

The impaired clinician and the health and wellness of practitioners in anaesthesia and critical care

To the Editor: Within the medical fraternity as a whole, but particularly within the fields of anaesthesia and critical care, the use of the term impaired, when referring to colleagues, engenders thoughts of a severely incapacitated state either induced by alcohol and/or drug addiction or severe physical or psychological affliction, that places both the patient and clinician at significant risk of injury or death.

Whilst it is true that the above scenario describes the most severe form of the impaired clinician, the more common scenario is a far more insidious condition characterised by progressive isolation, depersonalisation and unhappiness that manifests as a slow but progressive decline in clinical performance, vigilance and ultimately results in an extremely unsafe state for both patients and the clinician concerned.

The presenting features/symptoms are identical, whether the wellness problem relates to:

- Drug / substance abuse
- Physical ill health
- Overwork – poor balance of mental / physical capacity with work load.
- Ageing and its associated physiological changes
- Adverse outcome stress
- Depression and other mental ill health
- Family and financial stressors

It is the failure to appreciate the above scenario that may have contributed to the current crisis existing within our fraternity. Seven deaths of anaesthesia colleagues countrywide in 18 months all due to suicide, constitutes a massive human disaster and is reflective of the great seriousness of the problem.

The analogy is often drawn between the operating theatre and an aircraft cockpit. Whilst there are many differences (not least in that the craft obeys no manual), in many ways the analogy is correct and the diligent pursuance of systems and protocols should reduce risk to ourselves and our patients. These protocols are deficient for normal theatre operation and almost absent for post-crisis/disaster situations. Debriefing/destressing protocols, so routine in military/airline situations are conspicuous by their absence. The death by suicide of seven pilots in one country in a short time span would spark a massive crisis management emergency. Pilots are expected to undergo regular assessments of both their physical and psychological fitness to perform their work. Why should the situation be any different in anaesthesia?

Before we can even begin to tackle the problem, we must investigate why these deaths are occurring. Assuming that suicide would represent the most extreme response to the problem (tip of the iceberg) and, therefore, that ultimately the minority of impaired clinicians will ultimately pursue this path, it is likely that the problem is much bigger than is currently appreciated.

The first step for all of us is to acknowledge that we in fact have a massive problem within our fraternity. Next would be a concerted, national effort, to create a forum for the assessment of the scale of the problem; understanding the root causes, followed by an intense countrywide effort to create structures that deal with impairment (in all its forms) and its prevention.

There is a desperate need for a non punitive reporting mechanism for the practitioner himself, peers and nursing staff. This should

trigger a voluntary wellness assessment/ questionnaire and the provision of voluntary/mandatory support systems for all aspects of wellbeing.

In Johannesburg, after the deaths of two young colleagues less than 10 months apart, we decided to form an employee health and wellness committee to study the issue; provide an immediate emergency service to the department and finally to develop a long term strategy for the improvement of the health and wellbeing of every clinician within the department.

What we have found, in fact, is:

- that the need for such an entity is much greater than we ever anticipated; that the current Department of Health structures are merely punitive and 'after-the-fact' institutions designed to deal with the issue once patients or clinicians are harmed;
- that as a country we are far behind the world trend in identifying and dealing with this problem and;
- that overall, there is a disquieting silence from the fraternity regarding this issue probably reflecting a state of ignorance and the denialist 'it won't happen to me' mentality.

How we have arrived at this point, and the degree to which this problem affects us all is the current subject of a registrar driven MMed dissertation at the University of the Witwatersrand. This study will aim to identify and quantify the degree of burnout within the private and public sectors in Johannesburg and will hopefully provide many of the answers needed to move forward on this issue, assuming that burnout may ultimately lead to suicide.

We implore SASA, CASA, the heads of academic departments countrywide, the HPCSA and clinicians on the ground to understand that this problem is literally killing our colleagues at a rate unrivalled by any other "disease." We need a national initiative created immediately, involving all the leaders of our community, that will respond to this problem. We require real mentorship of young anaesthesiologists, real programmes that aim at preventing the tragic outcomes we have become so used to, and a change in the mindset within our profession that places the absolute highest priority on ensuring that all its affiliates are performing optimally within the work place both emotionally and technically.

We must realise that we are connected, that no single practitioner can be truly isolated and that we all suffer, to varying degrees, the ills that have resulted in these tragic deaths. We must stand together, open and honest about our problems and demonstrate real concern for our colleagues. We must ask the difficult questions and go through the development of the processes that will provide a healthier working environment and a nurturing and caring fraternity. The alternative is inhumane and unacceptable in a society of intelligent and caring people.

Lastly, perhaps the first, seemingly unimportant, step is to begin today to view our colleagues as important and necessary parts of our lives and to treat each other in such a way that engenders a state of open communication and support. Each and every one of us is an incredibly important part of the future success, of not just our fraternity, but our country as a whole. Every anaesthesiologist is responsible for contributing to the development of a system that allows for the optimisation of our mental and physical wellbeing, so that clinicians and patients can enjoy safer theatre and critical care environments in the future.

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