After Mid Staffs: NHS must look to care of its own staff

NHS staff can be brutalised by severe pressure of work, which is exacerbated by the poor management exemplified by Mid Staffs, an anonymous occupational health physician believes

I worked for many years in several NHS trusts before the problems at Mid Staffordshire emerged. I was a consultant occupational physician, tasked with looking after the health and welfare of some 12 000 NHS staff. Other consultant NHS physicians I have met have had similar experiences.

I came to the NHS as an outsider, having trained and specialised in occupational medicine abroad. The first post I held in occupational medicine in the UK, while undertaking training for membership of the faculty, was in industry. I found that line managers in engineering regarded the workforce in a similar way to how they view other parts of the production process: if someone was getting worn out or damaged, then the underlying cause should be fixed to prevent it happening again. Although they were not happy to see reports on new cases of work related ill health, they saw them as just as necessary as the plant engineer's report on machine maintenance.

When I started working in the NHS I was taken aback by the resentment and anger that staff expressed toward their employer. However, their feelings became understandable when I tried to present anonymised statistics about work related ill health to management, as I had done in industry. Managers saw my reports as likely to cause them trouble and to provide ammunition for staff who were thinking of making compensation claims. I was told that no other NHS occupational health department produced such reports, and they were "filed" in the bin. NHS managers seemed not to understand that it had a duty to protect its staff from the pressures of work. This was a callous disregard for staff wellbeing.

As I persisted in trying to get trusts to tackle this problem over several years, I was investigated for spurious reasons such as "not getting on with others" and had to leave my position with a pay-off and a gagging clause. I have applied for six other consultant posts in the NHS since. On each occasion I have been interviewed but failed to secure the post for unexplained reasons.

After leaving the NHS I analysed national statistics to see how work related ill health in healthcare staff compared with that in workers in other industries. What I found confirmed my impression that work related ill health was worse in the NHS. I presented a paper on this topic at a conference in the early 2000s. It was recorded in the proceedings, which were brought to the attention of the Health and Safety Executive, with no response to tackling the causes.

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I found that healthcare workers were some 70% more likely to have developed work related stress, depression, or anxiety than was the general workforce at that time (146/7056 (2.1%) *v* 818/63179 (1.3%) cases; odds ratio 1.77 (95% confidence interval 1.48 to 2.12)).[1] This odds ratio has worsened since then, and it is now 2.10: the 2012 prevalence of work related mental health problems in health professionals was 110% higher than in the general workforce, as shown in recent government statistics (2560 *v* 1220 per 100 000 employees).[2] Why is this?

Firstly, the NHS is a labour intensive industry that is not easily mechanised. Manual handling while maintaining patient dignity in often cramped conditions and under time pressure is difficult. The environment is highly emotive, with near limitless demands but finite resources.

Secondly, there were more occupational health resources available in industry compared with the NHS, despite a much higher requirement in the NHS—such as for immunisations and dealing with exposure to body fluids. For example, when I worked in industry there was one occupational health physician for every 7000 employees, compared with one for every 11 000 employees in the NHS; and there was one occupational health nurse for every 1000 industry employees but one for every 2700 NHS employees (personal observations).

The 2009 Boorman report into what health interventions would improve the wellbeing of NHS staff was a lost opportunity.[3] The recommendations dealt only with the need to tackle staff sickness absences and with providing counselling and lifestyle changes, none of which have credible evidence bases. Tackling the underlying causes of ill health (understaffing, poor people management, inappropriate targets) was not emphasised.

Thirdly, in most organisations occupational physicians can appeal to senior management's altruism to try to obtain resources to promote employee health and welfare. This does not work when you are directly competing with the urgent needs of ill patients and with ongoing government initiatives to reduce waiting lists.

Fourthly, in the NHS trusts in which I worked, responsibilities for overseeing safe working practices were not delegated to people who had the necessary authority. The board did not consider any statistics related to work-related ill health; no director was held responsible.

Fifthly, after working in these trusts for several years I realised that most senior managers moved to new positions in three to four years. Managers seemed prepared to take the chance that they would not be in post when the results of their decisions became apparent.

Sixthly, the ability of an organisation to learn from its mistakes and take corrective action to prevent recurrence is essential for its survival. When shown evidence of escalating cases of work related ill health, senior NHS managers usually put the increase down to greater awareness of cases. No action was taken to prevent recurrence. Eventually, the bearer of bad news was shot.

NHS managers have not grasped the enormity of this waste. Work related ill health leads not only to the loss of staff who provide services but also to then having to treat them as patients. The factors I have identified have led to the brutalisation of some NHS staff so that they no longer respond appropriately to distress in their patients, as recorded in the inquiry in what happened at Mid Staffs. If we wish healthcare staff to behave with compassion they must be treated with such.

References are in the version on bmj.com.

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FROM THE FRONTLINE **Des Spence**

Scrap the royal colleges' fellowships

We are all a product of our time, a morass of contradictions, conflicts, and prejudices. I was raised on a isolated Scottish island, attended a comprehensive school, and worked in many different jobs. I pride myself on my ordinariness and the ordinariness of my medical work. Egalitarianism is branded in my psyche. I am intent on never appearing intimidated—even when I am. I am respectful but not deferential. I dislike titles, including "Doctor," reasoning that these are merely a weapon of intimidation. Success and contentment are not in the gift of others, or possessions, but a purely personal perspective.

So I have mixed emotions towards honours, knighthoods, and the rest. These are from a class ridden past, mere baubles designed to affirm separation and superiority. Today honours strive to be more egalitarian, with the odd postal worker and teacher recognised for their daily dedication. But honours are still part political patronage, closed but to a select elite few. It is the powerful and privileged, not the hardworking teacher, who have the highest honour of falling asleep in ermine and claiming expenses in the House of Lords.

They are a product of yesteryear's deference, club mentality, and divisiveness, celebrating superiority and elitism, and they reinforce hierarchy

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What of medical gongs, the "fellowships" to the medical royal colleges, presented in gowns at ceremonies with curling cucumber sandwiches? Doctors are awarded these through nomination by colleagues and subject to committee review. Fellowships are seen as a tradition—harmless and an important recognition of hard work and commitment.

I am not angry that I have never been nominated (or perhaps I am just in denial). But aren't fellowships outdated, just like those badly painted portraits of past presidents, all looking the same irrespective of sex, hanging on the college walls? They are a product of yesteryear's deference, club mentality, and divisiveness, celebrating superiority and elitism, and they reinforce hierarchy.

Some doctors also complain that those who pursue their medical careers often do so to the detriment of their colleagues who are left holding the on-call pager. Some even suggest that fellowships are a cynical conspiracy to make money by preying on middle aged insecurity. A fellowship of the Royal College of General Practitioners, for example, costs £620 along with some truly dreadful but expensive polyester merchandising tat. The bottom line is that many ordinary, hard working consultants and general practitioners never receive a gong or recognition.

What value do fellowships add to the profession? Aren't fellowships a potential barrier to challenging authority and the establishment? Isn't it time to review our medical honours system?

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LAYING FOUNDATIONS **Oliver Ellis**

On first name terms

My first proper job was as a salesman at a big chain of electrical shops. During my induction the manager introduced himself as John Clark. I had just left school, and my only retail experience was from watching reruns of the 1970s British sitcoms *Are You Being Served* and *Open All Hours*, so I had no idea whether I should call him John or Mr Clark. I spent the next week addressing him as "Excuse me" and desperately listening out for cues from my colleagues.

Seven months into my first job as a doctor, and after six years of medical school, I still feel a bit uncomfortable about how to address my seniors—especially consultants. To my ear, calling doctors by their surnames has a whiff of *Are You Being Served*. But calling consultants by their first name, without first being explicitly invited to, would be unthinkable.

I've recently been experimenting with "Boss." It does make me sound a bit like a doomed henchman in a 1980s action movie but has the advantage of having just one syllable and being a bit less stuffy.

The world has become a less formal place. Politicians don't wear ties, gardeners don't doff their caps, and people use first names.

What patients and doctors call each other is a different matter. Many patients prefer to use surnames.

But when patients aren't in the room, why can't our interactions catch up with the rest of the world?

As a medical student I was once given a comprehensive telling off for the way I was standing. "When you present a patient, stand up straight, feet a shoulder width apart, hands behind your back." Stand at ease, in other words, which was odd, because I had no memory of ever joining the army.

Doctors are increasingly recognised not to be gods. So many scandals and screw ups could have been averted if juniors had had the courage to challenge what they were being told. Perhaps more commonly, being able to question your senior's clinical reasoning helps you to learn why they are doing what they are doing. Getting rid of the rigid interpersonal hierarchy can only help this happen.

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Of course, the boss still makes the final call. But your seniors derive their authority from their experience and knowledge, not from outdated etiquette. The few consultants I have known who preferred to be called by their first names still had the full respect of their juniors.

So let's be on first name terms. It'll make work a nicer place, and it might make medicine better.

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