The Anesthesiologist as the Second Victim of an Adverse Patient Care Event: Practice, Competence and Colleagues
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Stem Case and Key Questions Content
Over the last few years Alex, one of our anesthesiology faculty, has been doing primarily high profile case assignments (mostly ASA III and above patients) and taking a significant amount of overnight call assignments. He has been extremely helpful and attentive to his colleagues, patients, needs of the Anesthesiology Department, and requests of the surgeons. Alex has been known as an outgoing person who is jovial and friendly with members of the department and OR staff. Over the last three months, however, he called out sick a few times. His passion for sports and spending time outdoors is well known to the department, but he has almost stopped talking about these activities. He has stopped teaching residents and there has been no further development in his research project. It was noted by several members of the OR team that Alex is becoming overly argumentative with his colleagues. His rapport with recovery room staff is now far from perfect. Alex was overheard complaining that he is “working very long hours”, “surgeons have become more and more demanding and capricious”, and he “needs to get a good rest from all of it”. He even expressed that he is dissatisfied with his career choice, and that he is “considering quitting all this once and for all and looking for a place in healthcare administration”, complaining that sometimes he feels that his patients are like impersonal objects who only remember their surgeons.

1. What happened to Alex? What went wrong with his career and professional practice?

2. Do you see symptoms of substance abuse, depression or personality disorder? Or is he just simply tired and burned out?

3. What might be different in Alex’s behavior if his problems were due to substance abuse, depression, or other psychiatric illness?
4. How can we help him? Is this fixable?

5. What is the role of the Department, either chief or colleagues or both? Can the department interfere?

6. What can we do to prevent “second victimization” in ourselves?

The Chairman Dr. M asks you to look into Alex’ problem. You find out that his narcotic record keeping is excellent and his patient narcotic usage is not out of the ordinary. You decide to approach Alex to ask him about his problems and offer your help. He is asked to meet with you today.

1. Is it appropriate to approach Alex regarding your concerns? If so, should we offer to let him resign, or offer him help before he leaves the practice?

2. If you decide to talk to him, how would you start the conversation?

3. Can you ask him about his personal life? Is it appropriate to ask personal questions and, if yes, to what extent?

4. Should you bring one of your colleague anesthesiologists with you to the meeting or meet with Alex alone?

5. Describe the setting for the meeting. Is it better to meet in an informal atmosphere? How about inviting him to your home?

You decided to meet with Alex at the hospital cafeteria and your colleague anesthesiologist Dr. N kindly agrees to accompany you. Alex tells you that he has no specific stressors in his life. Sports had become boring for him over the last couple of years so he lost interest. He says he is extremely tired, and despite his insistence that he still has a passion for anesthesia and critical care, he complains that work has become a routine and he is “desperate for a change”. At the end of the conversation you asked Alex if he has specific problems with any members of the anesthesia team. Alex admits that one of his colleagues constantly makes derogatory comments in regards to his recent case with adverse outcome.

1. What advice can we give to Alex? Should we just leave him alone to cope?

2. Is he at risk for clinical incompetency or substance abuse?

3. What if anything would you report to Dr. M? What would be your recommendations?
4. If Alex asks for advice, what will you say?

5. Should you find out who is allegedly making negative comments about his clinical abilities or does he need to deal with it on his own? Would you report this problem to Dr. M?

6. If you were a Department Chair, how would you treat Alex?

Model Discussion Content
Most healthcare professionals choose their profession because they wish to improve the lives of others. When a patient is accidentally harmed in the care process, this can be a traumatic experience not only for the patient but also for the staff involved.

Adverse events within health care settings can lead to two victims. The first victim is the patient and family and the second victim is the involved health care professional. The term ‘second victim’ refers to the healthcare professional who experiences emotional distress following an adverse event. This distress has been shown to be similar to that of the patient, the "first victim (1). It leads to burnout. The second victim phenomenon was first described in 2000. In 2009, Scott et al. introduced a detailed definition of second victims (2). The prevalence of second victims after an adverse event varies from 10.4% up to 43.3%. Common reactions can be emotional, cognitive, and behavioral. The coping strategies used by second victims have an impact on their patients, colleagues, and themselves. After the adverse event, defensive as well as constructive changes are to be implemented in practice. The second victim phenomenon has a significant impact on clinicians, colleagues, and subsequent patients. Because of this broad impact it is important to offer support for second victims. When an adverse event occurs, it is critical that support networks are in place to protect both the patient and involved health care providers (3, 4).

Burnout is a state of emotional, mental, and physical exhaustion caused by excessive and prolonged stress. It occurs when one feels overwhelmed and unable to meet constant demands. As the stress continues, you begin to lose the interest or motivation that led you to take on a certain role in the first place (5). For many years, employers and entrepreneurs have realized that on-the-job factors significantly affect workers’ ability to perform their duties appropriately and to be productive and successful. Burnout is a known concern for many large companies and corporations in terms of staff rotation and retention. The epidemic of burnout has spread around the world, and this epidemic did not leave healthcare, especially critical care specialties, untouched. A number of studies have been done regarding burnout in medical professionals. Significantly higher burnout rates have been found among Emergency Medicine physicians, anesthesia providers, and obstetricians (6, 7, 8). The high incidence of burnout was recently reported among anesthesiology residents and academic chairpersons (9, 10, and 11), with burnout and job dissatisfaction on the rise. Individual factors, stress, family issues, separation from a significant other, and lack of supportive community are all reported,
which can lead to depersonalization, exhaustion and finally to inefficacy, poor clinical and academic performance, and presenteeism (9,11).

Burnout can be easily mistaken for substance abuse, depression or personality disorder. Key features of depression and substance abuse can include persistent sadness, anxious mood, hopelessness, quietness, aloofness, restless irritability, feelings of guilt and worthlessness, disinterest in work-related activities, sleep problems, and medical errors. The same signs and symptoms may be present in case of a “second victim” (12, 1). However, in the case of burnout the symptoms are job-site related and more about dissatisfaction, rather than hopelessness and withdrawal, as is in cases of substance abuse and/or depression. Burnout is about not enough. Being burned out means feeling empty and devoid of motivation, and beyond caring. If excessive stress is like drowning in responsibilities, burnout is like being all dried up. There is one other difference between stress and burnout: while you are usually aware of being under a lot of stress, you don’t always notice burnout when it happens (13, 14).

Many large corporations have established special programs to prevent burnout and to provide help to those who have fallen victim to it. This approach seems to be missing in the field of Anesthesiology. Every department needs to assume a certain responsibility for its members. In some departments a Clinical Practice Committee takes the lead. The department can help by establishing a fair system for case assignments, on-call schedules, and vacation distribution, and by enforcing mutual respect and a collegial environment.

Prevention of emotional exhaustion is probably the best way to prevent burnout. Utilizing recommendations initially developed for commercial pilots and flight attendants (5) and modified for Emergency Room physicians (14), we can make recommendations for Alex. To alleviate and to prevent further burnout we can advise him to:

1. Balance stress and recovery to achieve best performance  
When feeling emotionally exhausted, push yourself beyond your ordinary limits and regularly seek recovery, and you will grow. This is similar to lifting weights at the gym: when tired, push a little more every day.

2. Create a ritual of disconnecting  
New technologies such as Blackberries and social networking tools (e.g. Facebook), make it easy for us to never truly disconnect. For many it is not unusual to bring work phones and laptops on vacation, and check e-mails and take phone calls the entire time. This is a socially sanctioned but faulty “live life as a long distance runner” logic.

3. Create healthy breathing, eating, sleeping, and exercising habits  
Breathing: This is an easy way to relax and prevent burnout throughout the day. Make a habit of
breathing in to a count of three and out to a count of six, for several minutes. 
Eating: Eat small meals at regular intervals (five to six times a day is recommended), in amounts that 
are satisfying (not over- or under-filling).

Sleeping: Get 7-8 hours of sleep per night. 
Exercising: Work out, and add or keep some form of sports or training in your routine. 
Simple things like exercise, a hobby, and availability of significant others would be the best advisable 
preventers of burnout (14). The Department’s role is to enforce respectful, safe and fair environment 
at the work place, and to shield members of the department from those who are unfair and abusive. 
Every time there is a destructive force interfering with job performance, satisfaction, and personal 
safety, it is in the department’s best interest and responsibility to interfere and protect its members. 
A meeting with a “second victim” colleague anesthesiologist can begin with an informal one-on-one 
assessment of his/her needs, while also taking the needs of the Department into account. The 
individual's goals can be achieved through a carefully formulated series of questions in order to fully 
understand any issues that he or she is experiencing. Only then an initial assessment can be made as 
to what form of stress management help will take. Distressed physicians can be taught the essentials 
of stress management and shown techniques that will enable them to deal with stress, making it 
manageable and thereby increasing performance and value to the Department (15). 
“Second victims” may experience lack of respect. This may be responsible for increased absenteeism; 
lack of workplace motivation and employee satisfaction; increased turnover; and a lack of trust and 
team building among anesthesia providers. Additionally, it can cause serious damage to self-
estee

The most obvious tangible benefit of the Department’s, Chairperson’s and/or colleague’s interference 
is an enhancement of the anesthesiologist’s personal productivity, since he/she can then focus their 
attention on patient care and OR productivity to achieve results more quickly and effectively. There is 
a need to recognize the nature of the second victim phenomenon and the need for organizational 
support for affected healthcare professionals. Attention should be paid to the organizational climate 
where these issues should be addressed and discussed in a non-judgmental manner. There is a need 
for support structures that can meet the needs of involved individuals. The support structures have to 
include both timely and transparent procedures for the investigation and analysis of adverse events, 
and areas where staff involved in adverse events can meet with colleagues to share their emotions 
and receive personal and professional reassurance. These issues are critical to prevent and manage 
adverse events and to promote culture of safety (1).

References