Musings on Leadership, Quality & Safety & Burnout: What Goes Up Must Come Down

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Women’s Auxiliary Endowed Chair in Pediatric Urology & Regenerative Medicine
Hospital for Sick Children
Toronto, Ontario
Factfulness

Ten Reasons We’re Wrong About the World—and Why Things Are Better Than You Think

Hans Rosling with Ola Rosling and Anna Rosling Rönnlund

New York Times Bestseller

“Get your facts first and then you can distort them as you like.”

- Mark Twain

Marty Sept. 2019

Enjoy the read Kenny.
The Year's Hottest Gift!

OFFICIAL GOVERNMENT APOLOGY

SNIFF... WE'RE REALLY, REALLY SORRY...

This certificate entitles

Martin A. Koyle

(Name goes here)

To ONE OFFICIAL CANADIAN GOVERNMENT APOLOGY®

* Financial compensation and sincerity not included. One apology per recipient.
Photos courtesy of
Dr. Mark Zaontz
What does “Tenerife” mean to us?
What does “Tenerife” mean to us?

**Blue Skies**

Between 1959 and 2009, airline safety has improved dramatically. The red line indicates the number of fatal accidents per million departures. The number below the year indicates total fatalities.

- Aircraft of 15 passengers seats or more. Excludes acts of violence.
- As of Aug. 25

Source: Boeing Co. (accident rate); Ascend Worldwide Ltd. (passenger fatalities); Getty Images (photo)
How Safe is Healthcare?


- Dangerous > 1 / 1,000
- Ultra Safe < 1 / 100K

Total lives lost per year vs. Number of encounters for each fatality.
Characteristics of an “ideal-type” high reliability organisation

- Clear Organisational Goals
- Strong Organisational Culture
- Presence of Redundancy and Slack
- Mindful behaviour
- Comfortable with paradox
Construct of the HRO
Formalizing a Systems Approach to Avoid Catastrophic Accidents

Deming’s Theory of Profound Knowledge (TPK) used to provide foundation for the systems approach

- Organizations are systems that interact within their internal and external environments
- Statistical process control is the foundation of process optimization
- Theory, prediction, and feedback as the basis of learning
- Organizations have cultures that influence the system and desired outcome
“To Err is Human” changed landscape.
Team factor and perioperative outcomes

- Surgical errors are more often related to teams rather than to one single person
  - 70% of errors had 2 or more clinicians involved
- Communication/collaboration in surgical teams
  - Correlates with risk-adjusted morbidity
- Communication breakdowns:
  - Second contributors to errors after inexperience

Davenport DL. J Am Coll Surg 2007;205
Schmutz J,. Br J Anaesth 2013;110
Culture of blame vs. “Just culture”

The Swiss Cheese model
Adapted from J. Reason, 2000

Provider
Training
Distractions
Fatigue

Technical
Poor designs
Deferred maintenance

Organization Culture
Incomplete policies

Team
Shifting responsibilities
Handovers

HARM
Patient

“Quote”

“The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes.”
(Leape 2009)

Dr. Lucian Leape is a professor at Harvard School of Public Health, he is a health policy analyst whose research has focused on patient safety and quality of care.
In an HRO, a Safe “Improvement” Culture is a Just Culture... a place where we can talk without fear...
Serious Safety Event Rate
Nationwide Children’s Hospital
Rolling 12-month Serious Safety Events expressed per 10,000 adjusted patient days
NCH experiences a Serious Safety Event once every 122 days

HPI Engaged
Zero Hero Began

Desired Direction of Change

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Stand up if you...

...Have cared for a patient that experienced a medical error?

...Have been involved in a case where there was a medical error leading to morbidity/death/malpractice threat?
YOUR INTENDED CAREER PATH

WHY YOU DRINK

YOUR ACTUAL CAREER PATH

PRESTIGE

BIRTH

TIME

DEATH
Kotter’s Change Management Model

1. Establish a Sense of Urgency
2. Form a Powerful Guiding Coalition
3. Create a Vision
4. Communicate the Vision
5. Empower Others to Act on the Vision
6. Plan for and Create Short Term Wins
7. Consolidate Improvements & Produce More Change
8. Institutionalize New Approaches

Change Behavior

Change Sustainability

Need for Change

Change Direction

Committed Leadership

Source: John Kotter
Leadership becomes a key: Management differs!

Leadership & Management

- Instilling an inspiring vision
- Getting important things done
- Instilling good operational processes

WHEN I TALK TO MANAGERS I GET THE FEELING THAT THEY ARE IMPORTANT.

WHEN I TALK TO LEADERS I GET THE FEELING THAT I AM IMPORTANT.
Different people with different experiences & expectations … but some things we do do share!
Changing Practice…
Changing Behavior, Results
Brooks Koepka

“When somebody tells me I can't do something, I'm very eager to go out and go do it. Even if it's me telling myself, 'You can't win this golf tournament.' I want to prove to myself I can.”
Returning to Canada after 35 years of training & practicing in the USA
Delusions of grandeur?
9 years later…
2011... Never would I have thought
Too many chocolates, too little time. Lucy and Ethel tackle "Job Switching."
The Medical System
Challenging Human Experience
Everyone can blame someone else
CHAPTER 6

Stage Three: The Wild, Wild West

By any measure, Martin Koyle is living the American dream. So why is he so frustrated?
Urologist burnout: Frequency, causes, and potential solutions to an unspoken entity

Julie Franc-Guimond, MD, FRCS*c; Brian McNeil, MD, FACS;c; Steven M. Schlissberg, MD, FACS;c; Amanda C. North, MD, FACS;c; Alp Sener, MD PhD, FRCS.c

Table 1. Overview of published articles pertaining directly to factors contributing to burnout among trainee and practicing urologists

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Study type</th>
<th>Country</th>
<th>Sample size</th>
<th>Response rate</th>
<th>Pertinent findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>O’Kelly et al8</td>
<td>2016</td>
<td>Survey</td>
<td>U.K., Ireland</td>
<td>1380</td>
<td>575 (42%)</td>
<td>15% reported self-medication or EtOH to combat burnout</td>
</tr>
<tr>
<td></td>
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<td>8% sought professional help for burnout</td>
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<td></td>
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<td>60% would have attended counseling if provided</td>
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<td>80% felt burnout should be evaluated in urology practices</td>
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<td></td>
<td>Highest burnout associated with age &lt;45, private practice, leadership roles, hospital management</td>
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<td></td>
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<td></td>
<td>Characteristics associated with burnout included high administrative work load, volume of clinical work, lack of institutional resources, pension, patient expectations</td>
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<td></td>
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<td>Operative decision making, research and medico-legal pressures did not impact burnout rates</td>
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<td>Gender or ethnicity had no impact on burnout</td>
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<tr>
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<td></td>
<td>119 (66%)</td>
<td>25% of residents in training experienced burnout</td>
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<td>8% had emotional exhaustion, 22% had depersonalization</td>
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<td>Characteristics protective from burnout included being in a relationship,</td>
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<td></td>
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<td></td>
<td>&gt;1 extracurricular hobby, seniority in residency and older age</td>
</tr>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Gender had no impact on burnout</td>
</tr>
<tr>
<td>Bohle et al9</td>
<td>2001</td>
<td>Survey</td>
<td>Germany</td>
<td>128</td>
<td>75 (59%)</td>
<td>Increased risk of burnout associated with academic practice, residency and age &lt;45 years</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>&lt;50% reported seeing their family physician for work related anxiety and depression</td>
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<td>&gt;50% admitted to self-prescription of analgesics and benzodiazepines</td>
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<td>Greatest risk of burnout was overwhelming administrative responsibilities</td>
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<tr>
<td>Wines et al10</td>
<td>1998</td>
<td>Survey</td>
<td>Australia</td>
<td>275</td>
<td>205 (75%)</td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Factors associated with burnout

<table>
<thead>
<tr>
<th>Causative factors</th>
<th>Protective factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic exposure to high levels of stress</td>
<td>Reducing time spent at work</td>
</tr>
<tr>
<td>Increased work load</td>
<td>Gaining seniority</td>
</tr>
<tr>
<td>Lack of institutional resources or management support</td>
<td>Working in a positive work environment</td>
</tr>
<tr>
<td>Too many bureaucratic tasks</td>
<td>Being in a meaningful relationship</td>
</tr>
<tr>
<td>Lack of control and autonomy</td>
<td>Having extracurricular hobbies</td>
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<tr>
<td>Financial concerns</td>
<td>Achieving work &amp; life balance</td>
</tr>
<tr>
<td>Patient expectations</td>
<td></td>
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<tr>
<td>On-call responsibilities</td>
<td></td>
</tr>
<tr>
<td>Poor level of job satisfaction</td>
<td></td>
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<tr>
<td>Young age</td>
<td></td>
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<tr>
<td>Female gender (association may vary among countries)</td>
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<tr>
<td>Negative marital status or being married to another physician</td>
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<tr>
<td>Poor working relationships</td>
<td></td>
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<tr>
<td>Conflict between work-life balance</td>
<td></td>
</tr>
<tr>
<td>Having young children</td>
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</tr>
</tbody>
</table>
THE TIPPING POINT

MALCOLM GLADWELL

with a new introduction by the author
Culture Change

Peer support: A powerful culture change tool

I made a mistake because I am a bad doctor or bad person

Expectation of emotional denial

Isolation

Self care is selfish

I made a mistake because I am human

Normalizes reactions

Community/solidarity

Self care is essential
“This patient (outcome) defines me... It is my legacy”
Almost a year ago, I read with interest the article by Franc-Guimond et al in CUAJ entitled, “Urologist burnout. Frequency, causes, and potential solutions to an unspoken entity.” The last person in the world I thought it would affect was me. I was always mentally “up” and excited about my career, innovation, and promoting change. In fact, I had always said to my kids and those that I mentored that if your career only becomes a job and a means to an end, it is time to reassess or even quit what you are doing. What changes a year can bring!

As someone who enjoyed diversity of work and the responsibilities of medical leadership, I would have thought I was immune to “burnout.” Whether a culmination of moving, traumas in my life — both mental and physical — or disappointment with the healthcare that I am providing in Canada, I have changed. This manifests as a frequent sense of cynicism and criticism of the system that I work in, and a feeling that successes are not rewarded and only failure leads to a response. My sense of community seems to be diminished. Worse is a feeling of inadequacy to change my practice environment.
Just wanted to let you know I really enjoyed and appreciated your article. My husband also agreed; he is also a physician and it is a backstabbing world. We are both somewhat disillusioned with medicine and are trying to think of different careers for our child! The new legislature on misconduct is also scary for doctors, particularly for male physicians. Anyway many thanks for sharing. We are all there with you.

I just saw your CU AJ editorial on burnout. Part of me believes you and I are very similar people, people who see the best in others and the system, and hope and want change. I know it’s not the same, but I’ve been very disappointed recently with my ability to impact things that I think could be so much better. I haven’t given up yet, but sometimes I ask myself why am I trying so hard to change something that won’t change (someone told me that was the definition of insanity).

Why I am writing? Because I really appreciate your honesty and desire to help others and wanted to thank you for the editorial.

Thought I’d drop you a note of sympathy after reading your CU AJ editorial. I don’t think I can say I am burned out for now, at least not yet, but certainly get disenchanted with the lack of incentive to provide outstanding care and the red tape/barriers to try to improve our system in a meaningful way.

Congratulations on publishing a very valuable article/letter. Beautifully written, it will certainly resonate with many physicians in the same situation. It took courage to write it and courage to publish it.

As “men of science” that physicians are supposed to be, perhaps some will explore the reasons for so-called “burnout.” Key phrases appear in the fourth paragraph: “impersonal aspect of care,” “hospital and university culture of distinct and competing silos,” “lots of middle management and ever-changing strategic plans, often reacting to provincial healthcare budget,” etc. Additionally, you write, the single-payer system has stagnated,” become “an entitlement system where patients had no skin in the game,” “no shows,” overabundance of NPO violations causing surgical cancellations, etc.

It is an extraordinary letter, sadly reflecting an individual’s impressions. But certainly, he is not alone. Doctors are apparently no longer appreciated for what they do and when they do it, by either the government or by many too many patients. And their personal sacrifices seem to be a “given” that society expects while valuing their skills as cheaply as possible.

I’ve been retired for nearly 25 years. I’m old. I practiced when it was still “fun.” I quit before I burned out, fortunately. I cry when I realize what present-day physicians have to endure in their work. I cry further when I realize what the future will bring as a result of these burnouts today. Why will the talented persons, who would be my children’s and grandchildren’s doctors, seek a medical career then? How tragic! How sad!

Again, my hat’s off to Dr. Koyle and Dr. Siemens for this publication.

Sincerely,
Harry C. Miller, MD
CUA member since 1963
Upon returning to Canada, Koyle promptly realized that the Canadian health system was quite different than the romanticized version he had been promoting during his time in the US.

“I realized from day one that all that I was, was a number,” he said. The system, although advertised as universal, lacked strongly in quality of patient care and career gratification. In the US, Koyle discussed his feeling of belonging to a “community” and being “part of a family.” He personally knew other physicians, and trusted them with his patients when referring them to other specialists. He also felt a general feeling of gratification and mutual appreciation within this supportive network.

As Koyle summed up his contrasting experience practicing in Canada: “My support from the institution is very different, my control in my environment is very different, my relationship with my patients and with their families and with their providers is very different, and the outcomes are very different in that in the States where my primary physician… was the quarterback in the system in that patient’s care.”

“Here, the buck stops at me… I’m not providing the healthcare that I want to provide to people [due to these social dynamics of the Canadian health care system].”
‘Every [physician] carries within himself a small cemetery, where from time to time he goes to pray – a place of bitterness and regret, where he must look for an explanation for his failures.’

René Leriche,
La philosophie de la chirurgie, 1951
Walk past suffering colleague?
Why talk about Burnout?
BURNOUT FACTS

2.4%
2.4% of people in Finland met the criteria for burnout.

26 - 46.5%
Between 26-46.5% of intensivists met criteria for burnout.

30 - 40%
Between 30 and 40% of healthcare workers consider leaving their jobs due to burnout symptoms.

No gender differences are found in the development of burnout. However, emotional exhaustion and professional efficacy are more common among females, depersonalisation among men.

BURNOUT SUBSCALES
There are three burnout subscales:
- emotional exhaustion,
- depersonalisation,
- professional efficacy.

RISK FACTORS
- Long working hours,
- Low job control,
- Excessive workload,
- Less family time,
- Workplace politics,
- Serious family issues,
- Exposure to a traumatic event,
- Low reward,
- Perfectionism,
- Idealism,
- Job insecurity,
- Physical illness,
- Divorce/separation,
- Great sense of responsibility.

EFFECTIVE COPING
- Active problem focused coping
- High levels of job support
- Workplace justice
- Flow proneness

FOR LITERATURE, GO TO: WWW.BARENDSPSYCHOLOGY.COM
The International Classification of Diseases, or the ICD-11, the World Health Organization's handbook that helps medical providers diagnose diseases, classifies burnout as "a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed," according to WHO.

Many initial reports characterized the classification as a medical condition, but WHO clarified Tuesday afternoon in a tweet that burnout is an "occupational phenomenon," not a medical condition.

#Burnout is included in the 11th Revision of the International Classification of Diseases (#ICD11) as an occupational phenomenon.

It is NOT classified as a medical condition bit.ly/ICD11BurnOut

Burn-out an "occupational phenomenon": International Classification of Diseases

28 MAY 2019 - Burn-out is included in the 11th Revision of the International Classification of Diseases (ICD-11) as an occupational phenomenon. It is not classified as a medical condition.

It is described in the chapter: 'Factors influencing health status or contact with health services' – which includes reasons for which people contact health services but that are not classified as illnesses or health conditions.

Burn-out is defined in ICD-11 as follows:

"Burn-out is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions:

- feelings of energy depletion or exhaustion;
- increased mental distance from one’s job, or feelings of alienation or cynicism related to one's job; and
- reduced professional efficacy.

Burn-out refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life."

Burn-out was also included in ICD-10, in the same category as in ICD-11, but the definition is now more detailed.
The “Healthcare Personality”
-Gabbard JAMA 254:2926

**Adaptive**
- Diagnostic rigor
- Thoroughness
- Commitment to patients
- Desire to stay current
- Recognize responsibility of patients trust

**Maladaptive**
- Difficulty relaxing
- Problem allocating time for family
- Sense responsibility beyond what you control
- Sense “not doing enough”
- Difficulty setting limits
- Confusion of selfishness vs. healthy self-interest
- Difficulty taking time off

Gabbard JAMA 254:2926
Breaking Down Burnout

Burnout among American surgeons

Darrell A. Campbell, Jr. MD, Seema S. Sonnad, PhD, Frederic E. Eckhauser, MD, Kyle K. Campbell, and Lazar J. Greenfield, MD, Ann Arbor, Mich
Professional Consequences of Burnout

Adverse Influence On:

• Patient satisfaction
• Patient compliance
• Physician prescribing habits
• Turnover/absenteeism
• Detrimental attitudes: cynicism, resentment
• Intent to leave medicine

1 Health Psych 12:93; 2 JGIM 15:122; 3 Arch IM 169:990; 4 JGIM 22:177
# Distress Leads to Medical Errors

- West JAMA 296:1071

<table>
<thead>
<tr>
<th>Variable</th>
<th>Instrument</th>
<th>OR of subsequent error</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnout</td>
<td>MBI-DP</td>
<td>1.10</td>
<td>.001</td>
</tr>
<tr>
<td></td>
<td>MBI-EE</td>
<td>1.07</td>
<td>&lt;.001</td>
</tr>
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<td>MBI-PA</td>
<td>1.08</td>
<td>.02</td>
</tr>
<tr>
<td>Depression</td>
<td>Positive 2-item screen</td>
<td>1.93</td>
<td>.08</td>
</tr>
</tbody>
</table>
Emotional Exhaustion, Depersonalization, & Medical Errors

- Annals of Surgery 251:995
Human cost of Burnout

- Loss of idealism, commitment
- Cynicism - work is not meaningful
- Feelings of guilt, shame, unworthiness
- Loss of direction/purpose – Depression!!
- Divorce. Substance Abuse. Early mortality. Suicide
What is the difference between depression and burnout? An ongoing debate

Qual è la differenza tra depressione e burnout? Un dibattito in corso

IRVIN SAM SCHONFELD1*, RENZO BIANCHI2, STEFANO PALAZZI3
*E-mail: ischonfeld@ccny.cuny.edu

1Department of Psychology, The City College of the City University of New York, USA
2Institut de Psychologie du Travail et des Organisations, Université de Neuchâtel, Svizzera
3Unità Operativa di Neuropsichiatria AUSL, Università di Ferrara

SUMMARY. Burnout has been viewed as a syndrome developing in response to chronically adverse working conditions. Burnout is thought to comprise emotional exhaustion, depersonalization, and reduced personal accomplishment. Historically, however, burnout has been difficult to separate from depression. Indeed, the symptoms of burnout coincide with symptoms of depression. Evidence for the discriminant validity of burnout with regard to depression has been weak, both at an empirical and a theoretical level. Emotional exhaustion, the core of burnout, itself reflects a combination of depressed mood and fatigue/loss of energy and correlates very highly with other depressive symptoms. Work-related risk factors for burnout are also predictors of depression. Individual risk factors for depression (e.g., past depressive episodes) are also predictors of burnout. Overall, burnout is likely to reflect a “classical” depressive process unfolding in reaction to unresolved stress.

KEY WORDS: depression, burnout, stress.
**PTSD Diagnostic Criteria**

- Negative Alterations in Mood
- Alterations in Arousal or Reactivity
- Duration
- Avoidance
- Functional Significance
- Exclusion
- Intrusion
- Stressor

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**BURNOUT**

<table>
<thead>
<tr>
<th>HALLMARK SIGNS</th>
<th>SYMPTOMS (mirror PTSD)</th>
<th>KEY TRIGGERS</th>
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</thead>
<tbody>
<tr>
<td>Anger &amp; frustration</td>
<td>Physical</td>
<td>Personal characteristics</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Psychological</td>
<td>Previous exposure to trauma</td>
</tr>
<tr>
<td>Negative reactions towards others</td>
<td>Cognitive</td>
<td>Empathy &amp; emotional energy</td>
</tr>
<tr>
<td>Cynicism</td>
<td>Relational disturbances</td>
<td>Prolonged exposure to trauma material of clients</td>
</tr>
<tr>
<td>Negativity</td>
<td></td>
<td>Response to stressor</td>
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<tr>
<td>Withdrawal</td>
<td></td>
<td>Work environment</td>
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**COMPASSION FATIGUE**

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<thead>
<tr>
<th>HALLMARK SIGNS</th>
<th>SYMPTOMS (mirror PTSD)</th>
<th>KEY TRIGGERS</th>
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<tbody>
<tr>
<td>Sadness &amp; grief</td>
<td>Physical</td>
<td>Personal characteristics</td>
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<tr>
<td>Nightmares</td>
<td>Psychological</td>
<td>Previous exposure to trauma</td>
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<tr>
<td>Avoidance</td>
<td>Cognitive</td>
<td>Empathy &amp; emotional energy</td>
</tr>
<tr>
<td>Addiction</td>
<td>Relational disturbances</td>
<td>Prolonged exposure to trauma material of clients</td>
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<tr>
<td>Somatic complaints</td>
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<td>Response to stressor</td>
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<tr>
<td>Increased psychological arousal</td>
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<td>Work environment</td>
</tr>
<tr>
<td>Changes in beliefs, expectations, assumptions</td>
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<td>Work-related attitudes</td>
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<tr>
<td>“Witness guilt”</td>
<td></td>
<td></td>
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<tr>
<td>Detachment</td>
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<tr>
<td>Decreased intimacy</td>
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**VICARIOUS TRAUMATIZATION**

<table>
<thead>
<tr>
<th>HALLMARK SIGNS</th>
<th>SYMPTOMS (mirror PTSD)</th>
<th>KEY TRIGGERS</th>
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</thead>
<tbody>
<tr>
<td>Anxiety, sadness, confusion, apathy</td>
<td>Physical</td>
<td>Personal characteristics</td>
</tr>
<tr>
<td>Intrusive imagery</td>
<td>Psychological</td>
<td>Previous exposure to trauma</td>
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<tr>
<td>Somatic complaints</td>
<td>Cognitive</td>
<td>Type of therapy</td>
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<tr>
<td>Loss of control, trust &amp; independence</td>
<td>Relational disturbances</td>
<td>Organizational context</td>
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<td>Decreased capacity for intimacy</td>
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<td>Healthcare structure</td>
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<td>Relational disturbances (crossover to personal life)</td>
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<td>Resources</td>
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<td>Re-enactment</td>
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During our careers as pediatric surgeons we pass through, sometimes with ease, sometimes with difficulty, a number of transitions. We begin our journey as students, transition to residency with all of its challenges, then a fellowship. The next major transition in our careers is embarking on clinical practice, which has its many varied stages. And finally, there is the transition away from pediatric surgery practice into retirement. Each transition has its unique stressors.

Physician wellness is an important and essential metric of healthcare system quality. Physician wellness affects the personal and professional life of the surgeon and patient safety. Supporting surgeon wellness is a shared responsibility at the level of individual, colleagues/peers, physician leaders, institution, and government.
Figure 2. Have you experienced burnout as a surgeon at any time in your career?

- Yes: 52.09% (137)
- No: 41.83% (110)
- Unsure: 6.08% (16)

Figure 3. Were you resistant to talking about burnout because of the possible stigma?

- Yes: 45.32% (63)
- No: 53.24% (74)
- Prefer not to answer: 1.44% (2)
Figure 5. Have you witnessed a colleague experience burnout?

- Yes: 72.62%
- No: 9.89%
- Unsure: 17.49%

Figure 6. Are you aware of a surgical colleague who has committed suicide?

- Yes: 29.28%
- No: 70.72%
Overworked Overscheduled
Bombardment by EMR, Unnecessary Emails & Social Media = Physician Frustration
Documentation eats patient care for breakfast
Lack of Autonomy
“In The Tyranny of Metrics, Jerry Muller has brought to life the many ways in which numerical evaluations result in deleterious performance: in our schools, our universities, our hospitals, our military, and our businesses. This book addresses a major problem.”

—GEORGE A. AKERLOF, Nobel Prize–winning economist
"The more layers between frontline clinicians and those making momentous decisions about how care should be organized, the more cynicism and disengagement you're likely to experience. Improving patient care should be the major motivation for organizations to change and change quickly."

Clinician Engagement Improves Care Quality Most of All
What are the top two ways in which clinician engagement improves health care?

- Higher clinical quality: 72%
- Improved patient satisfaction: 55%
- Improved clinician satisfaction: 51%
- Lower cost of care: 15%
- Higher organizational revenue: 2%

Base: 706 (multiple responses)
NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society
Work Life Balance in Healthcare
Burnout

- Lack of Autonomy
- Work-Home Interference
- Challenges > Skills to Address

- Excessive Workload and Dysfunctional EMR
- Loss of Meaning in Work
- Inadequate Personal Time and Physician Personality

Complications
- Adverse Events
- Isolation
- Dysfunctional Response to Injury
Why is the Second Victim Syndrome important?
Second Victim Definition

“… involved in an unanticipated adverse patient event, medical error and/or a patient-related injury who becomes victimized in the sense that the provider is traumatized by the event.”

Second victims often feel that they have failed the patient and begin to second-guess their clinical skills and knowledge base.
Adverse Event Victims….

- First Victim… Patient and Family
- Second Victim… Providers
- Third Victim… Institution
Who are Second Victims?

Nurse loses a young patient close to same age as son

Physician has been involved in several tragic cases back-to-back

Housekeeper learns that a patient she befriended is now in intensive care

Pharmacist learned a patient had an anaphylactic shock due to medication error

Transporter must bring an infant down to the morgue
Medical error: the second victim

The doctor who makes the mistake needs help too

When I was a house officer another resident failed to identify the electrocardiographic signs of the pericardial tamponade that would rush the patient to the operating room late that night. The news spread rapidly, the case tried repeatedly before an incredulous jury of peers, who returned a summary judgment of incompetence. I was dismayed by the lack of sympathy and wondered secretly if I could have made the same mistake—and, like the hapless resident, become the second victim of the error.

Strangely, there is no place for mistakes in modern medicine. Society has entrusted physicians with the burdens of health care, and they are held to be infallible. With the exception of mistakes that are built into existing unwitting physician medical mistakes, improvements that are made.

Virtually every realisation of makeout and exposed—has noticed. You always tell anyone, what they need to over and over in your work. They can't understand this, you know? They can't understand a mistake.
Second victims are healthcare providers who are involved in an unanticipated adverse patient event, in a medical error and/or a patient related injury and become victimized in the sense that the provider is traumatized by the event. Frequently, these individuals feel personally responsible for the patient outcome. Many feel as though they have failed the patient, second guessing their clinical skills and knowledge base.
Impact of Errors on Physicians’ Life Domains by Level of Error Severity*

- **Increased Anxiety about Future Errors***
  - Serious Error: 66%
  - Minor Error: 51%
  - Near Miss: 51%

- **Decreased Job Confidence***
  - Serious Error: 36%
  - Minor Error: 31%
  - Near Miss: 31%

- **Decreased Job Satisfaction***
  - Serious Error: 48%
  - Minor Error: 34%
  - Near Miss: 32%

- **Increased Sleeplessness***
  - Serious Error: 48%
  - Minor Error: 33%
  - Near Miss: 33%

- **Harm to Professional Reputation***
  - Serious Error: 15%
  - Minor Error: 9%
  - Near Miss: 10%

*Reported Error-Related Impact
Do you want your Surgeon to have these symptoms...?

<table>
<thead>
<tr>
<th>Physical symptoms</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extreme fatigue</td>
<td>16</td>
<td>(52)</td>
</tr>
<tr>
<td>Sleep disturbances</td>
<td>14</td>
<td>(45)</td>
</tr>
<tr>
<td>Rapid heart rate</td>
<td>13</td>
<td>(42)</td>
</tr>
<tr>
<td>Increased blood pressure</td>
<td>13</td>
<td>(42)</td>
</tr>
<tr>
<td>Muscle tension</td>
<td>12</td>
<td>(39)</td>
</tr>
<tr>
<td>Rapid breathing</td>
<td>11</td>
<td>(35)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychosocial symptoms</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frustration</td>
<td>24</td>
<td>(77)</td>
</tr>
<tr>
<td>Decreased job satisfaction</td>
<td>22</td>
<td>(71)</td>
</tr>
<tr>
<td>Anger</td>
<td>21</td>
<td>(68)</td>
</tr>
<tr>
<td>Extreme sadness</td>
<td>21</td>
<td>(68)</td>
</tr>
<tr>
<td>Difficulty concentrating</td>
<td>20</td>
<td>(65)</td>
</tr>
<tr>
<td>Flashbacks</td>
<td>20</td>
<td>(65)</td>
</tr>
<tr>
<td>Loss of confidence</td>
<td>20</td>
<td>(65)</td>
</tr>
<tr>
<td>Grief</td>
<td>20</td>
<td>(65)</td>
</tr>
<tr>
<td>Remorse</td>
<td>19</td>
<td>(61)</td>
</tr>
<tr>
<td>Depression</td>
<td>17</td>
<td>(55)</td>
</tr>
<tr>
<td>Repetitive/intrusive memories</td>
<td>16</td>
<td>(52)</td>
</tr>
<tr>
<td>Self-doubt</td>
<td>16</td>
<td>(52)</td>
</tr>
<tr>
<td>Return to work anxiety</td>
<td>15</td>
<td>(48)</td>
</tr>
<tr>
<td>Second guessing career</td>
<td>12</td>
<td>(39)</td>
</tr>
<tr>
<td>Fear of reputation damage</td>
<td>12</td>
<td>(39)</td>
</tr>
<tr>
<td>Excessive excitability</td>
<td>11</td>
<td>(35)</td>
</tr>
<tr>
<td>Avoidance of patient care area</td>
<td>10</td>
<td>(32)</td>
</tr>
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Understanding Second Victims Trajectory
If this was a Jeopardy question for $500....

What is...?

“One medical school class / year”
An estimated 300 to 400 doctors kill themselves each year, a rate of 28 to 40 per 100,000 or more than double that of general population. That is according to a review of 10 years of literature on the subject presented at the American Psychiatry Association annual meeting in May, 2018.
“I was told by the psychologist at my med school's campus assistance program, that 75% of the class of 175 people were on anti-depressants. He wasn't joking. How broken is the system, that doctors have to be pushed into illness in order to be trained to do their job? ~ Jaya
Proportionate Mortality Ratio:
Male Physicians vs Male Professionals

“I have eaten, exercised, quit, thrown hay bales, thrown my pager, yelled, done counseling, seen psychiatrists, been hospitalized having detailed suicide plan down to supplies and practice, committed to not dying by suicide, played saxophone, gone to more counseling, meditated, cooked, eaten, drank Diet Coke, drank alcohol despite a strong family history of alcoholism and a general terror of alcohol consumption, drank Coke, and finally trying to learn how to love myself again…” ~ Ellen
Stages of Healing: The Second Victim Recovery

Stage 1: Chaos & Accident Response
Stage 2: Intrusive Reflections
Stage 3: Restoring Personal Integrity
Stage 4: Enduring the Inquisition
Stage 5: Obtaining Emotional First Aid
Stage 6: Moving On

STAGE 1: CHAOS AND ACCIDENT RESPONSE
- Error realized/event recognized
- Tell someone > get help
- Stabilize/treat patient
- May not be able to continue patient care
- Distracted
- Experience a wave of emotions

How did this happen?
Why did this happen?

STAGE 2: INTRUSIVE REFLECTIONS
- Re-evaluate scenario
- Self-isolate
- Haunted by re-enactments of event
- Feelings of internal inadequacy

What did I miss?
Could this have been prevented?

STAGE 3: RESTORING PERSONAL INTEGRITY
- Acceptance at work and in social network
- Managing gossip/grapevine
- Fear is prevalent

What will others think?
Will I ever be trusted again?
How much trouble am I in?
Why can’t I concentrate?

STAGES 1-3 MAY OCCUR INDIVIDUALLY OR SIMULTANEOUSLY
**STAGE 4: ENDURING THE INQUISITION**

- Realization of level of seriousness
- Reiterate case scenario
- Respond to multiple "whys" about the event
- Interact with many different event responders
- Understand event disclosure to patient/family
- Litigation concerns emerge

**STAGE 5: OBTAINING EMOTIONAL FIRST AID**

- Seek personal/professional support
- Get/receive help/support

**Questions**

- How do I document?
- What happens next?
- Who can I talk to?
- Will I lose my job/license?
- How much trouble am I in?

- Why did I respond in this manner?
- What is wrong with me?
- Do I need help?
- Where can I turn for help?
STAGE 6:
MOVING ON (ONE OF THREE TRAJECTORIES CHOSEN)

DROPPING OUT
- Transfer to a different unit or facility
- Consider quitting
- Feelings of inadequacy

SURVIVING
- Coping, but still have intrusive thoughts
- Persistent sadness, trying to learn from event
- Advocates for patient safety initiatives

THRIVING
- Maintain life/work balance
- Gain insight/perspective
- Does not base practice/work on one event
- Advocates for patient safety initiatives

- Is this the profession I should be in?
- Can I handle this kind of work?
- How could I have prevented this from happening?
- Why do I still feel so bad/guilty?
- What can I do to improve our patient safety?
- What can I learn from this?
Learning about Resilience\Recovery

DR. KURT HEISS: “When something goes south, many of us self-isolate....but the isolation is a killer.”

Spin Doctor
The hazards of taking care of others at the expense of yourself
By Patrick Adams and Mary Loftus, Illustrations by Andrew Baker
Becoming Resilient

- Personal Resilience and Wellness
- System focus on Patient Safety
- Peer Support
- Leadership Imperatives
Resilience

If Every Fifth Physician Is Affected by Burnout, What About the Other Four?
Resilience Strategies of Experienced Physicians
Julika Zwack, PhD, and Jochen Schweitzer, PhD
Avoiding Burnout

The Personal Health Habits and Wellness Practices of US Surgeons

Tait D. Shanafelt, MD,* Michael R. Oreskovich, MD,† Lotte N. Dyrbye, MD,* Daniel V. Satele,‡ John B. Hanks, MD,§ Jeff A. Sloan, PhD,∥ and Charles M. Balch, MD¶

- Exercise, personal time, family relationships
- Proper personal Healthcare
- Marked improvement in ‘distress’

Navy Seals, Abuse Survivors
Developing Resilience....

- Fostering Learned Optimism
- Cognitive and Emotional Training
- Facing down Fear
- Attracting & giving Social Support
- Imitating Resilient role models - Mentoring
- Physical Training & Wellness
- Solidifying Moral Compass
- Practicing Religion/Spirituality
- Focusing on Mission/Purpose
- Finding Meaning, Purpose, & Growth
Attracting & giving Social Support

Wellness in groups

Meet Your Happy Chemicals

Dopamine  Serotonin  Oxytocin  Endorphin

Loretta Graziano Breuning, PhD

Loretta@hnammammalinstluta.org
• Personal Resilience
• System focus on Patient Safety
• Peer Support
• Leadership Imperatives
To build on these early gains and successfully transform the health care industry, we need new financial and operational models that prioritize clinician well-being. All stakeholders — individually and collectively, on an organizational and a national level — must be accountable for addressing the root causes of burnout.”
• Personal Resilience
• System focus on Patient Safety
• Peer Support
• Leadership Imperatives
Do we ignore other maladies?
The unmeasured quality metric: Burn out and the second victim syndrome in healthcare

Kurt Heiss, Matthew Clifton*

Children’s Healthcare of Atlanta, Emory University School of Medicine, 1405 Clifton Rd NE, Atlanta GA 30322, United States

ONLINE FIRST

Physicians’ Needs in Coping With Emotional Stressors

The Case for Peer Support

Yue-Yung Hu, MD, MPH; Megan L. Fix, MD; Nathanael D. Hevelone, MPH; Stuart R. Lipsitz, ScD; Caprice C. Greenberg, MD, MPH; Joel S. Weissman, PhD; Jo Shapiro, MD
"Like I always say, there’s no ‘I’ in team. There’s a me though, if you jumble it up."

Badass Quotes By Dr House
I like people who buck the system. Individualists. I often warn people: "Somewhere along the way, someone is going to tell you, 'There is no "I" in team.' What you should tell them is, 'Maybe not. But there is an "I" in independence, individuality and integrity.'"

~George Carlin
If you want to go fast, go alone.
If you want to go far,
GO TOGETHER.

African Proverb
Culture Change

Peer support: A powerful culture change tool

I made a mistake because I am a bad doctor or bad person

Expectation of emotional denial

Isolation

Self care is selfish

I made a mistake because I am human

Normalizes reactions

Community/solidarity

Self care is essential
Culture Change

Peer support: A powerful culture change tool

- I made a mistake because I am a bad doctor or bad person
  - Expectation of emotional denial
  - Isolation
  - Self care is selfish

- I made a mistake because I am human
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**Always Reach Out**

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## Always Reach Out

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• Personal Resilience
• System focus on Patient Safety
• Peer Support
• **Leadership Imperatives**
Burnout should not be a silent epidemic

Currently, the plan for therapy varies greatly among cases, with no agreed-upon recovery program. Treatment protocols are not unified and definitely need to be. Like all other epidemics, we need to recognize the importance of physician burnout and meet the problem head-on. However, all these issues combined seem to indicate that in the future, we are going to have to train more physicians to meet our needs.

Edward J. Harvey, MD
Coeditor, Canadian Journal of Surgery
Start with “Why”
Attending Medicine, Mindfulness, and Humanity
Ronald Epstein, M.D.

STOP PHYSICIAN BURNOUT
What to Do When Working Harder Isn't Working
Dike Drummond, MD
Conclusion

Burnout is a serious problem in health care, especially for surgeons. Adding to the complexity of this issue, women Governors revealed a higher rate of burnout, and younger Governors noted a lower level of job satisfaction. Most of the Governors (93 percent) agree that it is important for the ACS to continue to address the issue of burnout among surgeons (see Figure 8). Governors overwhelmingly support the College’s continued focus on this problem and efforts to uncover solutions.
Jo Shapiro
Director, Center for Professionalism and Peer Support, Brigham and Women’s Hospital
Associate Professor of Otolaryngology, Harvard Medical School
Dear Professor Koyle,

This is your chance to attend a truly unique, insightful, personally and professionally beneficial event for everyone.

Learn about culture, leadership, management, mental health, resilience, exercise, and much more. All these skills - whether you are at the start of your career or an accomplished medical professional - are vital to personal and professional prosperity.

A key component of this event will center around the exploration of medical professionalism and wellbeing from the perspective of culture, self-development and mental health.

Experts will draw upon experience, studies and environmental aspects to examine the key factors of these areas. Direct comparisons between the UK and other cultures will be discussed to gain perspective and appreciation.

You will also hear the latest findings of the continuing cross-cultural study of professionalism and wellbeing, and the issue of hidden cultural bias will be examined.

Tickets for this event start from £20!
9:45am
**Culture, leadership and management**
Professor Dinesh Bhugra, President, British Medical Association

10:15am
**Mental health aware environments, policies, practice and platitudes**
Professor Deborah Cohen, Director of the Centre for Psychosocial Research Occupational and Physician Health, and the Director of Student Support, School of Medicine, Cardiff University

10:45am
**Resilience, wellbeing and exercise**
Dr Derek Tracy, Consultant Psychiatrist and Clinical Director, Oxleas NHS Foundation Trust, London

11:15am
**Tea and coffee break**

11:45am
**Culture, self, identity and performance: Implications for practice**
Professor Kam Bhui, Professor Cultural Psychiatry, Queen Mary University of London

2:00pm
**Developing a cross cultural curriculum in wellbeing and professionalism**
Professor Ania Korszun, Dr Ali Ajaz, Senior Lecturer in Medical Education, Centre for Psychiatry, Barts and The London Medical School, Queen Mary University of London and Dr Catherine Marshall, Lecturer in Medical Education, Centre for Psychiatry, Barts and The London Medical School, Queen Mary University of London

3:00pm
**Why martial art is good for mental health: a non-academic talk from an academic martial artist**
Professor Carmine Pariante, Professor of Biological Psychiatry at the Institute of Psychiatry Psychology and Neuroscience (IoPPN), King's College London

3:30pm
**Tea and coffee break**

4:00pm
**Panel discussion: What needs fixing – the environment or individual?**
Chairs: Professor Ania Korszun, Sir Simon Wessely, President, Royal Society of Medicine, Professor Kam Bhui, Dr Derek Tracy, Professor Carmine Pariante and Dr Catherine Marshall
“The current system is perfectly constructed to get just the results we are getting.” Deming.

“In the classic training program, we have taught how to perform surgery, but we have not taught how to live life as a surgeon.” Campbell
What you are deeply passionate about

What you can be best in the world at

What drives your resource engine
Your value doesn't decrease based on someone's inability to see your worth.
“You’re afraid that somebody will find out, that you’ll go in and somebody will say, ‘he’s crazy.’” But Koyle, who is now open to discussing his appointments, has found that his psychiatrist has helped him to a great extent, in addition to his yoga and practice of meditation. Today, he is a strong mental health advocate, and encourages those battling with burnout and depression to seek the help that they need.
A ‘work smarter, not harder’ approach to improving healthcare quality

Christopher William Hayes,1 Paul B Batalden,2 Donald Goldmann3

“Then again, if you’re not very smart, it’s OK to just work harder.”
Getting to NO!!!!!!
Doctors have an opportunity to fundamentally change the culture of medicine. By embracing data as an educational tool, and by working together to strengthen their collective performance, today’s physicians can improve patient health, boost clinical camaraderie and diminish the symptoms of burnout.

Follow me on Twitter or LinkedIn. Check out my website or some of my other work here.
Maloney’s 16% Rule:
Once you have reached 16% adoption of any innovation, you must change your messaging and media strategy from one based on scarcity, to one based on social proof, in order to accelerate through the chasm to the tipping point.
Conclusions – It can happen to any of you… Nobody is Perfect

- Quality & Safety focus
- Promote Resiliency
- Promote P2P networks & enhance communication
- Promote leadership - Model, Mentor, Define metrics
Why do we allow “Isolation”? 
Don’t walk past a colleague...
From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider

Thomas Bodenheimer, MD
Christine Sinsky, MD

ABSTRACT
The Triple Aim—enhancing patient experience, improving population health, and reducing costs—is widely accepted as a compass to optimize health system performance. Yet physicians and other members of the health care workforce report widespread burnout and dissatisfaction. Burnout is associated with lower patient satisfaction, reduced health outcomes, and it may increase costs. Burnout thus imperils the Triple Aim. This article recommends that the Triple Aim be expanded to a Quadruple Aim, adding the goal of improving the work life of health care providers, including clinicians and staff.


“The joy of practicing medicine is gone.”

“I hate being a doctor... I can’t wait to get out.”

“I can’t tell you how defeated I feel... The feeling of being punished for delivering good care is nerve-racking.”

“I am no longer a physician but the data manager, data entry clerk and steno girl... I became a doctor to take care of patients. I have become the typist.”
Photos courtesy of Dr. Mark Zaontz
Photos courtesy of
Dr. Mark Zaontz
Newton's third law of motion states; "what goes up must come down."
Toilet seats are not exempt from the laws of physics.