Professional Wellbeing Work Party of WFSA: it is time to reflect and do something about the anesthesiologist's occupational health

Gastão F. Duval Neto (Brasil)
Chair of the Professional Wellbeing Work Party of WFSA
Member of the Executive Committee of WFSA

Members of the PWWP

- Francis Bonnet (France)
- Steve Howard (USA)
- Pratyush Gupta (India)
- Olli Meretoja (Finland)
- Roger Moore (USA)
- Max-André Doppia (France)

The nature and intensity of the work performed by anesthesiologists has been transformed dramatically over the past few decades. The advent of new technologies has expanded the surgical horizon, but also has allowed the intervention for much more challenging medical conditions. In association with more difficult case loads are the pressures of increased economic competitiveness, and the need to do more with a downsized workforce. All this transformation has impacted the occupational wellbeing of the anesthesiologist. Occupational wellbeing is a reflection of job satisfaction, leading to enrichment in our entire life. Finding a healthy way to integrate work into our life in such a way that provides balance and personal satisfaction will lead to enhanced overall wellbeing.

Current epidemiological studies on physicians' occupational health have mainly focused on the detection and analysis of the prevalence of somatic and/or psychological pathologies, such as degenerative, cardiovascular, toxic and infectious pathologies, fatigue, burnout, depression and chemical dependency (1, 2). On the other hand, it is very evident how little has been done regarding the prevention of these adverse occupational health issues and the ongoing

maintenance of physicians' occupational wellbeing. The need for prevention is underlined by the increased risks that exist for anesthesiologists, a known vulnerable group.

Recently, in the area of the anesthesiologist's occupational health, knowledge about the risks of somatic and/or psychological pathologies exacerbated by the stresses of the clinical practice, has improved the diagnosis, prevention, and management of these adverse conditions (3, 4). However, it is still very important that anesthesiologists be informed about the aspects of their practices that produce the most stress and to provide direction as to how better working conditions could be established. Such need for such improvements becomes more evident in light of whether supportive systems have been established for impaired anesthesiologist by professional associations, state, or governmental organizations.

An example system of support for clinician wellbeing

A careful analysis of information concerning physician's occupational health, particularly for anesthesiologists, leads to the very disturbing and even alarming conclusion that such support systems are rarely present. Information provided through a recognizably competent support system, the Canadian Physician's Health Service, during 2002, can provide some guidance: The OMA Physician Health Program is a Canadian confidential service that provides assistance for the physician who suffers from occupational pathologies (Fig. 1). The Canadian Medical Association Center for Physician Health and Occupational Wellbeing, an institution that has conferred higher credibility and effectiveness to the OMA's activities and claims, was created in 2000.

FIGURE 1

Epidemiological data documented by OMA show increased psychopathological diseases related to the medical practice (job-related) when compared to strictly somatic occupational pathologies resulting from such problems as infections, irradiations, contaminations or gas inhalations.

Based on the attention paid to the physician's occupational health and wellbeing in Canada, Dr. Michael Myers, a clinical professor of Psychiatry, University of British Columbia, has edited a book through the Canadian Medical Association warning about risk factors of occupational pathologies, as well as funding sources for their diagnosis, treatment and support in Canada (5).

Specific risks

Current characteristics inherent to anesthesiology practice may result in certain correlations with psychological pathologies. The emerging risks of acute and chronic fatigue and high levels of occupational stress, need to be highlighted during both staff anesthesiologists' clinical practice and training programs of residents.

Prof. Olli Meretoja published a recent article "We should work less at night" (6). His conclusion was: "*There is growing amount of evidence that doctors' performance is poorer if they work for over-prolonged duties or at night. These working patterns decrease the standard of care and increase the health care expenses. Furthermore, night workers have serious health risks due to their non physiological work shifts. Effective ways to reduce the overall consequences of fatigue and night work include minimizing the amount of work carried out at nighttime and setting up rules for maximal hours for each work shift.*"

In Brazil, the managing department of drug addict physicians (Uniad) of the São Paolo's Medical School has presented a recent casuistry, shown in Table 1, including 57 anesthesiologists with clinical evidences of chemical addiction. The agents most frequently used were opioids (53%), benzodiazepines (30%), and alcohol (23%). Chemical dependency mainly to opioid drugs, significantly increases the difficulty of providing effective rehabilitation treatment, mainly due to the high risk of relapse and the associated risk of death by suicide or overdosing. Another rehabilitation difficulty faced by anesthesiologists addicted to opioids is the relatively greater availability and ease of diversion in operating theatre, recovery rooms and post anesthesia care units.

TABLE 1

Table 2 shows the frequency of psychiatric co-morbidities among the above chemically dependent anesthesiologists. As has been pointed out before, there is a relationship between psychogenic pathologies developed during the practice of anesthesiology (fatigue, depression, burnout, etc) and the chemical dependency syndrome. During training, the medical professional should be made aware of the risk of death with addiction. This is particularly true for resident trainees who are at increased risk for developing drug dependency. Recently, Collins et al.

analyzed all American anesthesia residents during a ten year period and found that 70 % of chemically dependent residents could return to medicine after a successful treatment program (7). However, only 60 % of those who returned to medicine could successfully continue in anesthesia and even 9 % of them experienced early death. The authors conclude that chemically dependent anesthesia resident may show best outcome if they select a lower-risk specialty.

TABLE 2

Prof. Francis Bonnet and his colleagues published a national survey concerning the incidence of addiction among French anesthesiologists (8). They documented that 11 % of anesthesiologists who responded were abusers or dependent to one or more substances other than tobacco. The substances used most frequently were alcohol (in 59%) and tranquillizers and hypnotics (in 41%). Increasing age increased the incidence of abuse. Addicted subjects reported issues in their work environment that may have contributed to the development of their pathology.

The burnout syndrome is a well defined medical condition, characterized by emotional exhaustion, depersonalization and diminished personal accomplishment (9). Emotional exhaustion represents the emotional depletion of an individual, and it is considered the syndrome's initial trait resulting mainly from excessive job demands and personal conflicts in interpersonal relationships, as well as from the accomplishment of professional duties. Depersonalization is characterized by health care provider's emotional insensibility. The appearance of this symptom is essential to the diagnosis of the burnout syndrome, since the other features can be found in depressive cases in general. Ultimately, the feeling of diminished personal accomplishment (or incompetence) revealed a negative self-evaluation associated to a lack of satisfaction and unhappiness at work.

Professor De Keyser and her group of work psychologists and anesthesiologists from the University of Liège in Belgium have shown a high incidence of the Burnout syndrome in Belgian anesthesiologists, especially young professionals before the age of 30 (10). There is a special concern about young residents, involved in educational training, where workload and occupational stress is sometimes excessive due to a lack of professional experience. In addition,

some trainees unfortunately make a shift from recreational consumption of addictive agents to substance abuse as a way to cope with difficult situations. Eventually, the health care provider's addiction jeopardizes the patient safety.

Another factor that impairs safety of anesthesia practice, is the presence of sleep deprivation and fatigue in anesthesiologists. There is growing amount of evidence that work slows and becomes more erroneous in work done by fatigued anesthesiologist as compared to a well rested colleague (11-14).

Concern about physician's occupational health has increased during the last two decades. One of the first papers on this topic was published in the BMJ and in the Western J Med. These papers emphasized that even 46 % of all Canadian physicians had advanced state of a Burnout Syndrome (15).

The current reality shows, with no doubt whatsoever, an exacerbated tendency toward the development of somatic and psychogenic pathologies with an occupational etiology. Possibilities of developing attitudes that protect health care providers' physical and mental health have been presented. Another approach option would be to foster systems that support the anesthesiologist's health by establishing institutional and governmental policies to prevent occupational disease. This premise can be simplified in the title of an editorial of BMJ written by Dr. Gavin Yamey "We should move away from a disease model and focus on positive function" (16).

The Brazilian Society of Anesthesiology (BSA) has a growing interest in anesthesiologist's occupational health since 2000. BSA has tried to understand, alert, and influence the kind of situations that have significant importance in an anesthesiologist's life. The actions that were developed were supported by the Occupational Health Committee of the BSA and the World Federation of Societies of Anesthesiologists (WFSA) along with its Professional Wellbeing Work Party (PWWP). BSA's Occupational Health Committee has developed epidemiological research, together with Prof. Isabelle Hansez of the Department of Work Psychology in University of Liège, Belgium, that aim to evaluate the level of occupational stress and the degree of adaptability to the residents' work conditions and their preceptors in the BSA and Education Govern Center's Teaching and Clinical Training Program. The key results of this work is summarized in Table 3.

TABLE 3

In Spring 2010, the Professional Wellbeing Work Party of the WFSA carried out research involving the 120 member societies from this organization by using a questionnaire that aimed at identifying the incidence level of occupational health problems amongst members of the particular society and approaches used by these societies to address anesthesiologist's occupational health.

The results show that more than 90 % of the National Societies considered the Burnout syndrome as a causative problem but only 14 % had developed any kind of coping strategy for this syndrome. The PWWP of the WFSA has organized a special symposium on this topic during the next World Congress of Anesthesiologists in Buenos Aires in 2012.

Jenny Firth-Cozens, special adviser on modernization of postgraduate education, synthesizes in an editorial of BMJ "Doctors, their wellbeing, and their stress. It's time to be proactive about stress - and prevent it" our feelings concerning the attitude towards the anesthesiologists' occupational wellbeing situations (17). She concludes her text in a sentence "*Stress is here to stay and the sooner we accept that tackling it is a normal part of management, and an essential part of patient safety, the sooner the lives of doctors and their patients will improve*."

The organizations involved with medical education and/or with medical practice need to understand that the consequences of physician and resident occupational ill-health result not only in worrisome changes in the anesthesiologist's somatic and psychological health, but also, impair medical safety practices concerning both anesthesiologist and patients while ultimately increasing the cost of health care.

We need to be more aggressive in providing formal education about occupational hazards that may impair physicians' health and well being, since we know that these hazards for the physician may also have serious consequences for patient safety. Nationwide policies to prevent and manage the burn out syndrome and related pathologies for health care providers need should also be developed.

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