Supporting a colleague in difficulty

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For many doctors, a new year brings new roles or new teams. Relationships are developed, and responsibilities for colleagues can increase. This is particularly true for doctors in training, who may be stepping up to registrar level, bringing supervision responsibilities for earlier-career doctors, and more contact with senior members of the team.

At this time of year, I'm grateful for the opportunity to speak with registrars across different hospitals as part of the various Step Up to Registrar days, providing a framework for identifying and supporting colleagues in difficulty – developed from evidence, expert consensus, and experience from speaking with doctors through the DHASWA 24/7 Advice Line.

Identifying colleagues in distress

Doctors in difficulty may self-identify, seeking out another doctor for support or approaching their hospital's doctor-support team. We can anticipate difficulty after clinical incidents with adverse outcomes, after complaint or moral injury.

We may see changes in behaviour: a change in character or **how** they work; a change in presence or **whether** they work; a change in function or **how well** they work.

The change in character may be emotions close to the surface: tearfulness, anxiety, irritability, anger; disproportionate responses to stressors; or decreased empathy or humour. The key here is a change in baseline behaviour – easy enough to detect with longstanding colleagues, but difficult when a doctor is new to the team; a reminder of the value of forging connections with new colleagues.

We may see a change in presence: lateness, frequent unplanned leave, or unpredictable separation from the team in the workday.

We may notice a change in their rate or quality of decisions and output. This can be frustrating for the team who carry more load; it's important to acknowledge frustration but also allow one's intrinsic compassion to surface. Behaviour is communication, and commonly doctors in difficulty have multiple contributing factors resulting in the behaviour – some outside their control or not visible to colleagues.

First-line management of doctors in distress

Whether and when to intervene depends on distress levels, the doctor's wishes, and risk to patients, colleagues or the doctor themselves. This is a peer-to-peer discussion; responsibility for clinical care lies elsewhere. The goals are to identify risk, identify level of insight, and to obtain consensus on help-seeking.

The conversation needs to be at the right time (not time-pressured), right place (private), right person (trustworthy, with some existing rapport). Respectful persistence is a good approach, and the C's model helps if there is resistance:

- *It's pretty **common** to be struggling... every doctor I know has been in this position at some point.*
- *I'm **curious** about what you said just now.*
- *I'm really **concerned** about what might be going on for you.*
- *I'm **confused** by you saying you're fine while you don't seem your usual self.*

On the 'do not do' list are:

- using many examples of behaviour – this is not performance management;
- gathering information from a wide range of people;
- managing them clinically;
- sharing your own story at length; and
- sharing to others without direct supervisory or pastoral responsibility.

Depending on insight and rapport, you might suggest:

- medical help: their GP (or DHASWA);
- hospital help: PGME/MEU;
- psychological help: the concept of talking to someone (their GP or DHASWA can make arrangements);
- informal help: people who can check in on them; and
- basic kindness to self with attention to physiological needs.

Risk to patients, colleagues or the doctor is a flag to escalate concerns to those with direct supervisory or pastoral responsibility for the doctor, your own supervisor, or doctor-support service.

Thank you, and best of luck to all the doctors stepping up this year. ■

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