human right.

Increasing patient expectations has led to an increasing number of complaints and litigation. In UK Primary Care, patients' written complaints about care increased by 4058 (4.5%) – from 90579 in 2016–2017 to 94637 (NHS Digital. Data on written complaints in the NHS, 2017–2018). In terms of impact on all parties, this is not sustainable. Where practitioners are unable to cope with understandable negative feelings of shock, burnout and anger following a complaint, there is a risk of post-traumatic stress disorder (PTSD), leading to their being described as a 'second victim' of the event (Chapter 4).

Maintaining resilience is challenging where a practitioner works in an organisation in which they feel undervalued and which appears to favour a culture of punishment rather than one of learning. Bourne found that complaints not only seriously impact doctors' psychological well-being but are also associated with defensive practice (Bourne *et al.*, 2016). This has a detrimental effect on patient care. Resolution of complaints and significant event analysis is essential for patient safety and service improvement. However, investigation procedures require transparency and timeliness to actually facilitate patient safety and practitioner resilience. A more resilient approach by practitioners to receiving complaints and their role in learning may then be possible to ensure better patient care.

Why now?

In the twenty-first century, healthcare workers face multiple local and global challenges to their resilience. In our initial chapters, we explore the emotional impact of working in healthcare (Chapter 2). Healthcare has both challenges and rewards. These are considerable, and we are all familiar with the feeling of seeing a life saved, a goal achieved, perhaps soon followed by the despair of a tragic outcome or setback. Every interaction involves the care of – and communication with – a fellow human with needs and vulnerabilities. The fact that professionals sometimes struggle is predictable and understandable. Often, we begin practicing these skills required for these experiences at a time in our lives when we are still maturing and adapting to the emotional landscape of adulthood. Learning to empathise with the suffering of others can be difficult. In addition to this, the transition from the classroom to the uncertainties of clinical practice can engender feelings of being unable to cope and not being good enough. Often referred to as 'imposter syndrome', Gottlieb *et al.* found rates of 22–60% in physicians and physicians in training (see Chapter 4). Gender, low self-esteem and institutional culture are risk factors, while social support, validation of success, positive affirmation and personal and shared reflections were protective (Gottlieb *et al.*, 2020). Feeling unsupported as we make our first clinical decisions can only exacerbate further feelings of being a fraud. Imposter syndrome is associated with increased risk of burnout and suicide.

Our patients require us to be cognitively 'at the top of our game' during every encounter. Diagnostic error is unfortunately common, and faulty cognition is a contributor to this. Evidence from neuroscience increasingly supports a link between our mood and cognition. This was recognised not only in the context of mental health but increasingly in the context of clinical reasoning. We discuss this in Chapter 3.

In addressing our cognitive performance, we need to consider our 'career cycle' (see Chapter 4). Our physical and mental abilities change over a working lifetime. In addition, our knowledge base and clinical experience change over time. There are transitions during our career (promotions, learning new procedures, complaints, personal life events) when our resilience may be more challenged and our propensity to burnout increased (Puddester *et al.*, 2009). During these times, our likelihood of making a major mistake rises. Chapter 4 discusses these phases and strategies for coping with them.

Since the 1960s, heart rate variability (HRV) has been recognised as part of the stress response. For example, patients with depression have reduced HRV. Our stress response, of which HRV is part, evolved over thousands of years and for a different stress landscape. Change, including in healthcare, proceeds at an increasingly rapid pace, and we have not necessarily adapted to this. Many healthcare workers report practicing in a state of constant stress (NHS England, 2018). In turn, our cognitive performance and clinical decision-making is impaired. In Chapter 5, we outline the physiology of well-being.

John Donne's assertion of our being 'involved in mankind' suggests that a connection or kinship with others should be mutually beneficial for all – as Donne also wrote, 'No man is an island'.

There is a responsibility to be cooperative with others in return for a right to receive cooperation and support from others. This is an affirmation of life and is reflected in the quality our relationships with our patients and colleagues. I, as an individual, my patients, my colleagues, my employer and regulator are all involved in mankind and connected to one another. In healthcare, as in life, we can achieve more for our patients through cooperation. Our singular well-being is dependent on our working together and only brought into being by our 'intelligent kindness' towards one another. This is considered at length in Chapter 6.

The individual practitioner cannot be resilient alone, and so we have to consider the role of teams on patient care and staff resilience. Riskin *et al.* demonstrated the effect of rudeness in healthcare teams and of a culture of rudeness in the working environment, both on procedural tasks and, even more so, on the communication tasks which underpin good clinical decision-making and effective patient treatment (Riskin *et al.*, 2015). Kindness to patients improves their health outcomes. Kindness to each other improves patient safety. Organisational kindness results in resilient professionals in a safer environment with better patient outcomes. It is a virtuous circle. We discuss this further in Chapters 7 and 8. Chapter 9 looks at resilience in practice and how approaches such as the 'most respectful interpretation' in assessing the motivation and intentions of others can be transformative in the relationships of healthcare professionals both with each other and with our patients.

Equality, diversity and inclusion in healthcare resilience

We cannot consider practitioner resilience and its relationship to patient safety without acknowledging that our lofty proclamations of equality for all is far away from the lived experience of many of our colleagues. For example, in the UK National Health Service (NHS), there is a significantly higher percentage of black, Asian, minority ethnic (BAME) workers than in the general population (21% versus 13.8%). In London, while 43% of the NHS workforce is from BAME backgrounds, they occupy only 14% of board-level positions in local healthcare (Kings Fund, 2018).

Staff experiences include the following:

> *'…patients really can be difficult. I mean, recently I had a patient who told me that I was the wrong colour to be English'*
> (Kings Fund, 2019)

While initiatives such as the British Medical Association's Equality Matters campaign and the BMA Charter on Racism in Medicine have sought to address this, the extent of the problem was brought into sharper focus during the 2020 pandemic, when it emerged that the death rate among BAME healthcare workers was disproportionately higher than non-BAME practitioners (Box 1.2). This was a tragedy set against the backdrop of a health service which would collapse without BAME staff.

There is evidence that BAME staff struggled more to obtain adequate PPE as compared to their white counterparts (Box 1.3).

Box 1.2 **Proportion of Covid-19 related death in UK healthcare workers from BAME background.**

UK healthcare workers from BAME background have been disproportionately affected by the Covid-19 pandemic. This is manifested by increased death rates across groups of healthcare workers:

- 21% of all healthcare workers are BAME.
- 63% of healthcare workers who have died were BAME.
- 20% of nursing staff are BAME.
- 64% of nurses who died were BAME.
- 44% of medical staff are BAME.
- 95% of doctors who died were BAME.

Source: Adapted from HSJ Survey (2020).

Box 1.3 **Access to personal protective equipment (PPE) in UK healthcare workers from BAME background.**

A survey published by the Royal College of Nursing on 28 May 2020 found that BAME-category nursing staff were more likely to have difficulty accessing adequate PPE during the Covid-19 pandemic:

- 43% of BAME staff had enough eye and face protection, as compared to 66% of white British nursing staff.
- 37% of BAME nurses did not have enough fluid-repellent gowns, as compared to 19% of white British nurses.
- 53% of BAME respondents had been asked to reuse single-use PPE, as compared to 42% of white British respondents.
- 40% of BAME staff received training in what PPE to wear, as compared to 31% of white British respondents.

Source: Based on Royal College of Nursing (2020).

Box 1.4 **Story of Consultant Urologist, Mr Abdul Chowdhury.**

Abdul Mabud Chowdhury was a consultant urologist at Homerton University Hospital in East London. After training in Bangladesh and working in Zimbabwe, he moved to the United Kingdom to work in the NHS.

At an early stage of the Covid-19 pandemic, Mr Chowdhury appealed to the UK prime minister for 'appropriate PPE and remedies' to 'protect ourselves and our families'.

Five days later, he was admitted to hospital and subsequently died of Covid-19.

Dr Chaand Nagpaul, chairman of the British Medical Association (BMA), said it was 'so tragic' that the 53-year-old had died after issuing a warning about a lack of PPE.

Source: Based on BBC News (10 April 2020).

Box 1.5 **The role of the active bystander.**

Active bystanders show that certain types of behaviours are not widely accepted by others and break the silence that has previously allowed them to thrive. Active bystanding to address behaviour targeted at minority or marginalised groups such as BAME students is also very important in demonstrating support and inclusion.

The BMA Charter advocates an ABC approach:

Assess for safety: if you see someone in trouble, ask yourself if you can help safely in any way.

Be in a group: it is safer to call out behaviour or intervene in a group, and where this is not possible, report the behaviour to others who can act.

Care for the person who may need help and ask them if they are okay.

Source: BMA (2020).

Nowhere was this more tragically illustrated than in the case of Abdul Mabud Choudhry (Box 1.4).

How are intelligent kindness and resilience relevant here? An individual cannot be resilient in a system which fails them. Many forms of discrimination including those based on race, gender, sexual orientation and belief exist in healthcare. As individuals and organisations, we need to recognise discrimination and make changes to create a level playing field for all. An individual's resilience is challenged if their workplace is permeated by discrimination. We should be mindful that our colleagues experience many repeated ways of discrimination:

> *'Modern racism is far more subtle. It's indirect, it's oblique and it is far more difficult for others who are not on the receiving end of it to detect'.*
>
> – Professor Binna Kandola OBE

Our own growth as resilient practitioners includes being able to empathise and understand the lived experiences of those who work alongside us. The concept of whistleblowing as a component of patient safety is now well established. Alongside this, we need to embed within our professional values the need to be 'active bystanders' for our colleagues whose resilience and well-being is undermined by discrimination (Box 1.5)

> *'What hurts the victim the most is not the cruelty of the oppressor but the silence of the bystander'.*
>
> – Elie Wiesel, Holocaust survivor

Conclusion

The global pandemic has reminded us of the need to protect healthcare workers in order to enable them to optimally care for patients. A UK Institute for Public Policy Research report in April 2020 (Thomas and Quilter-Pinner, 2020) reported that half of health workers felt their mental health had deteriorated in the first eight weeks of the pandemic, and 20% reported that Covid-19 and the resulting difficulties had made them more likely to leave their profession. They suggested five core guarantees that need to be given to the health and care workforce.

- *Safety*: Staff shouldn't be under pressure to work without adequate protective equipment.
- *Accommodation*: For staff facing long journeys to work or with concerns about family safety, there should be alternative accommodation provided.
- *Mental health*: Workers' mental health should be ensured by extending priority access to health and care professionals.
- *Remuneration*: Staff should receive their full salary if they fall ill; and, beyond the pandemic, no health and care professional should be paid less than the real living wage.
- *Care guarantee*: Government should support professionals to remain in work by ensuring that they are able to meet unpaid care commitments – such as childcare or caring for other dependent family members.

Organisations need to embed these guarantees, as part of resilience training and support for practitioners to facilitate safe and effective delivery of patient care. Possible approaches to training are considered in Chapter 10.

Healthcare practitioners are motivated, almost without exception, by a desire to safely and effectively restore their patients to health and well-being. During the pandemic, this has been universally recognised by the public in a myriad of forms – from a weekly round of communal applause to feats of extraordinary fundraising to support local staff. They deserve the thanks and respect of us all:

> *'It is not the critic who counts; nor the man who points out how the strong man stumbles, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood; who strives valiantly; who errs, who comes short again and again, because there is no effort without error and shortcoming…'*
>
> – Theodore Roosevelt

Further reading/resources

BBC News (2020) Coronavirus: NHS doctor who pleaded for PPE dies, 10 April 2020. bbc.co.uk (accessed 8.11.2020).

Bourne, T., Vanderhaegen, J., Vranken, R., *et al.* (2016) Doctors' experiences and their perception of the most stressful aspects of complaints processes in the UK: an analysis of qualitative survey data. *BMJ Open*, **6** (7), e011711. DOI: 10.1136/bmjopen-2016-011711. PMID: 27377638; PMCID: PMC4947769.

British Medical Association (BMA) (2020). *A Charter for Medical Schools to Prevent and Address Racial Harassment*. British Medical Association, UK.

Casey, D. and Choong, K. A. (2016) Suicide whilst under GMC's fitness to practise investigation: were those deaths preventable? *Journal of Forensic and Legal Medicine*, **37**, 22–27. DOI: 10.1016/j.jflm.2015.10.002. Epub 2015 Oct 22. PMID: 26519926.

General Medical Council (GMC). (2019) *Caring for Doctors; Caring for Patients*. General Medical Council, UK.

Gottlieb, M., Chung, A., Battaglioli, N., *et al.* (2020) Impostor syndrome among physicians and physicians in training: a scoping review. *Medical Education*, **54** (2), 116–124. DOI: 10.1111/medu.13956. Epub 2019 Nov 6. PMID: 31692028

The Health Foundation (2019) *Falling Short: The NHS Workforce Challenge*. The Health Foundation, UK.

Hofmann, P. B. (2018) Stress among healthcare professionals calls out for Attention. *Journal of Healthcare Management*, **63** (5), 294–297. DOI: 10.1097/JHM-D-18-00137. PMID: 30180024.

Horsfall, S. (2014) *Doctors Who Commit Suicide While Under GMC's FTP Investigation*. The General Medical Council.

HSJ Survey (2020). Adapted from COVID-19: the risk to BAME doctors. bma.org.uk (accessed 8.11.2020).

Jakab, Z. (2011) Available at: https://www.euro.who.int/__data/assets/pdf_file/0010/135586/RD_speech_Economist_20110317.pdf (accessed 16.10.2020).

Kings Fund, UK (2018). Closing the gap on BME representation in NHS leadership: not rocket science by Mandip Randhawa. Available at: https://www.kingsfund.org.uk/blog/2018/03/bme-representation-nhs-leadership (accessed 21.03.2021).

Kings Fund, UK (2019). We're here and you're there': lived experiences of ethnic minority staff in the NHS by Shilpa Ross. Available at: https://www.kingsfund.org.uk/blog/2019/11/lived-experiences-ethnic-minority-staff-nhs (accessed 21.03.2021).

NHS Digital (2017–2018) Data on written complaints in the NHS.

NHS England (2018) *National NHS Staff Survey*. Available at: https://www.nhsstaffsurveys.com/Page/1101/Past-Results/Staff-Survey-2018-Detailed-Spreadsheets/ (accessed 10.11.2020).

Puddester, D., Flynn, L. and Cohen, J. J. (eds.) (2009) *CanMEDS Physician Health Guide: A Practical Handbook for Physician Health and Well-being*. The Royal College of Physicians and Surgeons of Canada, Canada.

Riskin, A., Erez, A., Foulk, T. A., *et al.* (2015) The impact of rudeness on medical team performance: a randomized trial. *Pediatrics*, **136** (3), 487–495. DOI: 10.1542/peds.2015-1385. Epub 2015 Aug 10. PMID: 26260718.

Royal College of Nursing (2020) *BAME Nursing Staff Experience Greatest PPE Shortages Despite Risk Warnings* (accessed 8.11.2020).

Thomas, C. and Quilter-Pinner, H. (2020) *Care Fit for Carers: Ensuring the Safety and Welfare of NHS and Social Care Workers During and After Covid-19*. Institute for Public Policy Research, London, UK. Available at: https://www.ippr.org/research/publications/care-fit-for-carers (accessed 11.01.2021).