Preventing Physician Burnout by Providing Support During Crisis

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My name is Stacy Norrell, M.D., and it happened to me.

I was in our inpatient G.I. lab. We've all been there: fast-paced procedures often performed on critically ill patients. This patient was not the sickest among these. She was a 46-year-old presenting for PEG placement. We reviewed her health history and discussed her anesthetic concerns. I was well prepared for the case and was present in its entirety. As the gastroenterologist was removing the scope at the end of the procedure, I stepped out of the room, leaving a very capable advanced practice provider with the patient. I was gone for less than one minute when I heard an overhead call for help. The patient was bradycardic. I sprang into action. We were immediately in the throes of a code blue. I had plenty of help within minutes of the code being called. We did everything. After about 30 minutes, the patient's sister was made available for me to give her an update and to explain what had occurred. The patient suffered a massive pulmonary embolism and was unable to be revived. It was not preventable. This is unequivocally the worst part of our jobs. How do you break this news? How do you explain what has transpired to a family? How can you then, in nearly the same breath, ask this person to let their loved one go? How does the provider cope?

Clinical work in anesthesiology involves regular exposure to trauma, loss, injury and undesirable patient outcomes. As many as one in nine hospitalized patients are harmed by the health care they receive.[1] Undeniably, these adverse events can cause harm to the patient and their families. Oftentimes, an emotional burden is placed on the involved providers who may be ridiculed or even blamed for the adverse event. This is called the second victim phenomenon. It is estimated that one-half of all health care providers have been a second victim during their professional careers.[2,7] Feelings of guilt, shame, grief and sadness impart trauma and stress on the provider. Potential lasting consequences for the provider can include harm to their future patients secondary to distraction, loss of confidence in procedural abilities or decision-making capabilities, and even potential under-reporting of future complications. Furthermore, the second victim is at risk for clinical depression, anxiety and possible resignation from clinical duty secondary to the overwhelming burden they feel.

Both authors can attest to having been second victims at one point in our careers after unpreventable, adverse intra-operative events. At times, we have been saddened and felt helpless because, despite our best clinical efforts, sometimes patients succumb to their illnesses. This can be especially distressing after one has formed a relationship with the patient, parent and/or family. Thankfully, we had supportive clinical networks that offered time and guidance to process these events and learn from them.

The first step toward reducing the occurrence of adverse events and improving patient safety is to identify system-based errors, education-related deficiencies and other shortcomings that contributed to the error. Investigation of causality should include review of the possible role that excessive workload, staff shortages, simultaneous supervision of multiple complex locations and fatigue could have played in the occurrence. These factors can be distracting and stress-inducing. The second step is to mitigate the blame culture

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and instead create a culture of support that promotes competence and confidence.[3] The severity of the harm to the clinician can be lessened by altering the investigative process. Investigations should focus on constructive criticism and process improvement instead of being solely punitive.

In reality, as in the case presented, some undesirable events are out of our control. Most anesthesiologists readily comprehend this aspect of clinical practice but feel little comfort in the aftermath. Gawande found that half of all surgical adverse events are preventable, necessitating that half are not.[4] Almost six percent of surgical adverse events resulted in the death of a patient.[4] This is a heavy burden for perioperative physicians to bear, given the increased incidence of exposure. As a specialty, we must improve how we deal with patient morbidity and mortality by enabling healthy processes for discovery and recovery, and discouraging fears of repercussion.

Our institution has specifically taken measures to reduce the burden of exposure following adverse outcomes by creating a Perioperative Anesthesia-Crisis Response Team, or PART. PART serves the entire department of anesthesiology, including physicians, anesthesiologist assistants, nurse anesthetists, residents and students. The team meets with individuals who have experienced an adverse intraoperative event to discuss the critical incident and do a stress debriefing. This may take a few minutes to a few hours, depending on the situation. Individuals are guided through the institutional review process, including any risk management or legal requirements. Allowances are made to alter clinical assignments as needed to give time for mental and emotional recovery, which can mean time away from the O.R. or outside the location (e.g., G.I. suite) where the event occurred. These allowances can be tailored to the individual's needs, and the PART member oversees this process. Every professional's experience is different, with some requiring little to no support, while others may be severely impacted by the adverse event.

At our institution, each individual has the option of receiving additional individualized support from the employee assistance program (EAP). EAP offers counseling, group support and other resources aimed at reducing stress. The overall goal of the PART is to prevent burnout by helping to mitigate stress, anxiety, feelings of incompetence, shame, guilt and loss of self-confidence in our faculty and trainees. Our goal is to improve resilience and clinical performance. In a 2018 national Medscape survey, surveyors found that self-reported burnout rates among physicians stand at 42 percent, with anesthesiology specifically reporting 38 percent.[5] The phenomenon of burnout is no small matter, and anything we can do as an institution to help prevent or minimize burnout should be of utmost importance.

We believe that all health care providers who are exposed to patient morbidity and death should have support systems in place to prevent burnout and second victim occurrence. Physician burnout has been associated with decreased patient satisfaction, decreased quality of clinical care, increased rates of medical errors, increased physician turnover, physician substance abuse and dependency, and increased rates of physician suicide.[6] We encourage readers to discuss this need within your individual groups. Please feel free to contact the authors for guidance in your efforts.

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