WR P EM
Wellness Resilience and Performance

Self-Care Case Studies Facilitator Copy

Learning Objectives

1. Describe benefits of self-care to the individual health practitioner
2. Describe benefits of self-care to the patient and health system in general
3. Outline strategies for self-care at individual level (including boundary creation and self-compassion)
4. Outline strategies for self-care at a system level
5. Outline individual barriers to self-care, and strategies to overcome them
6. Outline system-level barriers to self-care, and strategies to overcome them

Case Study 1

Sam has been an intern for three months. During this time he also moved out of home. He likes work- it's busy, challenging and fun most of the time. The hours are long, and but he is getting paid for the time he works so the money is pretty good. His next term is surgery which sounds exciting according to the resident he is taking over from. "Yeah, it's great. You get to scrub in all the time, and you get to know the team really well because you're always at work. Make sure you get on the nurses' good side as you often don't get time for lunch and they'll sometimes share their food with you!" Sam laughs, and wonders if he should warn his touch footy team he might not be able to make many games again this term…

Questions:

1. What are the red flags that pop up when you hear Sam's story?
2. What are the positive aspects to Sam's story?
3. What suggestions could you make to Sam?

Sam has just gone through several significant life events: finishing uni, moving out of home and starting full-time work. We know any of these events is stressful, and having all 3 together is a significant challenge. Sam sounds like he is enjoying life at the moment but things are going well. We don't really know what his supports he has in place, for when things aren't going so well. Does he live with anyone? Is he eating well and sleeping enough? It sounds like he has some social supports with his footy team, however the challenges of shift work are likely to reduce his ability to access this activity and social group regularly. It doesn't really sound like he has a plan for ensuring he doesn't become isolated (or for that matter getting the basic physical aspect of health right!). Sam is being proactive at work and getting a handover about his next term. It's also good to hear he's being paid appropriately and appears to be valued for his work.

Things are only likely to continue to get busier and harder for Sam as he progresses through his medical training. Getting good habits established early on are important to make sure it becomes second nature, and that there is a stable foundation to build upon. We know eating (healthy) food regularly at work improves our performance and our ability to care for our patients. (1) Doctors who exercise regularly, drink in moderation and don't smoke, are more likely to recommend these important lifestyle modifications to their patients. (2,3) Conversely, doctors who are burnt out or depressed are more likely to make errors at work with subsequent poorer patient outcome (4).

We can suggest to Sam that he stops and takes stock of his life briefly- has he got the basics in order? What is he doing for food and would options such as online grocery shopping, home delivered prepared meals etc be helpful? Does he have adequate access to sleep (>7hrs/night) and regular exercise (at least 30minutes 3-5 times a week). Does he have his own GP and private health insurance (no longer covered on parent's policy)? Encourage Sam to maintain his social links with friends and family for meaningful non-work interactions and so that these supports are in place for the likely rough patches to come. He also needs to be organised about his upcoming term- long hours mean even more difficulty doing these basic things well. At an institutional level ensuring access to nutritious meals and snacks at work, advocating for healthy vending machine options, and also encouraging the use of on-call rooms for example may be helpful if staff work very long shifts followed by early starts.

Case Study 2

Raj has just started working as a PHO in ICU. He was offered this position partway through the year, and although he was looking forward to his year as a PGY3 resident this seemed like an offer that was too good to refuse. He has found the work interesting but a lot more stressful than he was expecting. The nurses seem to have very high expectations and want answers and action immediately, but the consultants want to know every detail before they let Raj do anything. He doesn't feel like he can do anything right. To make matters worse, he has just found out that his father who lives interstate has been admitted to CCU following a STEMI. Raj really knows he should go and visit his dad, but he's only just stated in ICU and he doesn't feel like he can ask for leave already. "Maybe I can swap into some more nights and then go and visit on my days off?" he muses…

Questions:

1. Why is Raj having trouble finding his feet?
2. What could he do to make his transition into this role smoother?
3. How should he manage the additional stress of his father's illness?

Just like the transition from medical student to intern, the transition from resident to registrar is also a period of high stress. Suddenly you are of the one making management decisions, often with little expertise. This can be particularly challenging mid-way through the year when doctors are often expected to be well established in their role. Raj is probably second-guessing his decisions, and the nurses may have unrealistic expectations given his level of experience. His supervising consultants appear to be providing a lot of input, but possibly not in a way which supports Raj in developing his clinical decision-making. Raj could be upfront with the nurses at the start of his shifts that he is new to the role, and will need to check in with his consultants more often then perhaps they are used to. He could also try to meet with the director of training, and ask for support in further developing his clinical skills to the level expected of a registrar. Making sure he is doing some reading around the clinical cases he sees so that he is building his knowledge (in context) may help, as well talking to other registrars and finding out their tips.

All of this will be made harder by the family crisis Raj is faced with. We often struggle as doctors to balance the responsibility we have to our work and patients with that of our family and friends. Raj should be able to approach his supervisor for assistance in arranging time off to visit his father. Ideally this would be paid carer's leave (or even annual leave), but in some circumstances there may not be capacity for additional leave. Negotiating shift swaps to facilitate days off may be an option. It is important that Raj's supervisors are aware he has this additional stress to manage, as it may impact on his work performance. It would be a bad outcome for Raj if in attempting to manage things by himself he did not visit his father (or tried to squeeze in a visit on days off) and became distracted or distressed at work with implications for his term assessment and potential references.

Hopefully the department supervisors have good systems in place to orientate Raj into his new role, and ideally have a mentor program that could help Raj with many of these initial challenges.

Case Study 3

Jess is an emergency medicine fellow, completing the year at a tertiary trauma centre. As part of this role, she takes first on call. It is 7am and she has just had to call the time of death on a young man who was brought in after a high-speed motor bike accident. The team are gutted, and the nurses have started to disperse for handover. One of the residents is walking around the trauma room picking up rubbish and tidying up. Jess overhears the night registrar telling the resident, "Don't worry about doing any of that- the nurses fix all that up!" She wanders out into the office to start the paperwork for the coroner, and decides that from now on, she will stay at the hospital when she is on call as the 10 minutes it took to come in probably made the difference for this patient…

Questions:

1. Who is at risk of being negatively impacted following this case and why?
2. What system factors could be implemented to limit these negative outcomes?
3. If you were one of Jess' mentors, what advice would you give her?

Scenarios like these are all too common in medicine. We care for sick patients and there are times when we can't save them all. Patient deaths affect us all differently, and specific cases in certain people may trigger even more exaggerated negative effects such as second victim syndrome (see more on this in the second victim module). Any of the team involved in the care of this patient (and in fact, anyone on in the department at the time) could be significantly affected. Unfortunately, the team dispersed without any debrief and with a looming change of shift it's unlikely these team members will be easily reunited. The resident who was tidying up, almost certainly was using this "mindless" activity as a mechanism to enable them to process what has happened. Although the night registrar's intentions were probably good, by denying the resident this activity and by not providing another avenue for some time out, the resident may struggle. Jess also is demonstrating some concerning (although understandable) thought patterns. She has also unfortunately missed an opportunity as a leader, to help her team through this difficult time.

Having in place standardized department processes or approaches can help guide more junior staff, as well as demonstrating that this is something the department takes seriously. Making sure there routinely is a (brief) informal debrief immediately after a critical case provides team members with the reassurance they crave about the appropriateness of their care (5). This case should be discussed at the department morbidity and mortality meeting, giving those involved another opportunity to reflect on their care and raise questions. It is essential these meetings are constructive and supportive so as to not further traumatize affected staff, and also to ensure future cases are discussed. Senior staff members would usually informally "check-in" with their junior colleagues after these cases which is great, but don't forget those who may be overlooked e.g. students or junior staff on rotation, administration and other staff not routinely involved in team debriefs or M&M meetings. Ensuring staff know how to access support both within the department (e.g. supervisors, mentors etc) as well as external Employee Assistance Schemes can help those affected reach out for help.

If you were mentoring Jess, you could encourage her to reflect on the clinical aspects of the case (as a way of developing life-long reflective practice) and identify any areas she was concerned about. There may be some legitimate areas to review and discuss, but likely you would discover that Jess is worried about some aspects that probably would not have affected the outcome. If Jess became convinced her 10 minute response time was instrumental in the death, she may never be able to take call from home again. Encouraging Jess to establish reasonable boundaries between work and home life is important for career longevity and sustainability. Introducing Jess to the concept of self-compassion (being kind, gentle and understanding with yourself when you're suffering,) can help Jess find a balance between important professional-critique and crippling self-doubt. (6) Suggesting strategies for how she would manage the team debrief initially and then subsequently supporting her team would help her develop an essential part of her role as a consultant. Finally, reassuring Jess that everyone has cases they were affected by and these feelings are normal (and will likely be experienced again in the future) may reduce the associated stigma.

Case study 4

Kerry is an emergency physician in her late 40's. She works fulltime in a busy regional ED and has recently taken on the Director role, which involves a lot more work out of hours than she originally anticipated. She has been trying to juggle family (2 kids in high school) and work but has been finding that she is getting increasingly tired and wonders if she is anaemic (although come to think of it, it's been a while since her last period). She requests a FBC and iron studies at work and discovers she is iron deficient. She starts iron supplements and makes a mental note to start eating more meat…

Questions:

1. What are the challenges that Kerry is faced with in terms of her health?
2. What strategies could she put in place to help manage these challenges?
3. How could the system be changed to help overcome the challenges?

This is a common scenario – busy work life, busy home life and something suffers. Kerry is faced with the same issues many of us are- how do I find time to look after myself, my family and my patients and career? Kerry is faced with a significant health issue that she doesn't appear to have recognised- what is the cause of her anaemia? By investigating herself and not having an independent and objective doctor assess her she may have missed an occult malignancy or other serious pathology.

By having her own GP who she sees regularly, Kerry could ensure she is provided with the same screening and preventative health strategies she would recommend to her patients. If she does have a more serious illness, she will need ongoing coordination of her care which arguably again would be better provided by an independent doctor. Kerry could also use this event as a trigger to stop and take stock of her life priorities, including work-life balance.

Some system strategies to help busy doctors (and other staff) include provision of staff health clinics, ensuring workload is reviewed and managed appropriately, staff immunization drives and generally having a culture which promotes wellbeing. (4)

References

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