

Wellbeing podcast transcript – episode 4

Competence 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: In this episode we're talking about the third core need that Michael found in his review, which is necessary to ensure a medical student or a doctors' wellbeing and that is competence. What does being a competent doctor look like to you, but I think more importantly, what does it feel like in practice?

ADAM: I think the important thing with competence is not to confuse it with excellence. I think we as doctors, as a profession, are constantly striving for excellence, we are constantly putting pressure on ourselves for excellence. The exams that we sit are looking for us to perform at the absolute best of our ability. I think when it comes to the concept of competence it's about feeling that you are able to do your best, to deliver safe

compassionate care but that also that the environment that you're working in allows that to happen. And that you, I suppose, help others around you to opt to deliver safe care and to work to the best of their competence as well.

ALICE: I think for me competence is a bit of a tricky term because I want to be able to work to the best of my ability.

ADAM: Yeah course.

ALICE: And you're right it's because we're used to striving for excellence. You want to be able to deliver excellent care for every patient. And I think actually we all just want the best possible outcome, and we can do that in a safe way, and we will always strive to go beyond that. But I think what's really important to remember is that the best possible outcome is not always a cure, it's not fixing every problem, it's finding what's important and being able to deliver that and I think that in the context of this review, that's what competence means to me.

CATHERINE: It's working within an environment that supports that. And I think that's the context of the review as well. About what's going on around me, how can that best support me to work to deliver the best care I can for patients around.

TANITA: So what needs to happen on the ground to make sure that you are supported to deliver that level of care to patients?

ADAM: We can operate to the best of our ability, we can deliver what we are able to do to make sure that patients are given the care that they need and deserve. But what needs to happen, as Catherine was saying, is that the environment that you're working in needs to allow you to operate at that level. If you are coming into somewhere where the workload is not manageable for the amount that's been assigned to you, or you're coming on to an area where there are rota gaps, there's a lack of staff – no matter what you do, you can put as much pressure on yourself as you like to deliver the best level of care that you can, you are always going to be on the back foot because the support mechanisms aren't there to help share that load. And I think that the more you push yourself to make up for those short comings on your own by giving, by putting onus on yourself to overcome those shortcomings you are going to burnout, you are going to feel that you're not delivering good care.

ALICE: I think what's really important from what you were saying Adam is that when the workload goes beyond what you can deliver safely and where you can, you know, take the time to show that compassion, it has a huge impact on us as doctors. So, I mean I'm thinking back to my own time working in A&E and I think everybody that has ever worked in A&E will have at least one 'oh my goodness my, workload was far more than I could possibly manage' story, and that's the nature of the work. But, for me when I know I have too much, my brain will just start to melt. I can think of one particular shift where, we came in to at least an 8 hour wait and that's the point at which we were starting. So, you're starting with people who are sick and angry. And you're then trying to manage

multiple people in one go to be as quick as you can, getting these people the care that they need or getting them to the place they need to be. And if you're exposed to those scenarios again, and again and again. I think eventually you're going to believe you're a terrible doctor.

CATHERINE: And I think that's what I would pick up on from what you were saying, Alice, is that, one-off situations where we might've felt overwhelmed, might be okay, we might be able to deal with that, but that chronic stress, that chronic feeling of being overwhelmed and the impact that will have on your stress levels in general, your wellbeing, your mental health cannot be underestimated. And the difficulty there of course, it ties in again to the quality of patient care that you're going to be able to provide.

ADAM: When that becomes normality is when you are going to be thinking 'is it because I am substandard doctor? Is it because I'm not delivering the care to my ability, delivering the standard of care to the best of my ability?' You know, we're not saying that these pressures are going away, they're not, they're not going to go away. They are going to be here, but we need to be making sure that the mechanisms are in place so that you are not made to feel that this is down to failings on your part. You are going to have days where you'll come onto an eight-hour wait, you are going to have days that the wards are extremely busy. But, it's when that is happening every day, it's happening every day to the point that where you're fearing going into work. Because you're fearing that you're going to make a mistake because you cannot deal with that workload.

CATHERINE: That must be happening quite a lot in GP at the moment though, Adam, with the pressures that are on GPs currently?

ADAM: Absolutely, I mean obviously you have the vast majority of GPs are operating at ten-minute appointments. And by then end of training you are expected to be operating at that level. And it is almost a... you feel it is a failing on your part if there are patients that are unwell who are ringing up and can't get the appointments. You feel the need to be filling every ten-minute slot of every day fitting in as many patients as you can.

But you are one person, you are one doctor and you are taking on the problems and stories of all of these patients that you're seeing on a ten-minute basis. There has to come a point part way through that day where you are beginning to not serve the patient to the best of your ability because you are fatigued, because you are feeling the pressure, because you're feeling that you're not being the best doctor you can be. And that is a self-fulfilling prophecy, that you're going to feel the same the next day and the next day until you burn out, and that is why there has to be mechanisms in place where you realise it is the system at large that has to change and it's not you that is failing.

ALICE: When you're so used to driving for excellence every single day, and every single day you don't achieve it that takes a huge toll on you and how you see yourself and how you value yourself. I think is what it boils down to for me.

CATHERINE: Doctors as, in a general sense, as a profession are a group of people that are acknowledged to be high achievers, that work incredibly hard and maintain in general a very high set of values about of what they want to deliver in terms of patient care. And in the report, I think it's referred to as moral distress that mismatch between your ability to deliver the care that you want to be able to deliver because of the pressure on you from the system, from the workload around you.

TANITA: We know that the population is getting older, more patients are presenting with comorbidities and really complex conditions. So, it doesn't seem like the workload is suddenly going to reduce any time soon. So, what do you guys think the systems that you work in could do to make things that little bit more manageable?

CATHERINE: Well clearly there's some huge recruitment drives going on in the NHS at the moment, we're aware that the NHS is short of thousands of doctors. And within each of our specialties there will be recruitment drives going on constantly.

I think though, acknowledging that, we have to look at the here and now. And the fact that we know there is a difficulty with filling the gaps in rotas and recruiting. So, there are other ways that we can look at improving our workload and workflow. An example that I've heard about in south west Wales is a system whereby, they're using technology to improve workflow. So, shared documents on computer drives whereby everyone from doctors, nurses, allied health professionals, managers can all access one live document: look at patient lists, workflow, pending discharges, shared job lists et cetera, which means that there's no duplication of work, everyone knows what's going on where. And it does and it has been shown to improve workflow within those departments.

ALICE: You're right it's all about thinking about the workload differently. And I know it's not about prioritising necessarily one service over another. But it's about thinking how can we make that as efficient as it can be? And I know in Scotland, one of the previous Scottish clinical leadership fellows, Liz, has developed a service with NHS Lanarkshire that looks at all patients referred in for hand surgery. So, they get options of self-management, they get options of physio and they get options of seeing a surgeon, rather than just going straight to see the surgeon, which led to longer waits, and then people get there, and they don't want an operation on their hand. So, she's done a lot of work around diverting workflow through enabling patients to make decisions for themselves. And that's cut down their wait times, it's cut down the number of people having unnecessary appointments. But also, it's taken a lot of creative thinking from her. So, I suppose a big part of it is giving people enough space to come up with the ideas to do things that might help us think differently, that might help us see the workload differently. And that actually gives the power back to patients, because if you give the power to patients and let them in some way self-manage or take a bit more control or have a bit more autonomy. Then actually, not everything in the world has to be done by a doctor.

ADAM: There's a really good example of a practice that I worked in a bit earlier on in my training - is this idea that everything does not need to be done by the doctor, there is a massive amount of scope for being able to identify tasks that actually other health

professionals are in just as good of a position if not a better position to look after these patients. When it comes to medication reviews increasingly pharmacists are being employed in general practices. There are, in terms of the knowledge of what the latest practice is for treating hundreds of conditions, pharmacists are actually at the frontline of that, they've got the knowledge and they are able to see patients on a regular basis to step treatment up and down. And that is being rolled out over a couple of practices I've worked at and its working really, really well.

So, I think it is going away from this, especially in primary care, going away from this old-fashioned model where you're working your way up to become the principal GP where you do absolutely everything and you are the expert on everything. It has to become more of a collaborative role, working within a multi-disciplinary team because there are patients that you're going to be best off seeing, but you can definitely lighten or spread the load between other people by just identifying the strengths of other people within your team.

ALICE: It's different experiences and expertise isn't it and how you build that, how you use that creatively, collaboratively, to make sure that everybody is doing a job that's interesting, but nobody is doing a job that's far too much.

TANITA: I think that's really fascinating and a great example of how acknowledging how everybody's competence is a really useful tool for managing workload but also for helping the patients. In other episodes we were talking about getting advice and support for your peers and from senior colleagues. What are your experiences of management and supervision? Because I think it's quite clear to people working across different professions, that the people that are supervising and managing you can have a massive impact on how competent you feel, and also on your wellbeing.

ADAM: I think as a trainee, it can't be underestimated that the quality of supervision makes or breaks your time working in a department. If you have an engaged supervisor who's passionate about the specialty that you're in, importantly remembers what it was like to be a trainee, remembers what it was like to be in your shoes, then you are much more likely to be able to imagine what it will eventually be like to be in their shoes and learn from them and they're able to impart their experience, but also, it's a two-way conversation – you are then able to tell them what it is like being a trainee now and what can be done to facilitate your time in a department.

CATHERINE: What I would say about supervision, because we've touched upon it previously in these podcasts is about how it can be formal or informal. But I think what is really important to acknowledge is that it reflects the diversity of our profession. Because supervision needs to be tailored to an individual potentially or a team itself. But it has to reflect and support the individual doctor potentially. So, there are particular doctors that may need extra support in certain areas and that might be because like myself I'm less than full time, I might need to focus specifically on specific areas. But it's that two-way relationship and being able to have an honest conversation that has sometimes been lacking in medical training and is acknowledged in this review.

ALICE: I've been lucky enough, so, in my deanery I have what's called cradle to grave supervision. I have one consultant who's looked after me over a number of years. What she will do is, sits me down, she makes me a cup of tea and she will just wait for me to reflect on all the different bits of feedback, all the different things that are going on and all the things we are going to talk about. And actually, having that ability to reflect, and a bit of mentoring and a bit of guided discussion about where you want to go, where you want to take things is hugely valuable. So, management supervision, when it's done well, when it gives you the space to direct things, to reflect, to learn things from your experiences is of great value, but when it's done badly it is hugely damaging.

ADAM: I think what you say is extremely, extremely important. I think we are guilty in the medical profession, that just because we become consultants it automatically means that we are excellent educators, excellent leaders, excellent managers and if it's not actually built into your training, you know, factors that are going to help you equip yourself for the skills that are needed to be an effective educator, to be an effective leader and manager. Then I just think that, hoping that this diverse group of people as you say are all going to come out with exactly the same skills at being excellent doing what they do, I think that's really quite naïve.

TANITA: I wondered what you thought more generally about the role of training in wellbeing. And if there are any changes to the way we currently train doctors in the UK that you think might help prevent poor wellbeing in the first place?

CATHERINE: One aspect that I think that we've picked up on with this review is that it's about future-proofing our medical workforce, and that has to go right back to medical students and how medical students' wellbeing is acknowledged and how medical students are able to be supported when they go on to the wards. And see the things that they may see, which is so novel to them as individuals.

ALICE: I know when I was at medical school, I was quite lucky because Steve Peters, who was the Olympic psychiatrist, was Undergrad Dean at Sheffield at the time. So, we got some training from him around the chimp theory, which is really about how to manage yourself and how to know when you're not working effectively and know what you need to do when that's happening. And that was something that's really helped me be more efficient around exam times and not flung yourself to oblivion. It's, it's helped me work more effectively and it's helped me know when I'm not being effective.

But, I know we've talked about this a bit, sometimes it's quite challenging even when you know you're not being effective and when you know you're not working well in the workplace to say actually I'm taking ten minutes time out, because it doesn't feel if there is ten minutes to take. So, I feel like there is a lot to be said for training people and those techniques to say how can you protect yourself, how can you recognise when you're working well, what should you do when you feel that's happening, how can you help build your resilience. But there needs to be a system in place to say actually it's okay to take ten minutes out, it's okay to go and do something different for a period of time and if you recognise this it's okay to talk about it, which maybe doesn't currently exist. I know

thinking about training as well, both of you have come from portfolio careers, so one career to the other and flexibility and that's something that comes out a lot in this review.

ADAM: Absolutely, I think you know currently and in the recent past training is a very rigid structure. You're expected to get on at one end of a treadmill and you're supposed to stick on that without any deviation and get out the other end as a formed consultant. And you can see in terms of delivering a workforce, why that is a model that people have thought is the way to do things. But I think, as you say Catherine to future proof it, you have to realise that everyone's lives, every person who doing general practice training or every person who's becoming a general surgeon cannot follow exactly the same path and shoe horn their lives into that.

There has to be a culture where going less than full time is not seen as an inconvenience, is not discouraged because it doesn't fit well with the way the workforce is being planned. People should be encouraged to take career breaks to explore areas of their interest. People should not feel that they are going to be heavily penalised for going 'do you know what I made a mistake I'm part way down a career path and I don't want to carry on with it. I know I've learnt about myself a lot more, I've identified my strengths would be a lot better doing something different.'

I started off in surgical training and I'm now in general practice and that's because I feel that I got to learn a lot more about myself and I am definitely much more of a generalist than I thought. And actually, general practice allows me to explore other avenues that interest me to do my career, not purely the clinical work. And I think that we need to be moving to more flexible training where people can get away from this old snakes and ladders approach where if you are going to change your mind that you're not immediately bumped right back to the bottom or the start of a career path and have to almost start from scratch.

CATHERINE: Yeah, I agree with you Adam because personally I've come on a long journey through my training. I was an Anaesthetics and Acute Care Common Stem trainee and then I along the way again found that I had reasons to switch to a different career and went into psychiatry. What happened to me was, in some way there was some value in what happened though, because I think that I was able to move across into a career where some of these skills that I picked up on some of the core skills that I had learnt in anaesthetics, actually, weirdly enough were directly transferable to psychiatry. Some of those key very difficult conversations that you might have to have in anaesthetics, they're there in psychiatry every single day. The in-depth knowledge of pharmaceuticals and pharmacology, it's there in psychiatry every single day. And I think that, as you say, valuing people that move potentially in a different direction through their career and looking at the skills that they bring to their new place of work has to be something that we accept and look at and value.

ADAM: You need to be made feel that you're not being a nuisance, that you're not doing something that is harmful to your career by making that change. You know, we have to facilitate that this is something that should be encouraged because, especially going into

general practice, all the stuff I've done in the past it's not a waste of my time, they are all skills that I've taken on and deliver on a daily basis in my new career.

TANITA: So, I wanted to just kind of just step back a little bit now as this is the end of the series. We've talked a lot about Michael West's report and the key findings and the recommendations. But I just wanted to hear from you, your final sort of takeaways from the report and also from our conversations that we've had about it?

ALICE; I think my takeaway is that wellbeing is something that I've always been aware of, always thought of as important. But what this report really says to me is I go to work because I want to help patients. If I don't prioritise my wellbeing and the wellbeing of those around me, I'm directly harming my patients, so this is something I have to prioritise to keep my patients safe. And that message has really struck home for me.

ADAM: I agree with you Alice, you know wellbeing is not a luxury, wellbeing is not an option. I think wellbeing is something that needs to be taken seriously, that there needs to be mechanisms put into place to allow people to take care of their own wellbeing. Because without being able to do that, as Alice said, we are not operating to the best of our ability, but the patients, that are the whole reason that we are there to look after, stand to directly harm.

CATHERINE: I'd like to, it's not really my view here but finish perhaps on a quote from somebody that I think we as a group admire. To quote, Professor Dame Jane Dacre, former Royal College of Physicians President: 'Doctors deal with death, emergency and other people's misfortunes on a daily basis. They save lives. Somebody needs to start thinking about saving them.'

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.