



Psychosocial hazards as a doctor

Dr Rosalind Forward

Advisory Committee Member

Doctors' Health Advisory Service Western Australia (DHASWA)

Prior to becoming a doctor, I used to work as a WorkSafe WA Inspector – so I often think about health and safety. However, recently, when my (non-medical) husband's workplace had a visit from WorkSafe, he was really surprised by their focus on psychosocial hazards, and this made me wonder how many doctors are aware of psychosocial hazards in the workplace. How many organisations have them in their risk management plan, and how do we manage them?

SafeWork Australia defines a psychosocial hazard as "anything that could cause psychological harm (e.g. harm someone's mental health)".¹ Some examples include job demands, poor support, poor organisational change management, inadequate reward and recognition, traumatic events or material, remote or isolated work, violence and aggression, bullying, harassment, conflict or poor workplace relationships and interactions. As I read through these, I identified many of these in both my current workplace (as a GP) and in previous workplaces, especially in hospitals.

We often think of psychosocial hazards in terms of patient aggression and vicarious trauma. Medical school, specialty training colleges and training programs help (to varying effects) prepare us for some of these – but there are many other hazards we have to learn to deal with on our own.

How can you manage the stress related to not knowing your roster (with the inability to plan supports in advance) or manage imposter syndrome? Another common unidentified hazard is the one related to collegial conflict – such as with peers, nurses, bosses, juniors or admin.

These are all examples of psychosocial hazards we may face along our careers. But what can we do about these hazards, and how can we reduce the risk to our mental (and physical) health?

We've all heard the saying, 'you just need to be more resilient', and seen various programs to this effect; but that is only one control.

WorkSafe WA have produced a Code of Practice which encourages organisations (and individuals) to manage psychosocial hazards like any other – using the hierarchy of control – elimination followed by risk minimisation (engineering, substitution, isolation) and administrative procedures/policies and personal protective equipment (PPE) controls.²

It's really nice to see a significant focus on leadership, supervision and workplace culture. So, it's not just up to an individual to be 'resilient'. We all know that night shift is much less scary when the registrar or consultant on duty is kind or understanding. We all respond so much better when there's a little bit of flexibility in rosters or leave.

Let's review an example – the feeling of isolation (whether in a GP setting, in a rural location or on night shift). Can we

eliminate this? In some settings, yes – having two people on would help. But in many situations, it's not possible (or cost-effective) to have two doctors on.

So next, can we minimise this risk? Again, in some settings, yes – having a nurse on duty helps to have another person to run ideas past; or are there seniors or other juniors on duty who can support one another (or available at the end of the phone)? For this to be effective, we need to make sure these people are accessible, which is where administrative controls come in.



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It's not practical to have two people do every task – but often juniors are too afraid to contact their seniors (or are worried about what they would think). So why can't we establish set follow-up periods – e.g. on nightshift (the consultant or registrar) calling in at the start of shift (so at a bare minimum, they know who is there) at 11pm, and then again at 4 or 5am, to touch base and see how they are going. And then clarify that it's ok if they need to call overnight, and in what circumstances you want them to call you (e.g. resus, met call).

Another example is a support log (i.e. a list of names of people to call if help is needed, e.g. cannulation nurses, ED number). Similarly, in the big hospitals, if there are several juniors or seniors, each with their night task list, letting their peers and seniors see where they are up to and how many tasks they have outstanding so they can help each other.

In a general practice setting – sitting in your office and wondering if you're making the right decision can be quite isolating (especially for new registrars, or new employees) and having regular (but dedicated) check-in times (e.g. morning tea, lunch, staff meetings) where colleagues and

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registrars run non-urgent cases past each other and seek some feedback; and making this the norm.

I learn so much from my medical students and registrars that even now, as a fellowed GP, it reduces my isolation. Setting up this healthy and collaborative culture is what the Code of Practice is referring to – and it can make the difference between a safe and unsafe workplace in relation to psychosocial (and medical) management.

So, if you haven't thought about psychosocial hazards or risk management, it's probably time you do. Let's shift the focus from being 'resilient individuals' to having safe work systems and safe cultures. ■

USEFUL RESOURCES:

1. SafeWork Australia (2022) **Model Code of Practice: Managing psychosocial hazards at work:** safeworkaustralia.gov.au/doc/model-code-practice-managing-psychosocial-hazards-work
2. WorkSafe WA (2022) **Psychosocial hazards in the workplace: Code of practice:** worksafe.wa.gov.au/publications/code-practice-psychosocial-hazards-workplace