

Wellbeing podcast transcript – episode 2

Autonomy and wellbeing

SOPHIE: Hello and welcome to *Prescribing change*, a podcast from the General Medical Council. We've just published a UK wide review of medical students and doctors' wellbeing. This was independently co-chaired by Professor Michael West and Dame Denise Coia.

We asked Michael and Denise to identify factors that impact doctors' wellbeing. So that we can work with organisation across the UK to help tackle the causes. In this series, we talked to three of our clinical fellows about the findings and recommendations of the review. We also hear about their own experiences and stories about managing wellbeing on the frontline.

Visit our website to read the full report and if you want to share your story or give us feedback on the podcast, we'd love to hear from you, tweet us @gmcuk.

TANITA: Hi, I'm Tanita Cross and I'm the GMC's Digital Content Officer. I'm also the producer of this podcast, and I'll be conducting the interviews throughout the series.

So today, I'm talking to three of our new clinical fellows who are joining us from different parts of the UK, and different medical specialities. Thanks all for coming along today. Would you please start by introducing yourselves?

CATHERINE: Hi. So, my name's Catherine. I'm a psychiatry trainee from South Wales.

ALICE: Hi, I'm Alice. I'm an anaesthetics trainee based in Edinburgh.

ADAM: And I'm Adam, I'm a GP trainee based here in Manchester.

TANITA: Following extensive research and conversations with doctors and medical students, Professor Michael West's report suggests that there are three core needs that medics should experience within the workplace: autonomy, belonging and competence. In each episode, we'll be focusing on one of these needs, and today we're discussing a doctor's need for autonomy.

In the report, Michael West offers his definition, but I wanted to hear from our clinical fellows: what does autonomy mean to you?

CATHERINE: For me personally, I think it's about self-determination. It's about being able to speak out about what's happening in my own working life and have, feel like I have some semblance of control over that.

ALICE: So, I think autonomy for me is almost being treated as a grown up, which I know we talk about a lot, but it's essentially having the ability to influence the world around me and knowing that my view is respected and at least heard. I'm not an idiot, I know I'm not going to be able to work when I want and just do the shifts that I pick and choose, and not come in every Tuesday because I don't fancy it, you know, I know I work a professional job. But, I want to be treated like a grown up, I want to be respected, and I want to feel like my voice is heard and that, really, is what autonomy means.

I quite like the way that it's drawn in values in this report because, I think, anybody working in the NHS really has the NHS' values at their core almost every day, and being able to work in alignment with those values and being, having those reflected back at me, I think, is so important and I think, for me, that's what autonomy is.

ADAM: Absolutely. I think control is a very good word because it's very easy to be controlled as a doctor in training, a doctor post-CCT working across the specialties and across the health services. I think being allowed to take ownership of your own career, and how your career interacts with your personal life, is something that shouldn't be treated as a bonus, it should be something that is actually achievable. Because, if that is the case, and we promote having autonomy over our own work-life balance, then I think we are going to begin to see more people wanting to stay in the profession, feeling happier in the profession, and actually being able to deliver what they want to be able to deliver on a daily basis.

TANITA: Thank you for that, I think that's really useful as a starting point for our discussion today in terms of talking about autonomy and what it looks like in your practice. One of the things I wanted to cover actually just from what's been said so far, and knowing that the GMC's Chair, Dame Clare Marx, is a big proponent of the idea of clinical leadership, and I wondered as trainees, in the places where you've worked so far, which I'm sure are many, how connected have you felt to your senior leaders?

CATHERINE: In Wales, we have developed, as a group of psychiatry trainees, the all Wales psychiatry trainee feedback forum. These are forums that we developed to occur three times a year, and we have encouraged and invited senior members of our leadership team, such as from Health Education and Improvement Wales and training programme directors, to come and listen to trainees' concerns and to be directly answerable to them in that forum. I think from there we've been able to develop more of a conversation between ourselves and our leaders, but also to feel that our voices have been heard and acted upon.

ADAM: I think we're, well, the three of us here are a bit of a self-selecting group in that we are here on leadership and management fellowships. But, I think, what this highlights as well is the importance that trainees are empowered to feel that they can be leaders however large or small a scale that is.

An example from my own training is that there were some, there was quite a lot of feedback actually in the GP training scheme that the trainees weren't particularly happy across the board with how things were being delivered, and there were, one of the biggest points that kept coming back to us was that there was, there didn't seem to be a lot of collaboration between the training programme directors and those of us that were trainees on that particular scheme.

So, we created a working group amongst trainees that facilitated, really, a bit of a link between the group of trainees and the training programme directors, to explore more ways that we could improve the training scheme to make it more acceptable and to implement some of the factors that the trainees thought were missing. And I think that is what is really important in terms of trying to get autonomy as a trainee – is actually to feel that there is an open dialogue between our leaders and the trainers, so that there is just more of a conversation about the areas we feel could be improved on and then some feedback about how this could be achieved by working collaboratively.

ALICE: And I think, sometimes when you're having that conversation with leadership, you feel like it's only happening when you're knocking on the door and something's going wrong – they only want to hear from you when there's a problem to be solved. And increasingly, I think, what is important is that people engage with you at all times, so actually what's going well, what's working, what can we build on, what is good practice that we can highlight and grow and share?

And I think that is starting to happen and we're moving away now from this situation where you're the troublemaker who's knocking on the door and creating a fuss and moving towards somewhere where actually it's a collaborative discussion like you're talking about. And, for me, that is something that, having been involved in leadership and management for a number of years, I've seen that change happen and I feel more comfortable raising those issues and having those conversations, but it's not something that most people will find easy.

ADAM: And, as we've already mentioned, it is a change, it is a culture change. It is making people feel comfortable that they are well within their rights and, actually, should be encouraged to identify areas that they think can be improved and come up with suggestions of how they can do that.

CATHERINE: Yeah and I think the forums are a safe space to do that in.

ADAM: Absolutely.

CATHERINE: And as you've both said, probably looking from there to develop that relationship or that safeness to be able to speak on a more equal level with leaders, managers, and there creating a better culture and a more compassionate environment to be within to be able to have those conversations, some of them difficult but some of them will be positive as well – and that's the back and forth, isn't it?

ALICE: I think so and I think with the forums what's really important is that, you know, sometimes it can feel like the forum is something most people don't know is happening or people aren't aware of, that isn't promoted to everybody – people can't come because they're always on call that day or people can't come because they're rushing away to childcare commitments. And it's about making sure that we facilitate as many people as possible being able to get involved, being able to engage with that, rather than it being for a select few or a minority of people, it has to be everyone and that's I think a really important change and again we're talking about these culture shifts but that's another culture shift that I would love to see.

ADAM: And what I would love to see as well is within the health services by necessity there are hierarchies – you have the consultant right the way down to the new FY1 – but when it comes to driving change, identifying areas that need improvement and ways to do so, I think the hierarchies do need to be flattened a little and so that there is actual encouraged discussion with managers and leaders right at the top of an organisation with those that are at the coalface and working in those environments day to day.

TANITA: As you mentioned, Adam, you guys are like a self-selecting group, you're all on leadership fellowships, it's obviously an area that you are interested in. If you had in front of you now, a trainee who doesn't have any of that experience, but would like to start a forum in their practice or their hospital, is there any practical advice you'd give them of how they might go about that and what they might want to consider?

ADAM: I think the first thing that people need to do is just be aware of the environment that they're working in, identify the people that are making decisions and are potentially driving change and, as Alice said, there might already be forums that exist. You know, it's not always a case of having to be the pioneer and the trailblazer and having to start everything from scratch. It could be that they've entered a particular workplace or a particular department and these things exist, they're just not particularly well advertised, so it's very much in those first couple of weeks of a job, scoping around, identifying the people that can be of help, speaking to their fellow trainees, speaking to trainees a few years above them because they may have been in exactly the same position and have been able to have the opportunity to voice opinions, make some change, and that would be my first recommendation really to get involved. And as I said earlier, you can make, you can start making change and developing skills as leaders in medicine on a very local scale, on a very tiny scale – you don't have to be able to change the world immediately, it's about identifying what you can do locally first.

CATHERINE: Yeah, I agree, and I think one thing to recommend is start those conversations. As doctors in any area of the health services, I think we're very used to silo

working, so working on your own kind of workstream, getting on with what you're doing, and kind of not necessarily worrying about what's going on around you. It might be, for somebody starting in a new department, they've got a fresh pair of eyes, they are really able to perhaps see a little bit more about what's going on around them than people that have been there for a number of years, so yes these forums may exist but there are other ways of looking to create change and move things forward so, definitely, start the conversation, look with a fresh pair of eyes – as the most junior person on a team or in a department, actually, you should be the most valued in some ways because you are there, you're ready, you're keen.

ADAM: You're also the future of the profession that you're in. And you are going to be there in decades to come, but to be able to be facilitated to start thinking outside the box, thinking more widely across how healthcare is delivered from that every early stage will only foster that as you continue in your career.

ALICE: What I'm drawing from what you're saying that absolutely resonates with my experience is: find what's already being done, take your time to really know the issue, and if you're passionate about it, find other people who are passionate about it, ten voices are more powerful than one, especially if you are taking an issue forward, you need people behind you, you need people to support you. And, yes, you could do it on your own, but you rarely have to, if we work as a team you can actually achieve so much more.

TANITA: I wanted to pick up on a point, Alice, you mentioned earlier about inclusion because Michael West, in his report, makes the point about making sure that lots of different types of people have the opportunity to feel valued and be included in their working environment, so I'm glad you brought that up as well.

So, I wanted to move us a little bit away now from driving change and ask you if you have any examples from your working lives of, like, great things at places where you've worked, really good things that made your working environment just that little bit easier and somewhere that you wanted to go into every day.

CATHERINE: From my perspective, having mainly worked in the hospital environment through my career, I'd say that the value of a good doctor's mess cannot be underestimated. When we have had access to a private place where we can move ourselves away from direct scrutiny, relax and have a coffee or a tea with colleagues has been really, really helpful in terms of unwinding and being able to just support each other potentially.

ALICE: So, I know in Aberdeen in anaesthetics there's been an example of this that's been really successful where they essentially have a pizza day – an opportunity to informally debrief, so it's an opportunity to talk about the stupid thing you've done that week or the thing that you feel you haven't done to the best of your ability or the thing that's playing on your mind with the more junior and the more senior trainees where they have a really informal setting, have a place where everybody can sit and eat and just have a natter. And in some ways I think that's so important because having somebody say 'you

did that stupid thing, well let me tell you about the thing I've done that was ten times more stupid than that' is really good for your wellbeing, but also I think helps you process and learn from those events in a way that will help you better care for patients in the future.

And I think there's a lot to be said for shared learning so if somebody has an experience and keeps it to themselves, nobody else is learning from that, but if we can all sit down and informally say actually this happened to me and it made me panic in this way or I did this, this and this and I couldn't work out what was going on then everybody can learn from that and collectively we can think it through in a way that's ultimately going to make care better for patients.

CATHERINE: And on kind of a practical basis as well – that – to be a safe space where doctors can talk about encounters that have occurred and what's happened to them, it has to be away from where patients and other staff are so that people can relax and debrief in an informal manner.

ADAM: You're absolutely right there. Some hospitals, especially ones that I have worked with, do the mess thing very well, but some do it very, very poorly and they've neglected it. And that is a really valuable resource that actually with comparatively little funding can actually become that area where people can just take some time off the ward, chat to each other and go 'that was a really bad morning', you know, 'can I just chat this through with you?' – it's informal, it's not scary, it's somewhere where you can feel safe just to chat to people who are going through exactly the same things as you and, as you said Alice, someone that you find sat there having a cup of tea could have gone through exactly the same thing a month ago or last year and actually be able to give you some really practical advice on how to deal with it.

ALICE: We were having a conversation about resting at night and in the report there's an example of somebody sleeping on a trolley in recovery and I was looking at that and thinking, a trolley? What is this luxury? That's basically a spa hotel compared to the places I've slept in hospitals! But, you think about actually what you have and you're sleeping on a floor in a room where somebody's going to come in and wake you up at 6am and tell you, you shouldn't be there, and just trying to get some kind of rest on a shift can be horrendously challenging and when you know your brain isn't working, when you know you're not functioning and when in your heart you know you're unsafe and then you can't rest, it's really difficult to know what to do.

ADAM: I've worked in hospitals where they haven't been done up in decades, they are horrible, unpleasant places to be, no heating, you know, and they're just, when you have to sleep in those areas to then feel energised and ready to go look after patients when you're needed, it's just, it's just, it's just not, it's not a nice environment to be in.

TANITA: So, we've started talking there about night shifts and different shift patterns that leads us in quite nicely to the next area I wanted to talk to you guys about. We hear lots of stories and we have done for quite a number of years about rota gaps in the health

services, and obviously there's lots of causes and reasons why there are so many rota gaps but, of course, when there are rota gaps on a rota, it puts even more pressure on the people who are at work to cover the same amount of patients, to deliver the same level of care.

In fact, in our national training survey, we found that more than half of trainees in the UK received less than six weeks' notice, so not only are the rota gaps affecting you when you're in work, you're also completely unsure of when you're going to be available to take holiday, when you're able to sort of, I know lots of doctors who have missed friends' and relatives' weddings and even their own weddings in some cases – they've had to struggle really hard to kind of rearrange shifts and things like that.

So, I just wondered, to put it, to kind of bring it back to more of a positive hopefully, have you ever worked anywhere where the rota system worked quite well? And are there any tips you might have for people listening to this who look after rotas and are kind of looking for ideas to improve that whole process?

CATHERINE: It doesn't have to be rocket science. I think rotas that have worked well for me personally are ones that are pre-planned well in advance – there's no reason why that can't happen – we get more than six weeks' notice, a clinician is either inputting into the rota or is supporting somebody who is not clinically trained to look at the rota and think about the spread of doctors and expertise on that rota. And then look from there, once you have a rota in advance, there's plenty of time to do your swapping, and that then impacts on your work-life balance. It's really quite simple, something like that can work really well.

ADAM: I'm shocked that something as simple as being able to have, to know where you're going to be working, you know, the location of the hospital you're going to be working – when [laughter] – it's true though isn't it?

CATHERINE: Yeah, no, it's definitely true.

ALICE: You're right.

ADAM: ...when you're allowed to take annual leave, are you going to be working Christmas? Are you going to be able to attend your sister's wedding? All these things where I can't think of any other career that people would accept not being able to plan their lives. You know, being literally told with several weeks to go that you are suddenly moving to the other, well in Wales' case you could be moving to another end of the country. And when, as you say Catherine, when it's actually worked really well for me is when I took on the rota, so I rotated on to paediatrics, I took charge of the rota that we were working and that just meant that we could sit down, talk to everyone that was, that's on the rota, work out what works well for who and you have an idea of what it's like.

I find that the more removed the process of rota coordination is, if it's done by someone in an office that hasn't worked in that environment, they don't tend to have an idea of what it is like to not have these safety mechanisms in place to make sure that you actually can forward plan, you can plan where you're going to live, you can also plan that it is going to be safe for you to do a certain number of nights, be well rested and then come back and do your day shifts. And, as Catherine said, that's not a difficult thing to be able to sort out, it's something that, once you've got a good mechanism in place, it can be, it can be repeated and replicated for years to come.

ALICE: It's even simple issues like childcare and needing to book childcare more than six weeks in advance and I know that's something that people tend to bring up.

I've worked in rotas that have worked really well, I've worked on rotas that haven't worked so well and when they haven't worked well, the answer I'm normally given is 'well, we have no idea how many trainees are coming, we don't know who we're being sent, we haven't been given the information from the deanery, we don't know how many people we're staffing our rota with.' And, you think, there's a whole host of reasons that you're probably giving quite legitimately but it all seems to be a fundamental communication breakdown. And I think that is really, really challenging and I completely respect the issues that they're having, but they need to respect the impact that that has on my life and the life of people around me.

And when I've worked on really good rotas, so an example is I've worked on a rota where you're sent out a Google Doc, which is an Excel spreadsheet, with all of your shifts for the four to six months, whatever, and you put in not on-call [repeated x3] on every weekend and long day you don't want to do, you put in annual leave on the days you want to be on annual leave, you put in study leave on the days you want to be on study leave, and then the rota coordinator will go through and check if actually your days are or aren't feasible and if they're not feasible, you get a little email saying, 'Alice, really sorry, you're going to have to do some swaps for this one, I can't give it to you on the rota as stands'.

But I feel like there's an apology, there's an explanation as to why it can't happen and there's a lot of effort that goes into really accommodating what I need. But, I know the impact that that has on the rota coordinator and it's a huge task that you get pretty much no time to be able to do.

ADAM: There's a collaboration and there's flexibility. It's not just a hard no, you have been given this slot, it's completely up to you to make 150 swaps between seven people to make this happen. It's nice, as you say, to be given the opportunity to work with your colleagues and be adults, and actually go 'well, how can I help you out? How can you help me out?', and just facilitate it, you know.

A poor example is I turned up to, well I actually went to visit the A&E department that I was about to rotate into, and I was told that I couldn't give my six weeks' notice of the leave that I wanted because they didn't know how much trainees there would be and that we would have to wait until everyone had started on that start date and then they would

sort out leave. But, of course that meant that there wasn't going to be the six weeks' notice to be given that leave, so the system that you're talking about, Alice, is what should be replicated across the country. It does take a bit of effort, it is a lot of hard work, but the doctors and the rota coordinators should be willing to work together to be able to make that happen.

CATHERINE: And I think, as technology improves actually, there are technological solutions to some of the things that we're talking about. And I think Alice is bringing in that idea that as an engaged person on a rota, you actually are more willing to have a little bit more give and take with a rota, and that brings in that idea of the more live rota that I've heard about, which is whereby people are more aware of what's happening on a rota on a day-to-day basis because everyone's got access to a live document. It does mean that people can have a look, forward plan a little, is there some leeway in my own life where I can support here where there's a gap, or perhaps am I knowing that in a few weeks' time, there's going to be a problem with the rota, is there anything we can do about it now?

Rather than, what I think has happened in the past a bit more is that there's been a problem [repeated x3], everyone's kind of put their head under a stone and not forward planned in the same way, and there's been this last minute 5pm ring around – 'can somebody cover this gap, please?', which people, if you're not engaged or involved or empowered in your rota planning, actually you're not going to be willing to really help out at all either. So it's, what we're all talking about is that kind of that balance, that give and take, that ability to be able to support us to have work-life balance and then we probably, potentially, would support back.

ALICE: So, through the rota app I will get updates on my phone that come through as push notifications if there's a rota gap that needs filled.

CATHERINE: Well, that would be the ideal wouldn't it?

[Laughter]

ALICE: Normally, normally somebody eventually volunteers, reluctantly or otherwise, but normally it's you'll get paid as staff bank, you'll get time in lieu if you help us out and cover this for us.

ADAM: That sounds like an excellent process.

CATHERINE: But if you're more engaged, you're more motivated, aren't you?

ADAM: Of course, you are.

CATHERINE: You're more likely to pick up and support that.

ALICE: Well you do want to help them, but also you think I know I'm going to get the time back for this because I know you're going to respect what you say you're going to do. And for me, it just all boils down to this respect, and the fundamental idea of respect of people on the rotas that they have a life and that they'll help you if you help them.

TANITA: I think that's a really nice note to end on. So, thank you all again for your time today, it's been really interesting. And I think we've got some really practical tips in there for people who maybe are struggling with some of these issues in their current workplaces.

In the next episode, we're going to be talking more about the second core need for doctors that was identified in the wellbeing report, and that was belonging. I feel like we've touched on that a little bit in terms of team working and that kind of thing, but we'll go into that in much more detail and we'll also cover off things like culture and leadership as well. Make sure you have a listen to that next time with me Tanita Cross, Catherine, Alice and Adam.

ADAM: We as clinical fellows really want to hear your thoughts and ideas around all the issues we discuss so please tweet us at @gmcuk or visit the GMC website to read the full report.

SOPHIE: *Prescribing change* is a podcast by the General Medical Council. Thank you to Dame Denise Coia and Professor Michael West for co-chairing this review. And thanks to our guests, doctors Alice Rutter, Adam Thomas and Catherine Walton.