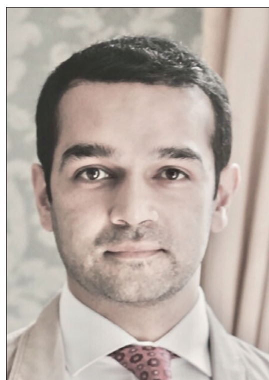
# Yonder



Yonder: a diverse selection of primary care relevant research stories from beyond the mainstream biomedical literature

## Burnout leave, asthma, Option Grids, and medicolegal risks

*Burnout leave.* Given that people's professional lives are so closely linked to their personal identities, it comes as little surprise that social scientists are so fascinated by what happens when individuals go on sick leave. When the cause of the sick leave is burnout, which is a contentious concept in itself, the legitimacy of the sick leave comes under further challenge. A recent Finnish study explored how sick leave was explained and justified in narrative accounts by burnout sufferers.[1] It found that sick leave involves negotiation of one's status and worth in the categories of 'respectable employee' and 'credible patient'. A transition to sick leave requires causal explanations of burnout, which aim to legitimise ill-being. The authors state that by making explicit the moral ambiguities of sick leave, their research findings could help healthcare practitioners to increase their understanding of why staying on sick leave is difficult both psychologically and socially for employees.

*Asthma.* Although there is a never-ending debate in the scientific community about the relative importance of diet and exercise in rising obesity levels, it's pretty clear that the children of today aren't as active as they could be, and that increasing physical activity levels would be good for them. A number of studies have previously shown that asthmatic children seem to be particularly inactive, and a recent New York-based research study sought to understand why this might be the case.[2] Through interviewing parents of inner-city children with asthma, they found that parental fear of exercise-induced symptoms, challenges with asthma management, unsafe neighbourhoods, and a lack of school engagement and facilities were all key reasons. As is so often the case, the barriers are complex and lie in sectors outside of health care. School and community stakeholders, in particular, need to step up.

*Option Grids.* Although few clinicians or patients would challenge the idea that shared decision making is the best way to make clinical management plans, it's not always easy to implement with the constraints of the modern healthcare system. Tools used in clinical encounters to illustrate benefits and harms of treatment options seem to be what are needed. Option Grids are an example of such a tool and are essentially one-page summary tables that facilitate rapid comparisons of options using questions that patients frequently ask. A recent UK study examined NHS clinicians' views about the use of an Option Grid for knee osteoarthritis.[3] They found that after experiencing the use of Option Grids, clinicians became more willing to use the tools in their clinical encounters with patients. Given that healthcare systems around the world are so overstretched, the authors conclude that tools which have been designed to fit smoothly into existing work patterns have a higher chance of being adopted widely.

*Medicolegal risks.* The Medical Protection Society (MPS) is a membership organisation that provides access to expert advice and support together with the right to request indemnity for complaints or claims arising from professional practice. Doctors with significantly more medicolegal cases than their peers are identified and reviewed by the MPS, and often selected to participate in a risk education programme. A recent MPS study sought to explore participating doctors' views of their experiences of this process.[4] Of the 20 participants, 19 were male, and 16 were GPs. Three key themes were generated: personal and professional impacts and actions (for example, doctor has acted to reduce clinical workload); comprehension and validity of the intervention (for example, risks were related to wider patient management); and feedback and proposals (for example, the supportive nature of the intervention should be clear from the start). Although the study identified some potential improvements to the intervention, the authors conclude that, for most doctors, participation led to some positive professional behaviour changes, and improvements in practice processes and personal wellbeing.

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