RESILIENCE IN ACUTE MEDICINE

Ben Lovell

ST7 Acute Medicine
University College London Hospital
GMC INVESTIGATION

- 92 physician deaths during GMC fitness to practice investigations 2005-2013
- 28 suicides
- GMC: ‘Doctors who commit suicide while under GMC fitness to practice investigation’ (2014)
  - “Make emotional resilience training an integral part of the medical curriculum"
Most Suicidal Occupations

More Likely Than Average to Commit Suicide

- Marine engineers: 1.9
- Physicians: 1.9
- Dentists: 1.7
- Veterinarians: 1.5
- Finance workers: 1.5
- Chiropractors: 1.5
- Supervisors of heavy construction equipment: 1.5
- Urban planners: 1.4
- Hand molders: 1.4
- Real estate sellers: 1.4
- Electrical equipment assemblers: 1.4
- Lawyers: 1.3
- Lathe operators: 1.3
- Farm managers: 1.3
- Heat treating equipment operators: 1.3
- Electricians: 1.3
- Precision woodworkers: 1.3
- Pharmacists: 1.3
- Natural scientists: 1.3
WHAT IS RESILIENCE?

- Personality trait?
- Skill?
- Behaviour?
- Characteristic?
- Ability?
- Quality?
WHAT IS RESILIENCE?

“Resilience is a dynamic capability which can allow people to thrive on challenges given appropriate social and personal contexts”

WHAT IS RESILIENCE?

“the capacity to withstand stress”

Finn GM, Hafferty FW. Medical student resilience, educational context and incandescent fairy tales. Med Educ 2014;48 342–344
WHAT IS RESILIANCE?

“the ability of an individual to re-establish psychological equilibrium following adversity”

WHAT IS RESILIENCE?

“the ability of a substance to absorb energy when it is under stress, and release that energy upon unloading”

Elements of Metallurgy and Engineering Alloys (2008)
WHAT IS RESILIENCE?

“the psychological growth that occurs following unhappy life events”

RESILIENCE CAN BE LEARNED, PRACTICED, HONED
WHY ACUTE MEDICINE?

- Temporary teams
- Constant ‘resetting’
- Lack of structure
- Lack of understanding
- Lack of role models
WHY ACUTE MEDICINE?

Where did the acute medical trainees go? A review of the career pathways of acute care common stem acute medical trainees in London

Emily Gowland, medical education fellow, Karen Le Ball, head, Catherine Bryant, deputy head and Jonathan Bluns, deputy head

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ABSTRACT

Acute care common stem acute medicine (ACCS AM) training was designed to develop competent multi-skilled acute physicians to manage patients with multimorbidity from ‘door to discharge’ in an era of increasing acute hospital admissions. Recent surveys by the Royal College of Physicians have suggested that acute medical specialties are proving less attractive to trainees. However, data on the career pathways taken by trainees completing core acute medical training has been lacking. Using London as a region with a 100% fill rate for its ACCS AM training programme, this study showed only 14% of trainees go on to higher specialty training in acute internal medicine and a further 10% to pursue higher medical specialty training with dual accreditation with internal medicine. 16% of trainees switched from ACCS AM to emergency medicine or anaesthetics during core ACCS training, and intensive care medicine proved to be the most popular career choice for ACCS AM trainees (21%). The ACCS AM training programme therefore does not appear to be providing what it was set out to do and this paper discusses the potential causes and effects.
MY HYPOTHESIS

People working in acute medicine:

- Require resilience to maintain their own wellbeing and excellent patient care
- Are motivated and hard working
- Possess the drive and self-discipline necessary to enhance their own resilience, and resilience in their colleagues
RESILIENCE

- **Pro-active**
  - Nurturing emotional/psychological fortitude

- **Reactive**
  - Using adversity as an opportunity to enhance resilience
PROACTIVE RESILIENCE

- Individual resilience
- Group resilience
Q: What evidence is there for individual resilience training?
INDIVIDUAL RESILIENCE


  - **Resilience workshops**
    - Over weeks
    - Focus on reflective practice
    - RCTs show improvement in self-reported resilience
    - Qualitative data show perceived strengthening of resilience
    - Time and resource intensive
INDIVIDUAL RESILIENCE


  - **Small group problem solving**
    - Weak positive evidence from low-quality papers
    - One negative trial
INDIVIDUAL RESILIENCE


  - **Cognitive behavioural strategies**
    - Used Stress Management and Resiliency Training (SMART) programme
    - Strong evidence of improved resilience scores
    - Extremely time and resource intensive
INDIVIDUAL RESILIENCE


  - **Mindfulness and relaxation training**
    - Conflicting evidence
    - Scarce literature for doctors
    - Strong evidence for nurses
INDIVIDUAL RESILIENCE


- **Mentoring**
  - “Optimistic findings”
  - No quantitative data
Q: What evidence is there for individual resilience training?

A: Almost none
MY SUGGESTIONS (1)

- Recording and acknowledging growth and progress
- Individualise learning
- Setting and achieving realistic goals facilitates resilience

## Junior Doctors’ Practical Procedures

Please fill in as appropriate!

If you are competent in a certain procedure, please observe and help your colleagues who have less experience.

Some are more realistic than others, but try to get as many as you can.

The aim: finish acute medicine with more practical skills than when you started.

- Ben

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<th>Chest drain</th>
<th>Pleural aspiration</th>
<th>Ascitic tap</th>
<th>Ascitic drain</th>
<th>Joint Aspiration</th>
<th>Central line</th>
<th>DC cardioversion</th>
<th>Lumbar puncture</th>
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(✔) = Simulation
MY SUGGESTIONS (2)

- Promoting individual value by developing specific roles
Respecting team members and recognising that they have other priorities

MY SUGGESTIONS (4)

- Role modelling paradigm
  - Language we use

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<tr>
<th>Instead of....</th>
<th>How about...</th>
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<td>Stressful</td>
<td>Stimulating</td>
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<tr>
<td>Difficult</td>
<td>Challenging</td>
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<td>I don’t know what’s going on with this patient</td>
<td>There’s a diagnosis to be made in this patient</td>
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<td>I really hate treating headaches</td>
<td>I really need to learn more managing headaches</td>
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<td>We’ve got so many patients to see</td>
<td>We’ve got lots of interesting stuff on the unit</td>
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MY SUGGESTIONS (4)

- Role modelling paradigm
  - Trainees are always subconsciously ‘auditioning’ role models
  - They want to hero worship someone – be a hero
COMMUNITY RESILIENCE

- Individuals are better prepared to handle stress and uncertainty when they consider themselves an important member of a group

- Communities provide a mutually supportive environment for young people in rigorous jobs
  - Lovell B. ‘We are a tight community’: social groups and social identity in medical undergraduates. Med Educ 2015: 49: 1016–1027

- Resilience facilitated by “social connection with peers and other adults, positive role-modelling by winners or achievers, and unobtrusive monitoring of well-being”
COMMUNITY RESILIENCE

- Enforced isolation
- Judging self
- Judging others
- Role modelling
- Self-isolation
- Like minds
- Difficulty sharing with non-medics
- Avoiding abandonment
- Keeping up
- Sharing resources
- Horizontal teaching/learning
MY SUGGESTIONS (5)

- A bit of friendly competition is a healthy motivator
REACTIVE RESILIENCE
FOLLOWING AN UNHAPPY EVENT...

- Resilience
- Learning & growth
- Recurrent negative thinking
ROLE MODELLING

- Transparency from leaders
- Acknowledgement that
  - Crises and mistakes happen at all levels of experience/seniority
  - We all need to keep learning
THE POWER OF REFLECTION

- Learning neutralises much of the unpleasant emotional reaction to stressor events
- Encourage team members to use a reflection model and discuss it with you
- Use it as a valuable CbD
- Are they willing to share it?
WHAT HAPPENED: A young woman was referred from the gynae ward at 4 am, with no power or sensation in her legs. On assessment, she had no sensation to all modalities below the level of T4, including her arms. She had no power at all in her legs. Power was patchy in her arms, and improved on encouragement. She was in urinary retention, and had no reflexes. Whilst I was concerned about a cord lesion, my impression was that the symptoms were functional in origin. I recommended reassessment of the patient in the morning, with MRI spine if the signs persisted.

FEELINGS: Whilst I wasn't 100% certain in my diagnosis, I was confident enough to leave further investigations and management til the morning. When I found out that patient had been transferred urgently to Queens Square and that preliminary MRI reports showed multilevel spinal infarcts, I was quite disappointed and upset. I know that the infarcts look established and that the outcome likely would not have been different if I had arranged urgent transfer to neurosurgery, it is still upsetting to miss a diagnosis.

EVALUATION: It was good that I had kept the patient on the handover list for early registrar review, and not dismissed the entire syndrome as functional. I could have done more at the actual time I was at the patient bedside. I could have referred to the neurosurgeon on call, by making the phone call and filling out the form on referapatient.org.

ANALYSIS: I think my reluctance to act on my findings at 4am came from several areas. I admit that I was not completely sure of the pathway of making out of hours neurosurgery referrals at the Whittington Hospital, but this was something that I could have easily found out. I was misled slightly by what I perceived to be a disconnect between the patients signs and her mental state - she was largely unconcerned by her paralysis, and complained only of a stuffy nose. I felt that this was more in keeping with a functional disorder. Finally, I was falsely reassured by the fact that the patient had been seen by ED and gynae doctors, none of whom was unduly concerned by the patient's neurological state.

CONCLUSION: The overriding theme of this encounter is that there was doubt in my mind. If doubt exists, it is usually the best path to rule out the more serious diagnoses. I could have run it by the consultant on call, in order to get a second opinion on the case.

ACTION PLAN: When doubt exists, seek support. This is what I teach my students and junior doctors, so it is a shame I didn't think to take my own advice. I also now think that 'functional' should be a diagnosis of exclusion, after organic diseases have been ruled out.
SUMMARY

- Be role models - happy and curious
- Nurture and strengthen communities
- Show staff you are invested and care about them
- Act quickly after adverse effects and use reflection to promote resilience
- Get trainees interested in resilience
THANK YOU