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

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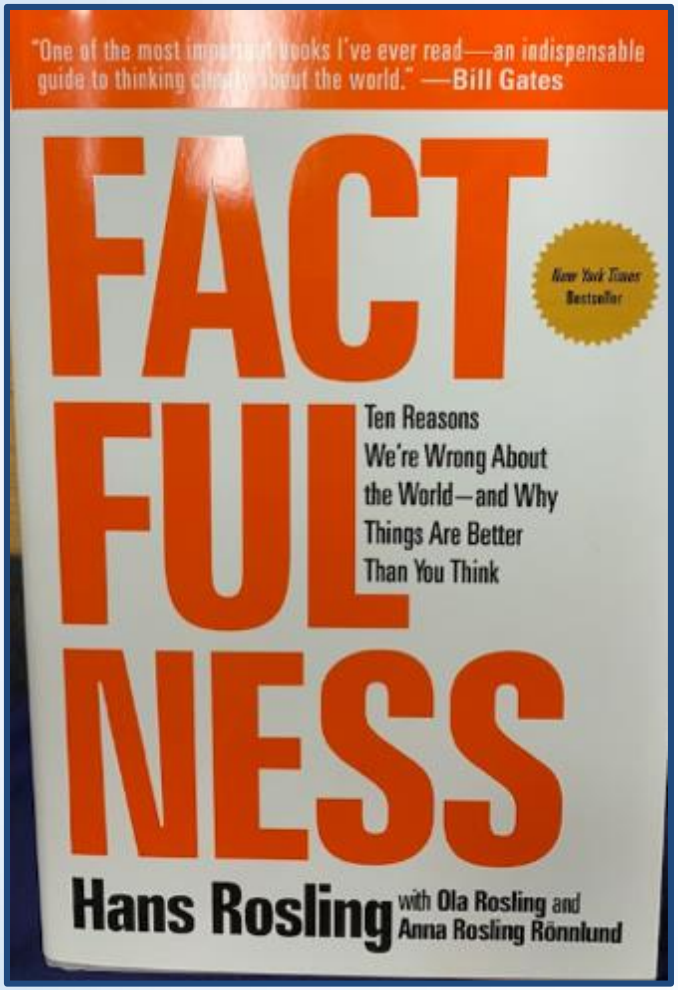
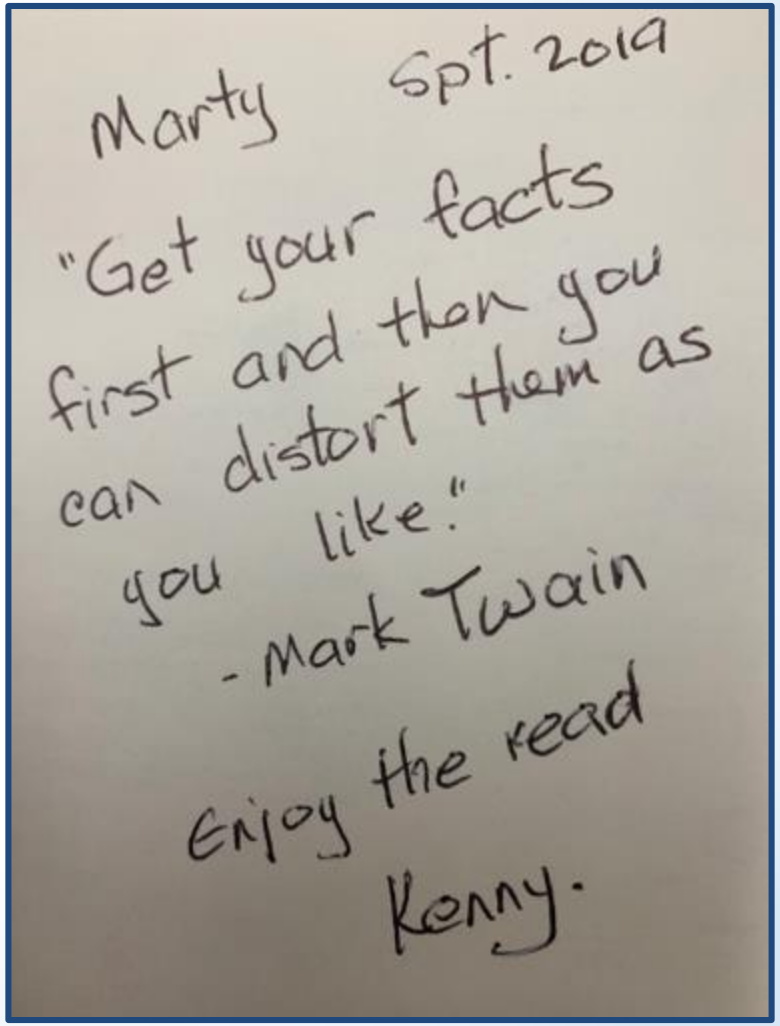
UNIVERSITY OF TORONTO | Division of Urology

AAPU

SickKids


"One of the most important books I've ever read—an indispensable guide to thinking clearly about the world." —Bill Gates
FACTFULNESS
New York Times Bestseller
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

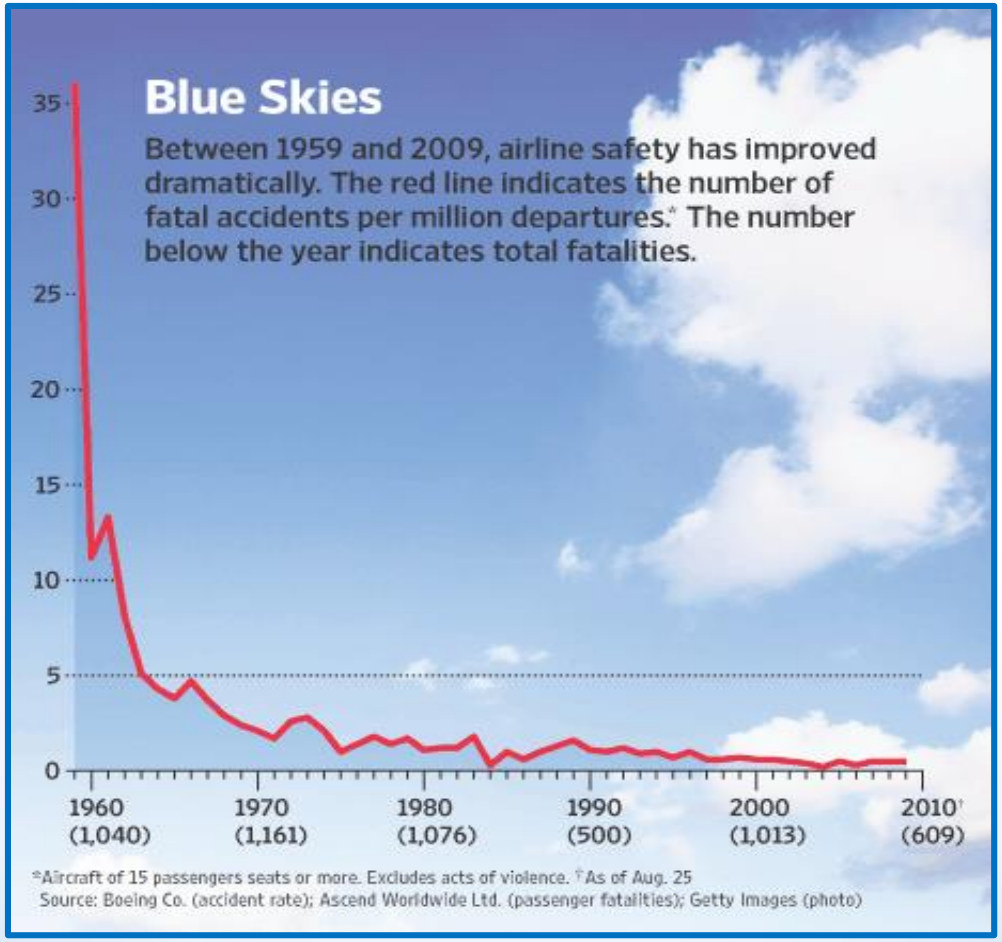

Marty Spt. 2019
"Get your facts first and then you can distort them as you like."
- Mark Twain
Enjoy the read
Kenny.


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.
NEASE '17
neasecartoons.com

Photos courtesy of
Dr. Mark Zaontz

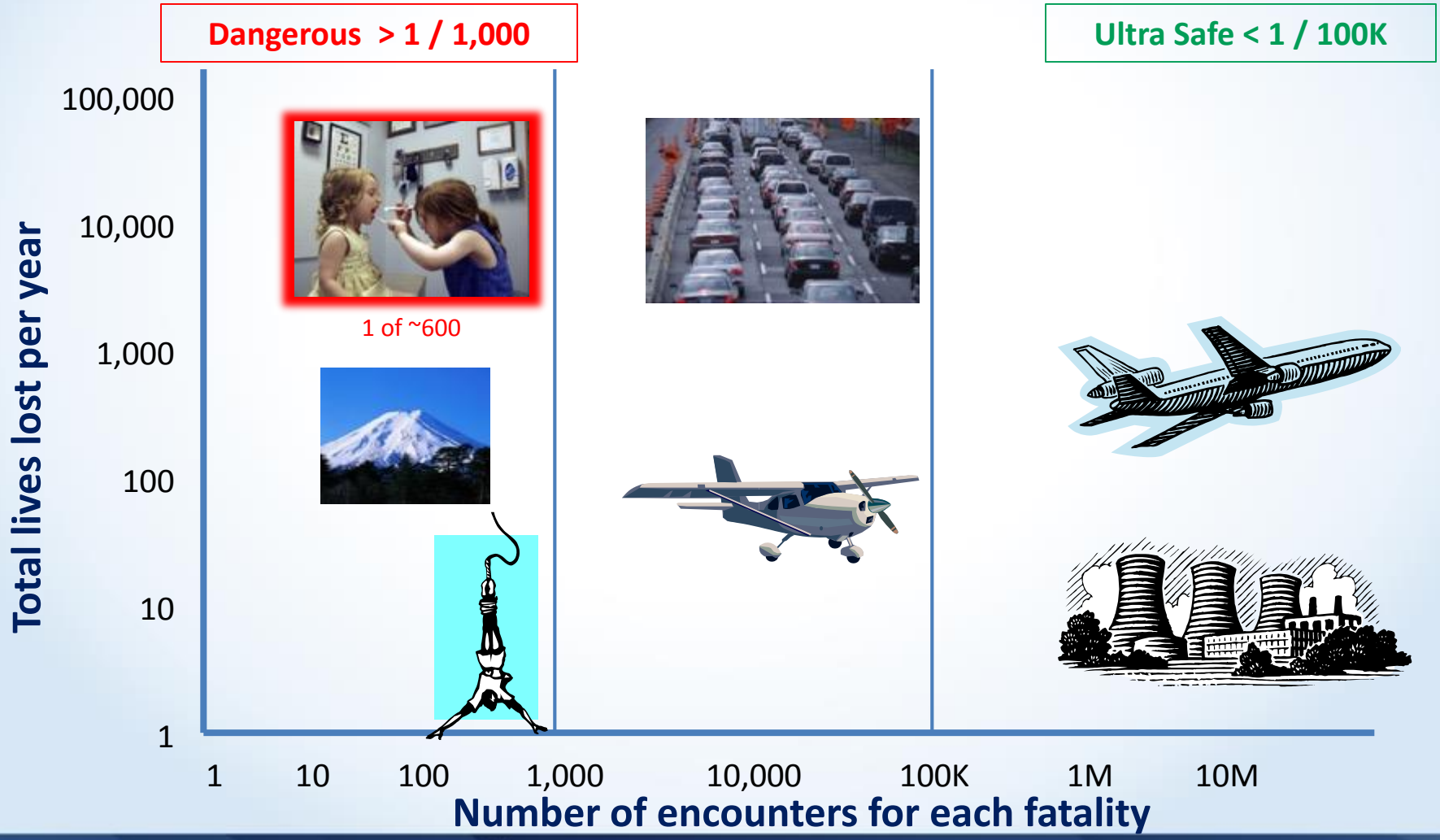
What does “Tenerife” mean to us?

What does “Tenerife” mean to us?



How Safe is Healthcare?

From: Highly Reliable Healthcare …the science of safety. Healthcare Improvement Performance , LLC. OCHSPS National Children's Network March 15, 2012.

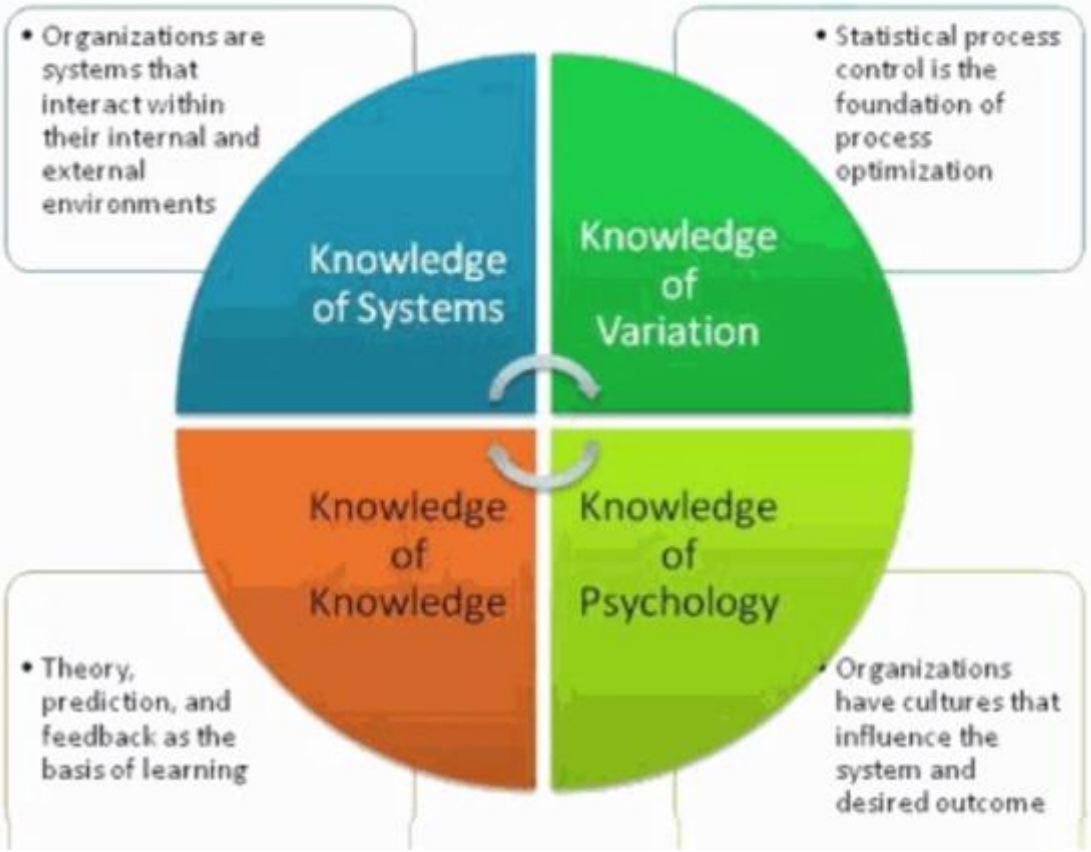


Characteristics of an "ideal-type" high reliability organisation

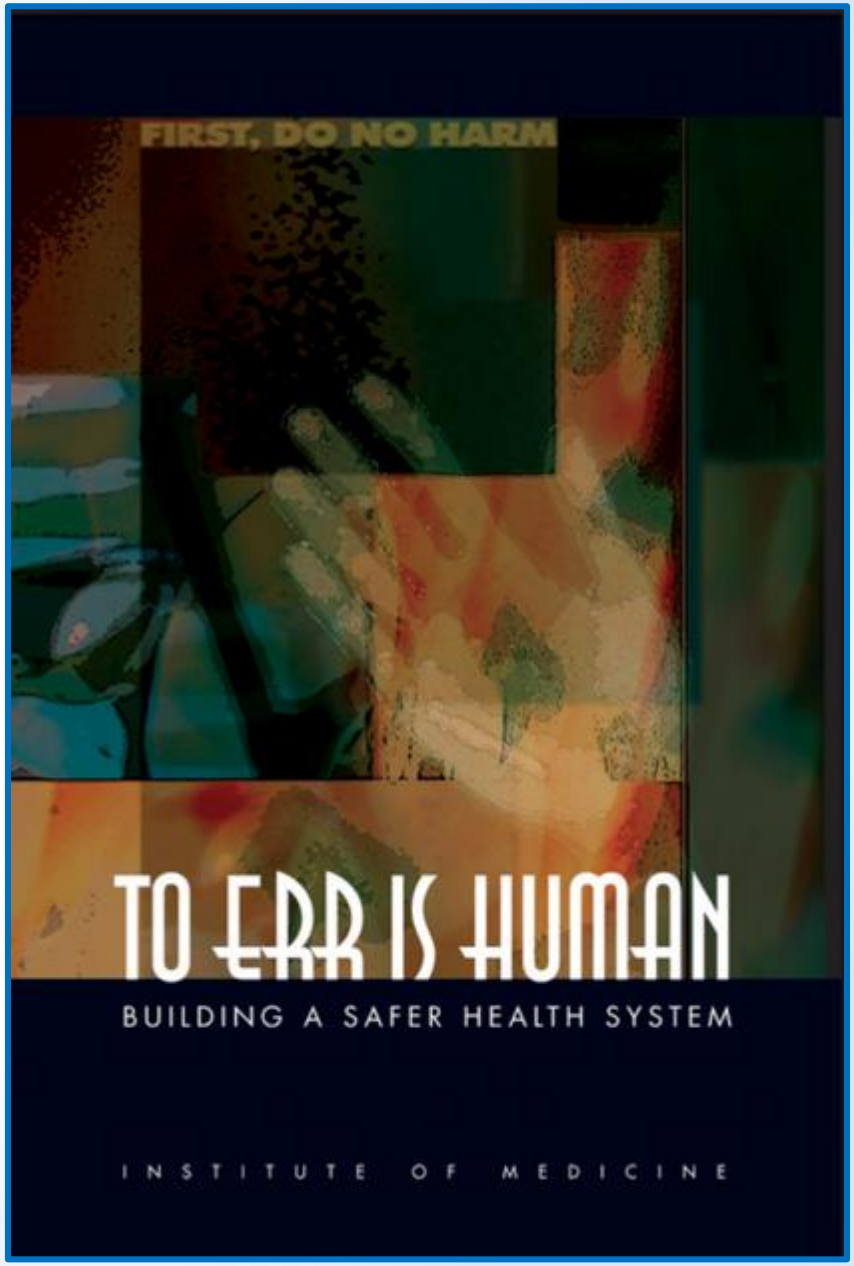
Construct of the HRO

Formalizing a Systems Approach to Avoid Catastrophic Accidents

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



“To Err is Human” changed landscape.



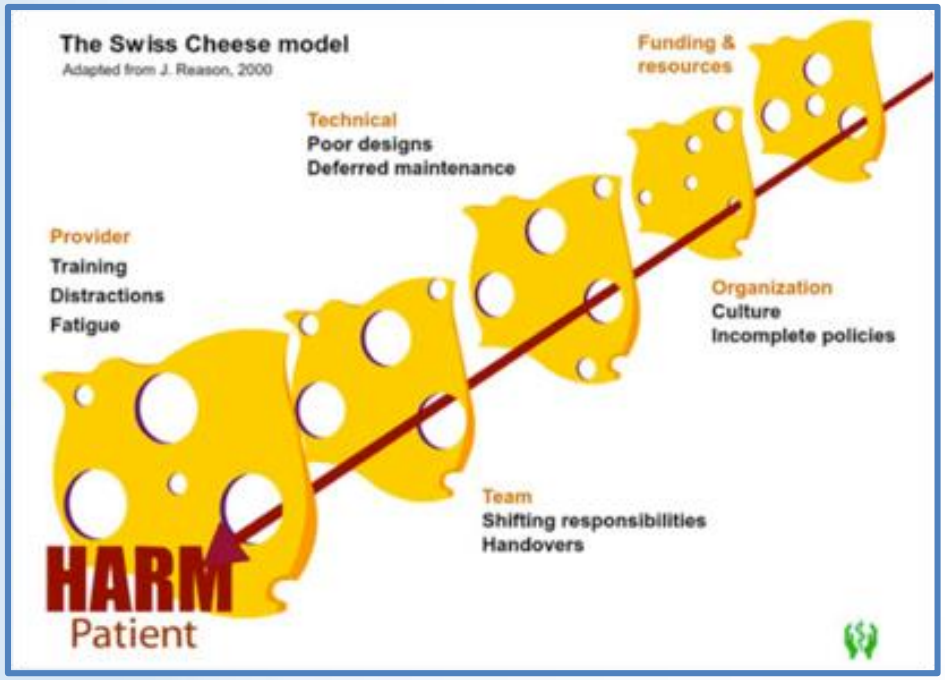
Team factor and perioperative outcomes

- 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”



“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

World Health Organization — Surgical Safety Checklist (First Edition)

Before induction of anaesthesia ▸▸▸▸▸▸▸▸▸ Before skin incision ▸▸▸▸▸▸▸▸▸▸▸▸▸ Before patient leaves operating room

SIGN IN

- ☐ PATIENT HAS CONFIRMED
  - IDENTITY
  - SITE
  - PROCEDURE
  - CONSENT
- ☐ SITE MARKED/NOT APPLICABLE
- ☐ ANAESTHESIA SAFETY CHECK COMPLETED
- ☐ PULSE OXIMETER ON PATIENT AND FUNCTIONING
- DOES PATIENT HAVE A:

KNOWN ALLERGY?
- ☐ NO
- ☐ YES

DIFFICULT AIRWAY/ASPIRATION RISK?
- ☐ NO
- ☐ YES, AND EQUIPMENT/ASSISTANCE AVAILABLE

RISK OF >500ML BLOOD LOSS (7ML/KG IN CHILDREN)?
- ☐ NO
- ☐ YES, AND ADEQUATE INTRAVENOUS ACCESS AND FLUIDS PLANNED

TIME OUT

- ☐ CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE
- ☐ SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM
  - PATIENT
  - SITE
  - PROCEDURE

ANTICIPATED CRITICAL EVENTS

- ☐ SURGEON REVIEWS: WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION, ANTICIPATED BLOOD LOSS?
- ☐ ANAESTHESIA TEAM REVIEWS: ARE THERE ANY PATIENT-SPECIFIC CONCERNS?
- ☐ NURSING TEAM REVIEWS: HAS STERILITY (INCLUDING INDICATOR RESULTS) BEEN CONFIRMED? ARE THERE EQUIPMENT ISSUES OR ANY CONCERNS?

HAS ANTIBIOTIC PROPHYLAXIS BEEN GIVEN WITHIN THE LAST 60 MINUTES?
- ☐ YES
- ☐ NOT APPLICABLE

IS ESSENTIAL IMAGING DISPLAYED?
- ☐ YES
- ☐ NOT APPLICABLE

SIGN OUT

NURSE VERBALLY CONFIRMS WITH THE TEAM:

- ☐ THE NAME OF THE PROCEDURE RECORDED
- ☐ THAT INSTRUMENT, SPONGE AND NEEDLE COUNTS ARE CORRECT (OR NOT APPLICABLE)
- ☐ HOW THE SPECIMEN IS LABELLED (INCLUDING PATIENT NAME)
- ☐ WHETHER THERE ARE ANY EQUIPMENT PROBLEMS TO BE ADDRESSED
- ☐ SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE REVIEW THE KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THIS PATIENT

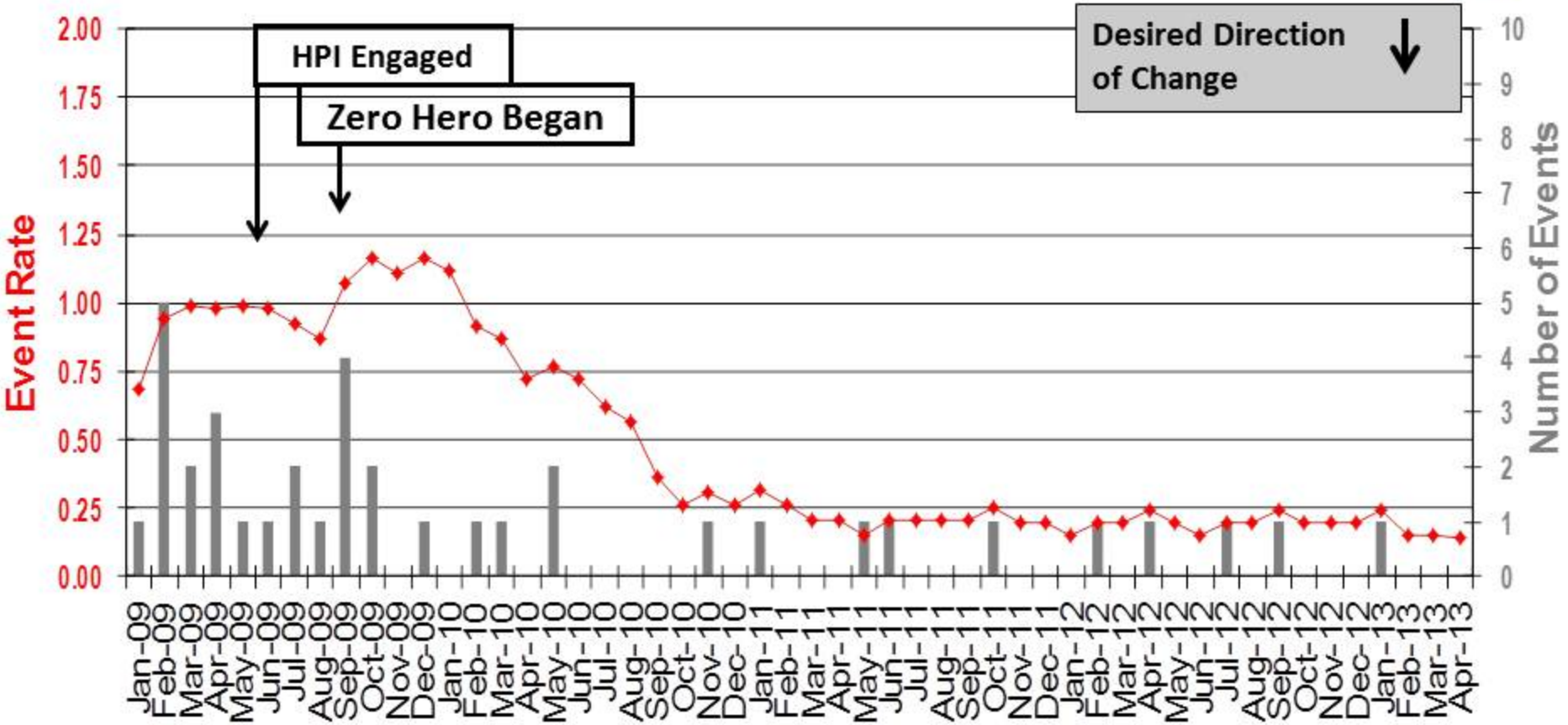
In an HRO, a Safe “Improvement” Culture is a Just Culture… a place where we can talk without fear…

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



CONFIDENTIAL: Protected under State QI Statutes

Nationwide Children's — When your child needs a hospital, everything matters.™

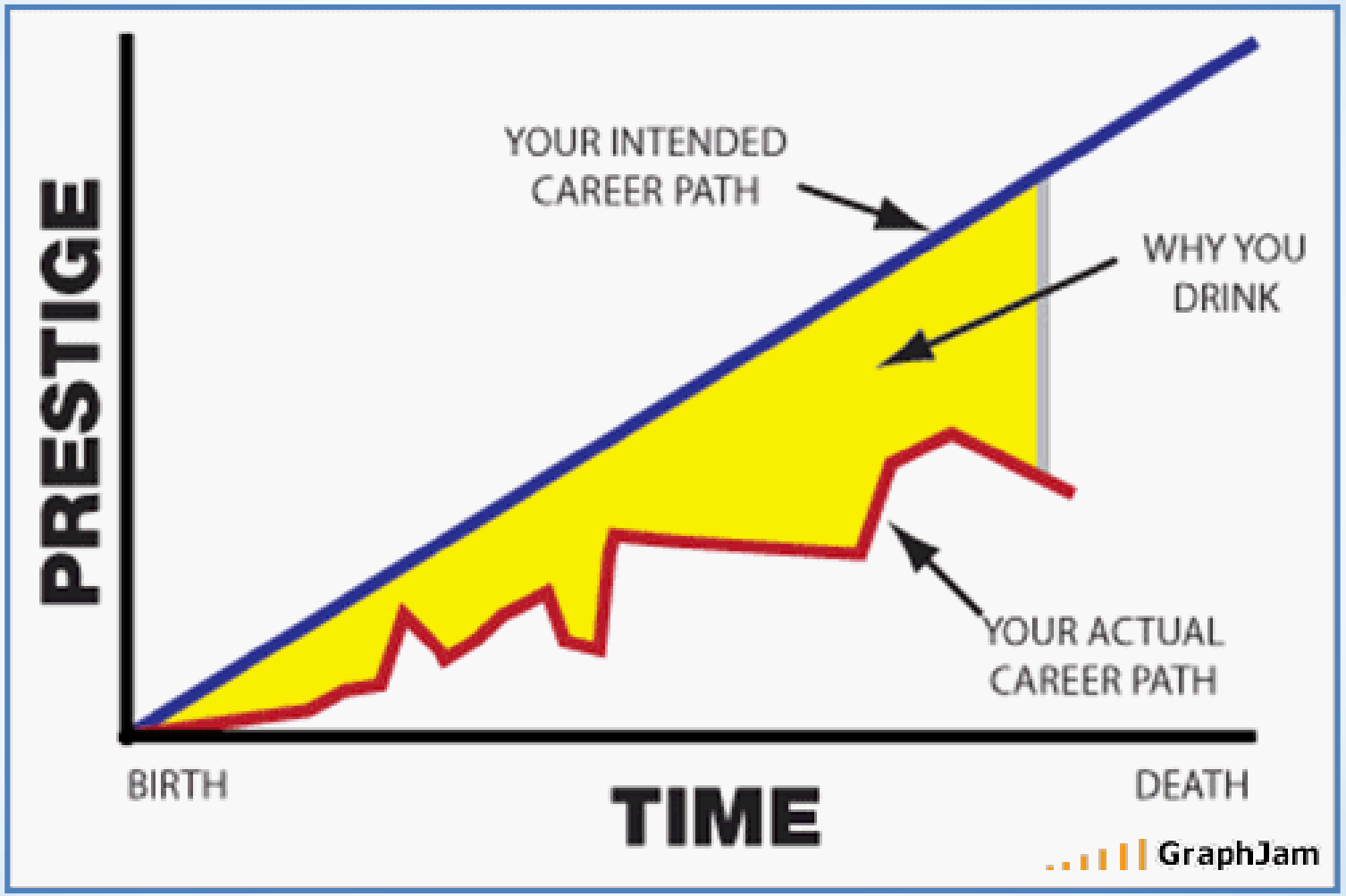
Zero Hero™ — Create a safe day. Every day.

SickKids VS

Stand up if you…

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

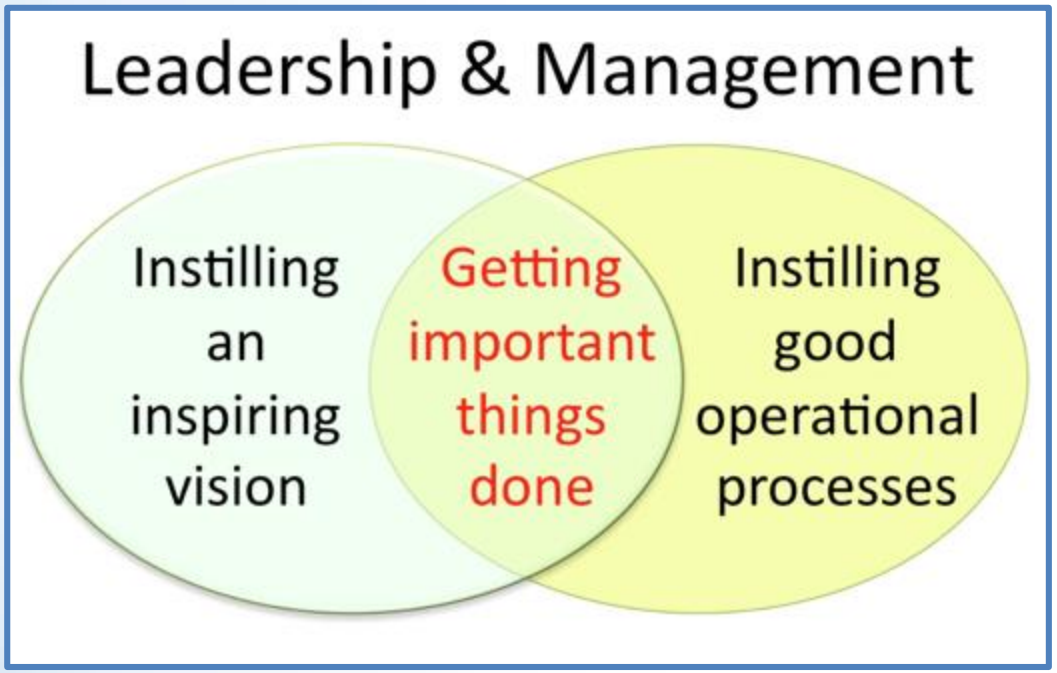
…Have been involved in a case where there was a medical error leading to morbidity/death/malpractice threat?


PRESTIGE
YOUR INTENDED CAREER PATH
WHY YOU DRINK
YOUR ACTUAL CAREER PATH
BIRTH
TIME
DEATH
GraphJam

Kotter's Change Management Model

Source: John Kotter

Leadership becomes a key: Management differs!

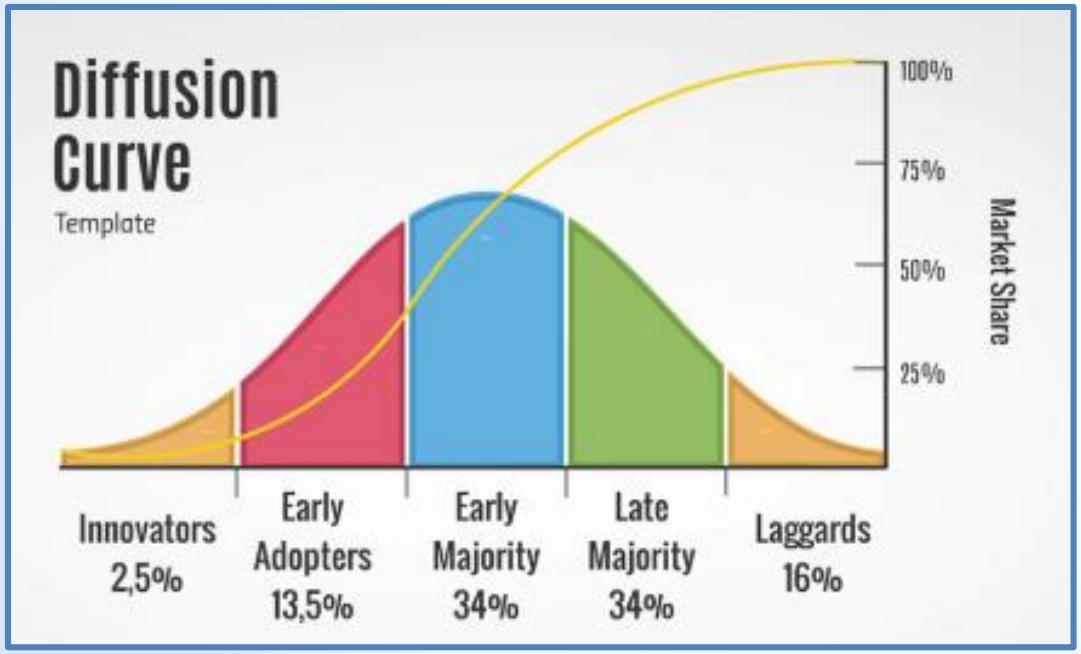


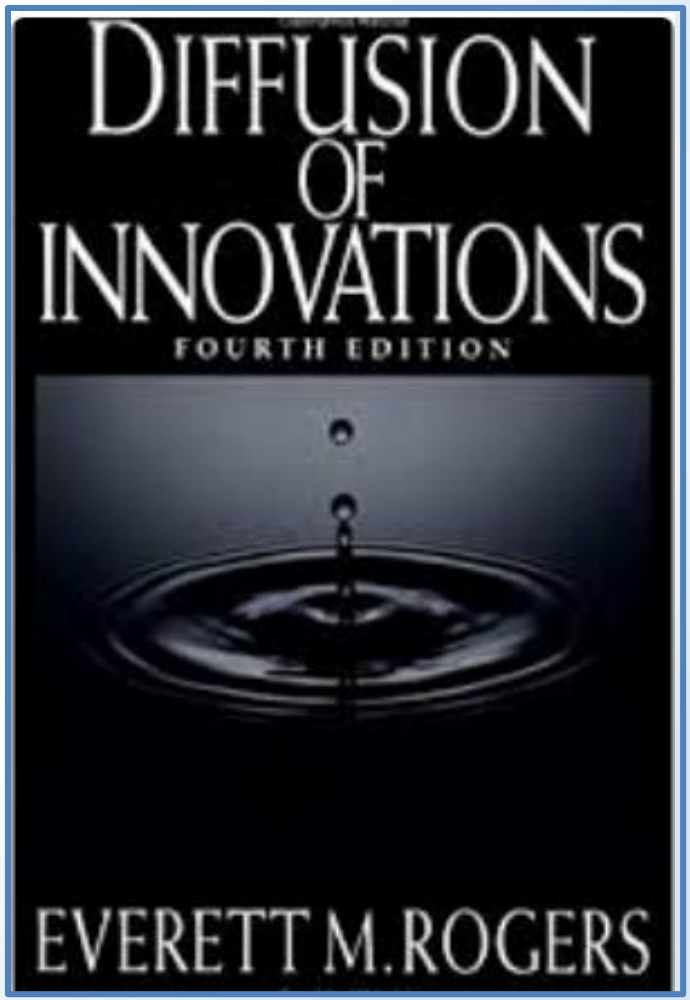
WHEN I TALK TO MANAGERS
I GET THE FEELING THAT
THEY ARE IMPORTANT.

WHEN I TALK TO LEADERS
I GET THE FEELING THAT
I AM IMPORTANT.

Different people with different experiences & expectations … but some things we do share!

Changing Practice…
Changing Behavior, Results

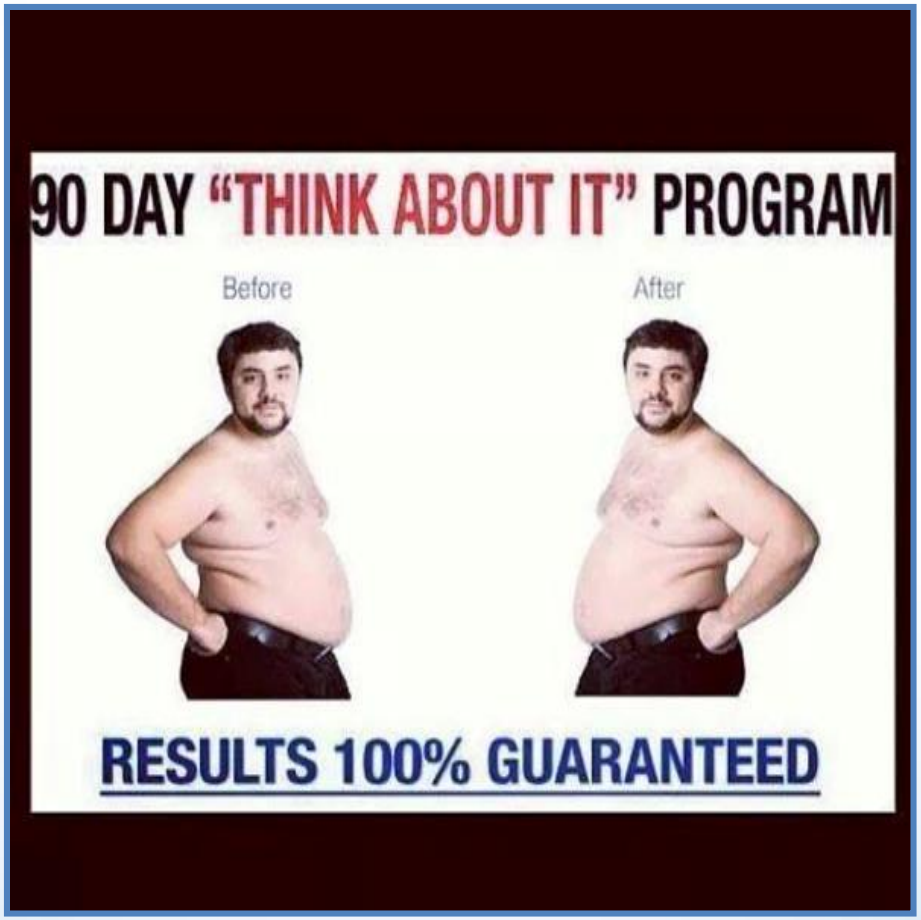




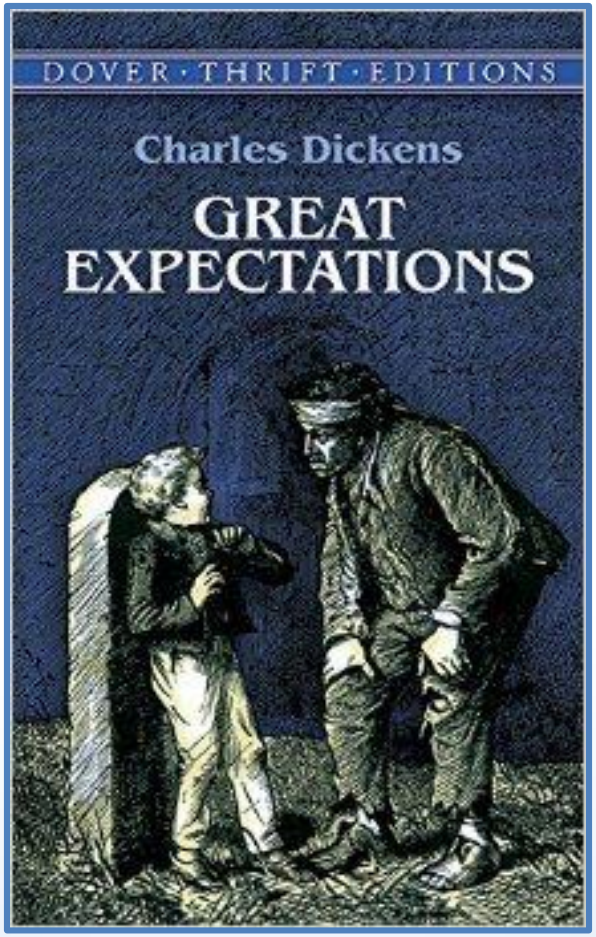
Brooks Koepka

"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."

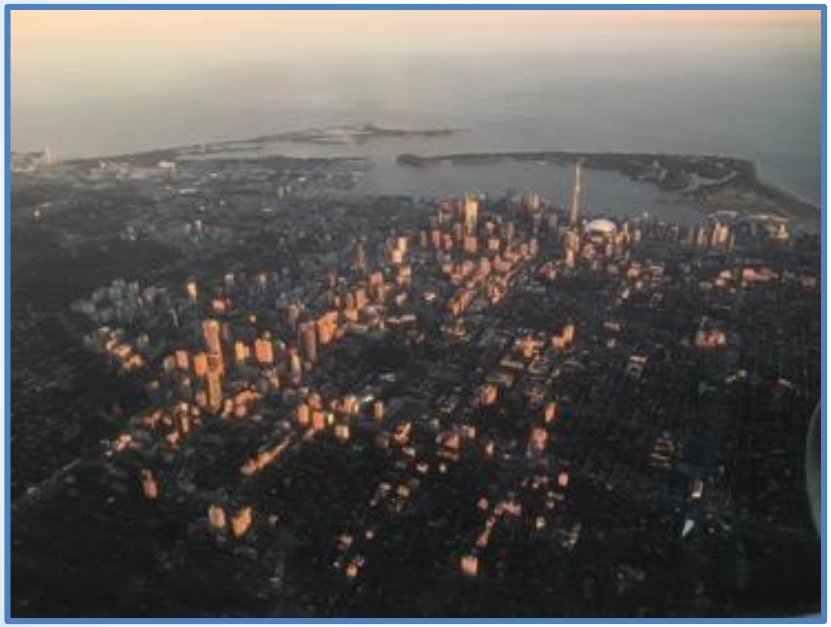
Returning to Canada after 35 years of training & practicing in the USA



Delusions of grandeur?
9 years later…



2011… Never would I have thought

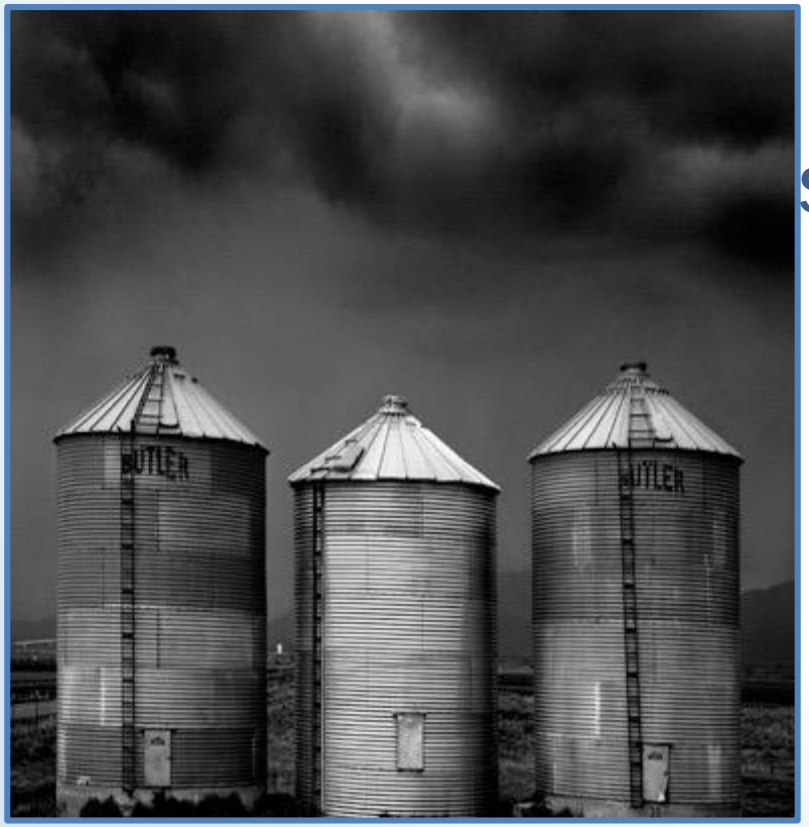


Too many chocolates, too little time. Lucy and Ethel tackle "Job Switching.

The Medical System

Challenging Human Experience

Everyone can blame someone else



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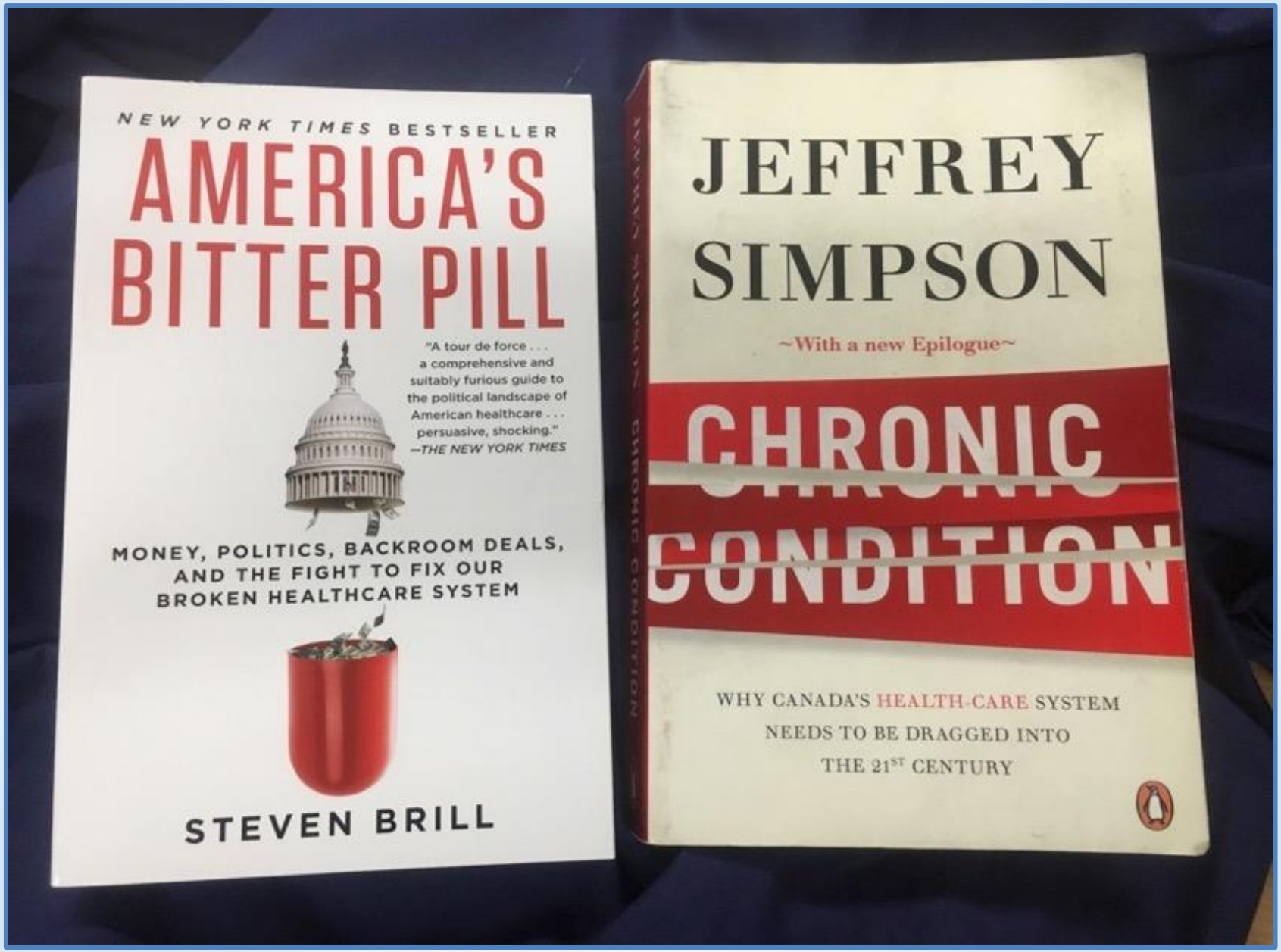

NEW YORK TIMES BESTSELLER
AMERICA'S BITTER PILL
"A tour de force . . . a comprehensive and suitably furious guide to the political landscape of American healthcare . . . persuasive, shocking."
—THE NEW YORK TIMES
MONEY, POLITICS, BACKROOM DEALS, AND THE FIGHT TO FIX OUR BROKEN HEALTHCARE SYSTEM
STEVEN BRILL
JEFFREY SIMPSON
~With a new Epilogue~
CHRONIC CONDITION
WHY CANADA'S HEALTH-CARE SYSTEM NEEDS TO BE DRAGGED INTO THE 21ST CENTURY

CHAPTER 6

Stage Three: The Wild, Wild West

By any measure, Martin Koyle is living the American dream. So why is he so frustrated?

CUAJ • April 2018 • Volume 12, Issue 4

REVIEW

Urologist burnout: Frequency, causes, and potential solutions to an unspoken entity

Julie Franc-Guimond, MD, FRCSC[1]; Brian McNeil, MD, FACS[2]; Steven M. Schlossberg, MD, FACS[3]; Amanda C. North, MD, FACS[4]; Alp Sener, MD PhD, FRCSC[5,6]

[1]Division of Pediatric Urology, Department of Surgery, University of Montreal, QC, Canada; [2]Department of Urology, SUNY Downstate Medical Center, Brooklyn, NY, United States; [3]John Muir Health Center, Walnut Creek, CA, United States; [4]Montefiore Medical Center, Bronx, NY, United States; [5]Department of Surgery, Division of Urology, Western University, London, ON, Canada; [6]Department of Microbiology and Immunology, Schulich School of Medicine and Dentistry, Western University, London, ON, Canada

CUAJ | JAUC

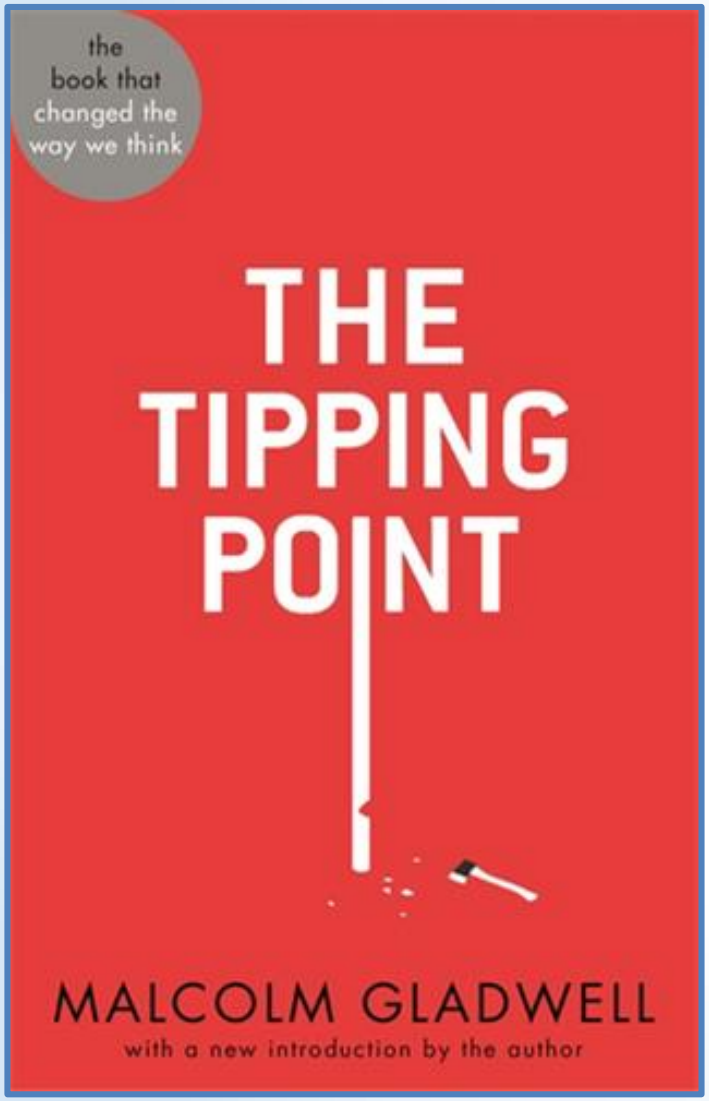
Canadian Urological Association Journal | Journal de l'Association des urologues du Canada

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

Author	Year	Study type	Country	Sample size	Response rate	Pertinent findings
O'Kelly et al[9]	2016	Survey	U.K., Ireland	1380	575 (42%)	– 15% reported self-medication or EtOH to combat burnout – 8% sought professional help for burnout – 60% would have attended counseling if provided – 80% felt burnout should be evaluated in urology practices – Highest burnout associated with age <45, private practice, leadership roles, hospital management – Characteristics associated with burnout included high administrative work load, volume of clinical work, lack of institutional resources, pension, patient expectations – Operative decision making, research and medico-legal pressures did not impact burnout rates – Gender or ethnicity had no impact on burnout
Roumigue et al[8]	2011	Survey	France	180	119 (66%)	– 25% of residents in training experienced burnout – 8% had emotional exhaustion, 22% had depersonalization – Characteristics protective from burnout included being in a relationship, >1 extracurricular hobby, seniority in residency and older age – Gender had no impact on burnout
Bohle et al[5]	2001	Survey	Germany	128	75 (59%)	– Increased risk of burnout associated with academic practice, residency and age <45 years
Wines et al[10]	1998	Survey	Australia	275	205 (75%)	– <50% reported seeing their family physician for work related anxiety and depression – >50% admitted to self-prescription of analgesics and benzodiazepines – Greatest risk of burnout was overwhelming administrative responsibilities

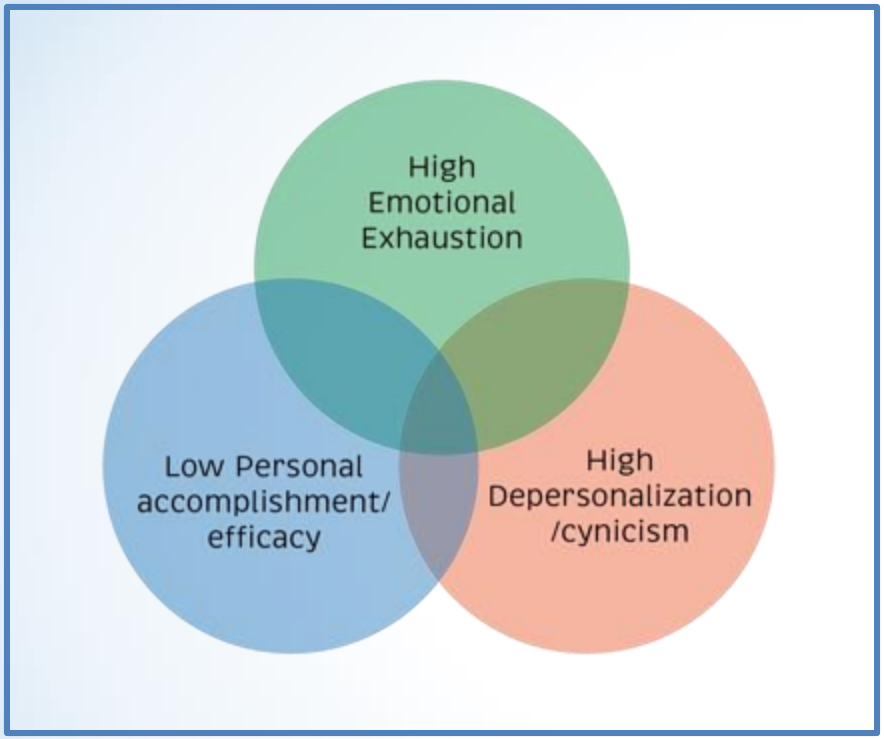
Table 2. Factors associated with burnout

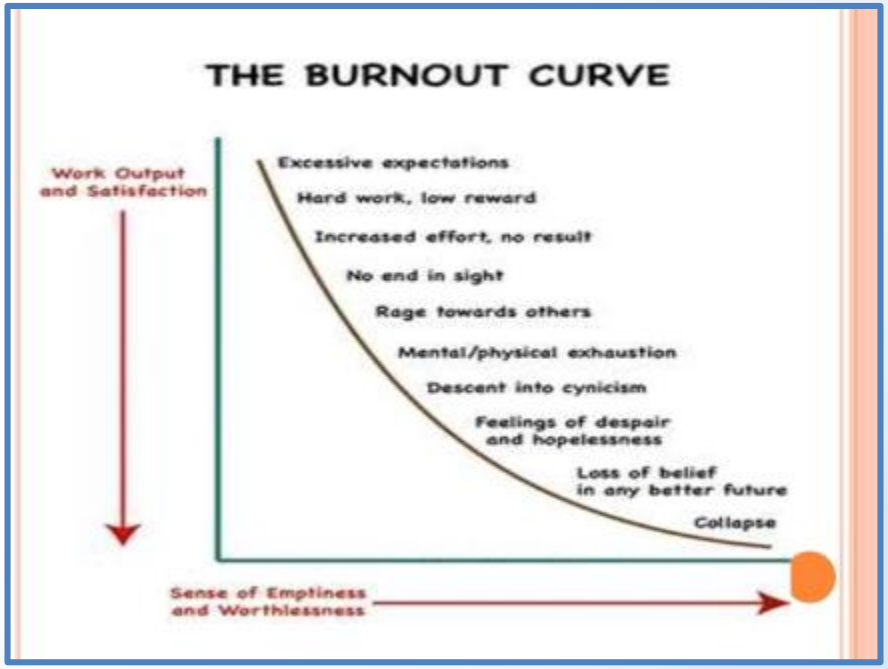
Causative factors	Protective factors
– Chronic exposure to high levels of stress	– Reducing time spent at work
– Increased work load	– Gaining seniority
– Lack of institutional resources or management support	– Working in a positive work environment
– Too many bureaucratic tasks	– Being in a meaningful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


the
book that
changed the
way we think
THE
TIPPING
POINT
MALCOLM GLADWELL
with a new introduction by the author

Culture Change

“This patient (outcome) defines me… It is my legacy”


High
Emotional
Exhaustion
Low Personal
accomplishment/
efficacy
High
Depersonalization
/cynicism


THE BURNOUT CURVE
Work Output
and Satisfaction
Excessive expectations
Hard work, low reward
Increased effort, no result
No end in sight
Rage towards others
Mental/physical exhaustion
Descent into cynicism
Feelings of despair
and hopelessness
Loss of belief
in any better future
Collapse
Sense of Emptiness
and Worthlessness

Martin A. Koyle, MD, MSc[1]; D. Robert Siemens, MD, FRCSC[2]

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EDITORIAL I didn't think it could (would) happen to me

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."[3] 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 CUAJ 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 I am 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 CUAJ 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

THE VARSITY

The University of Toronto's Student Newspaper Since 1880

A surgeon's account of physician burnout and depression

How the social dynamics of Canada's health care system may obstruct patient care

By Danté Ravenhearst
Published: 10:45 am, 11 August 2019

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.

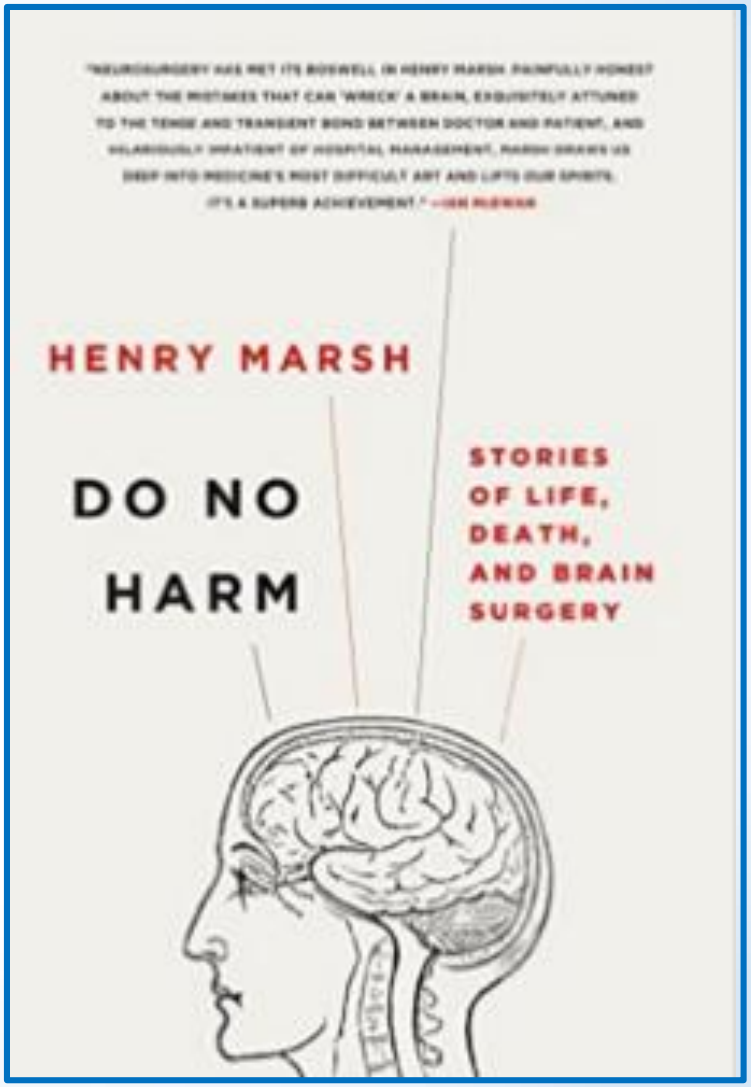
"I realized from day one that all that I was, was a number," he said. The system, although advertised as universal, lacked strongly in quality of patient care and career gratification. In the US, Koyle discussed his feeling of belonging to a "community" and being "part of a family." He personally knew 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."

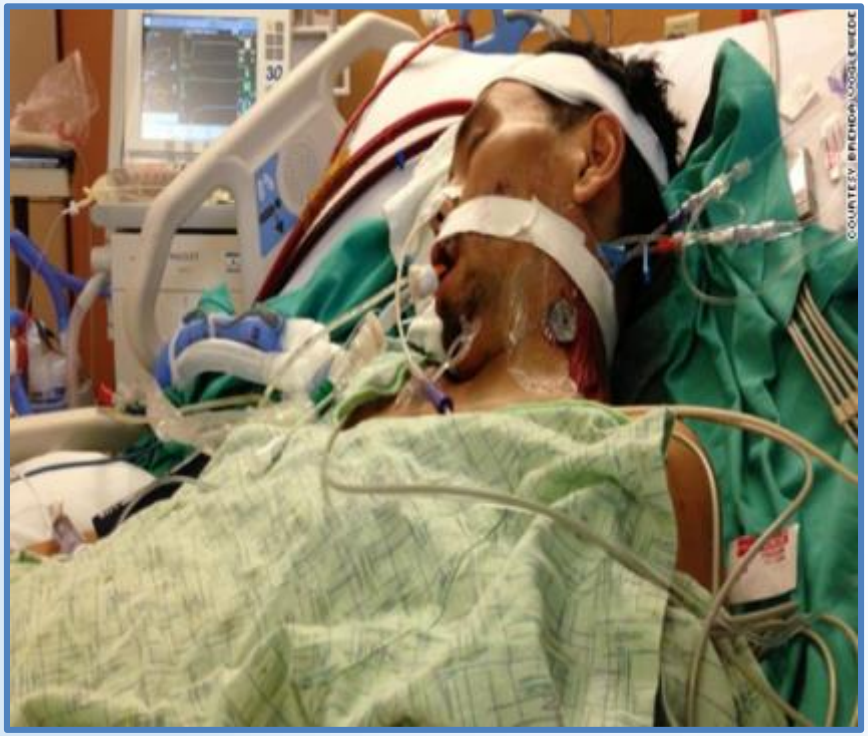
"Here, the buck stops at me… I'm not providing the healthcare that I want to provide to people [due to these social dynamics of the Canadian health care system]."

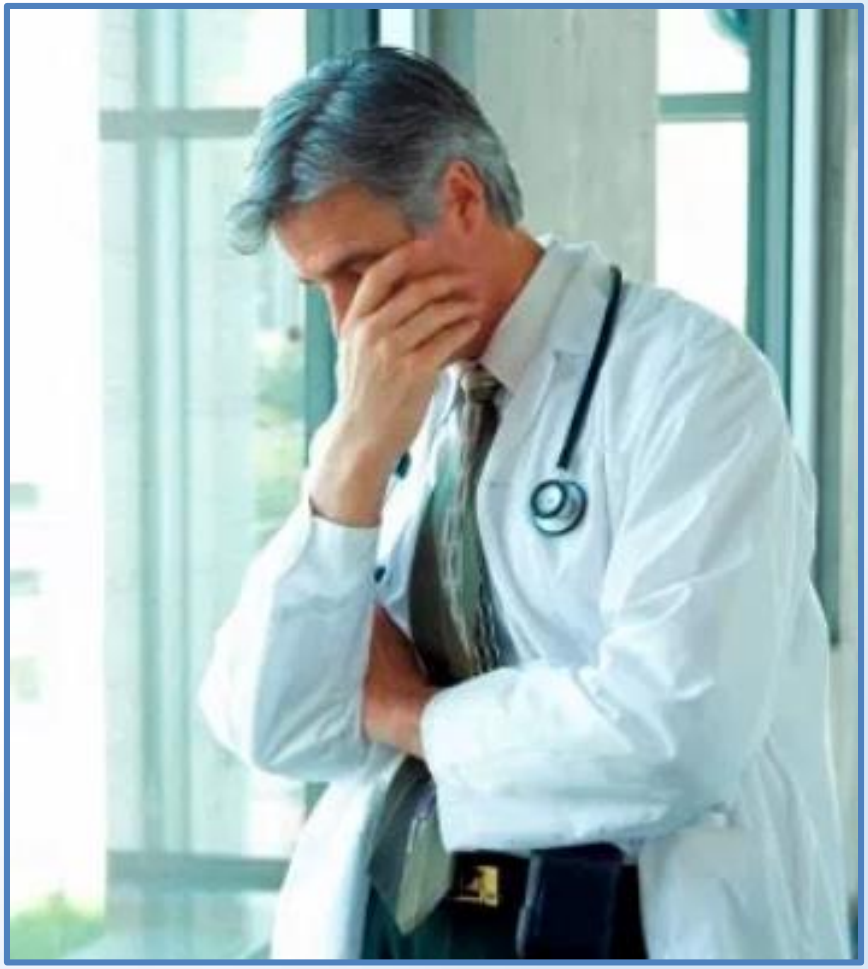
‘Every [physician] carries within himself a small cemetery, where from time to time he goes to pray – a place of bitterness and regret, where he must look for an explanation for his failures.’

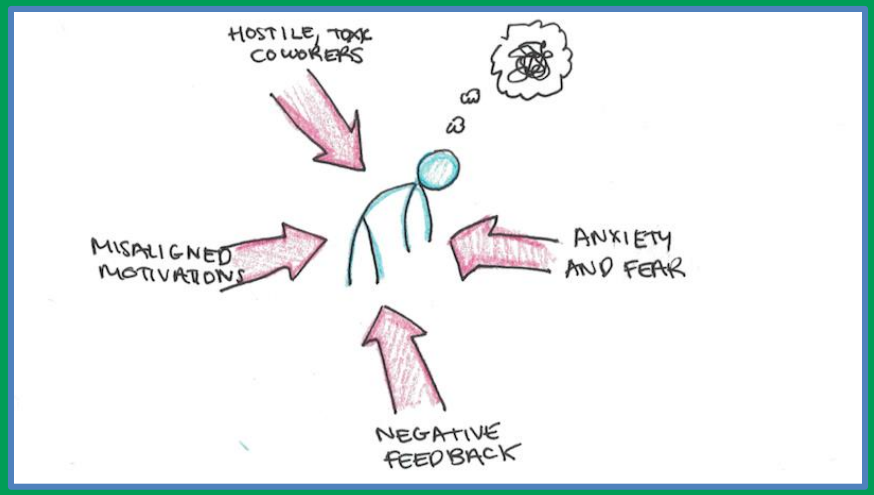
René Leriche,
La philosophie de la chirurgie, 1951



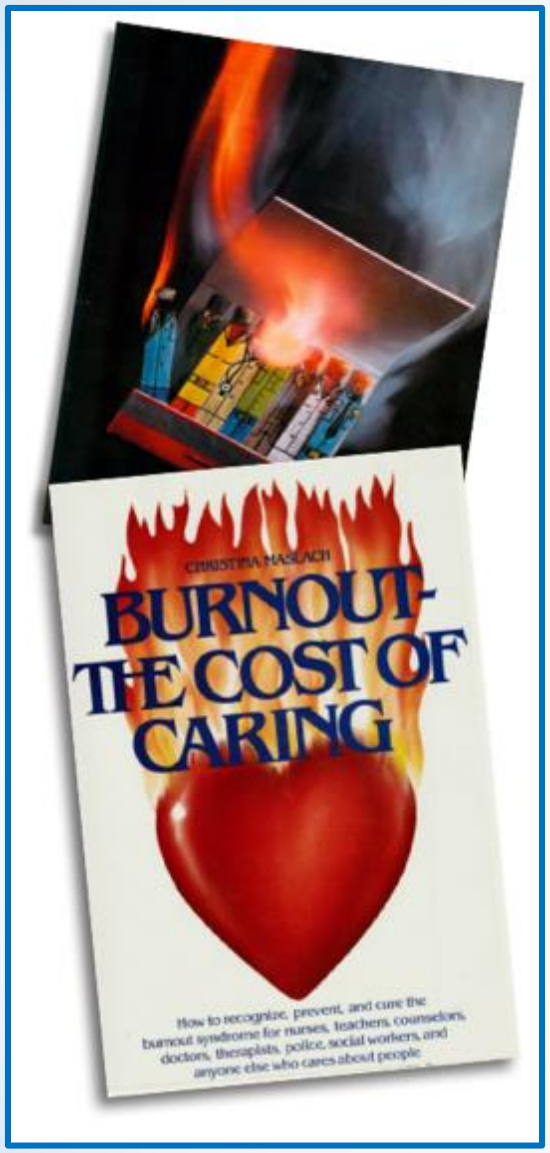
Walk past suffering colleague?







Why talk about Burnout?



Barends

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.

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

30 - 40%

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

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
- Workspace 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."

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.

HUFFPOST

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HEALTH 05/28/2019 13:40 EDT | Updated 05/28/2019 16:38 EDT

Burnout Is Now A Legitimate Diagnosis, Says World Health Organization

Burnout is now classified as "a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed," according to WHO.

By Jenna Amatulli, HuffPost US

Forbes

Billionaires Innovation Leadership Money Business Small Business

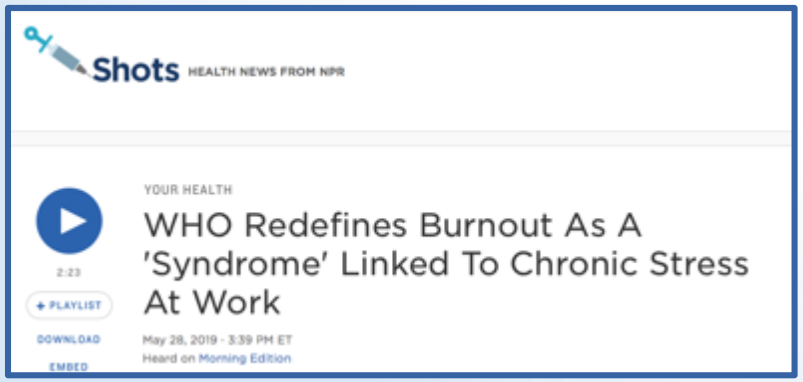
7,814 views | Jun 10, 2019, 11:41am

We Can No Longer Ignore Burnout Syndrome Related To Chronic Stress, Says World Health Organization

Naz Beheshti Contributor

ForbesWoman

I write about practicing mindful leadership and corporate wellness.



Shots HEALTH NEWS FROM NPR

YOUR HEALTH

WHO Redefines Burnout As A 'Syndrome' Linked To Chronic Stress At Work

2:23

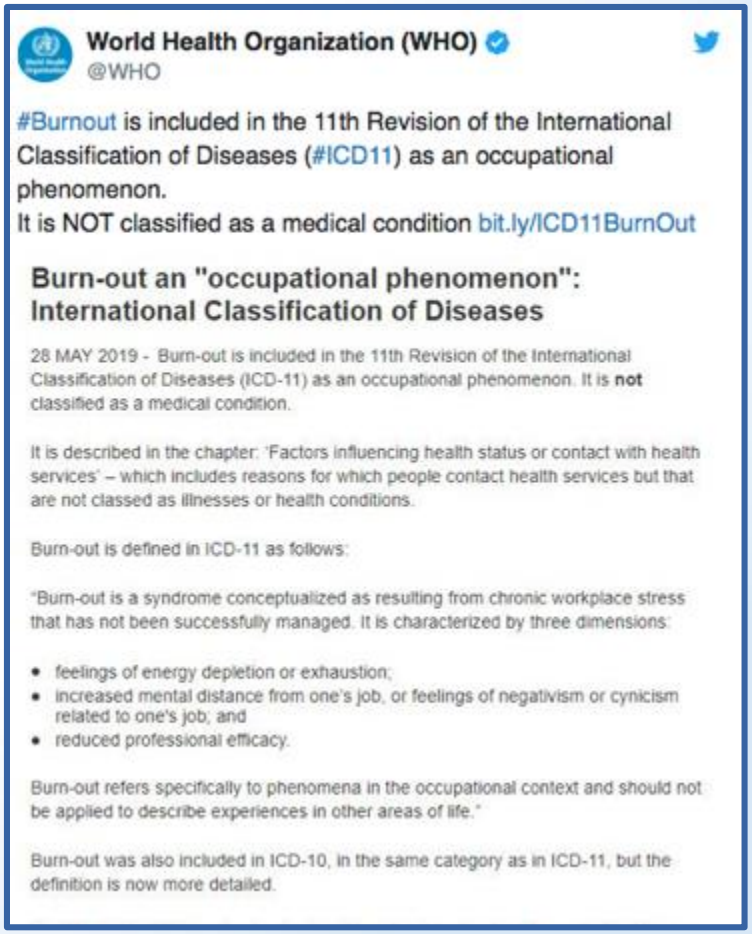
+ PLAYLIST

DOWNLOAD

EMBED

May 28, 2019 · 3:39 PM ET

Heard on Morning Edition



World Health Organization (WHO)

@WHO

#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 classed 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 negativism 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

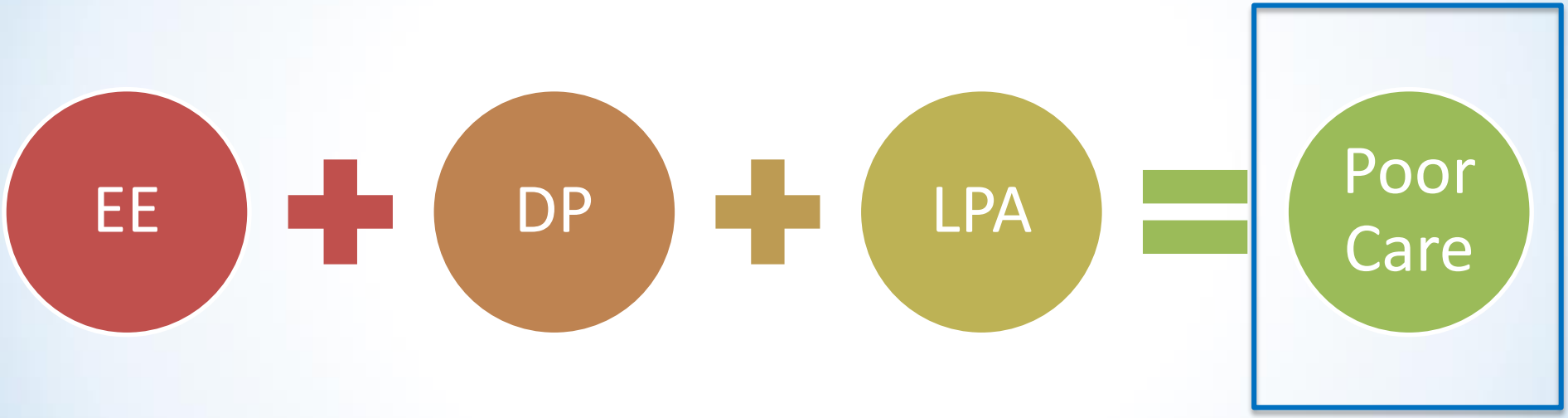
Adaptive

- 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

Breaking Down Burnout



Burnout among American surgeons

Darrell A. Campbell, Jr, MD, Seer a 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[1]
- Patient compliance[2]
- Physician prescribing habits
- Turnover/absenteeism[3]
- Detrimental attitudes: cynicism, resentment[4]
- Intent to leave medicine[3]

[1] Health Psych 12:93; [2] JGIM 15:122; [3] Arch IM 169:990; [4] JGIM 22:177

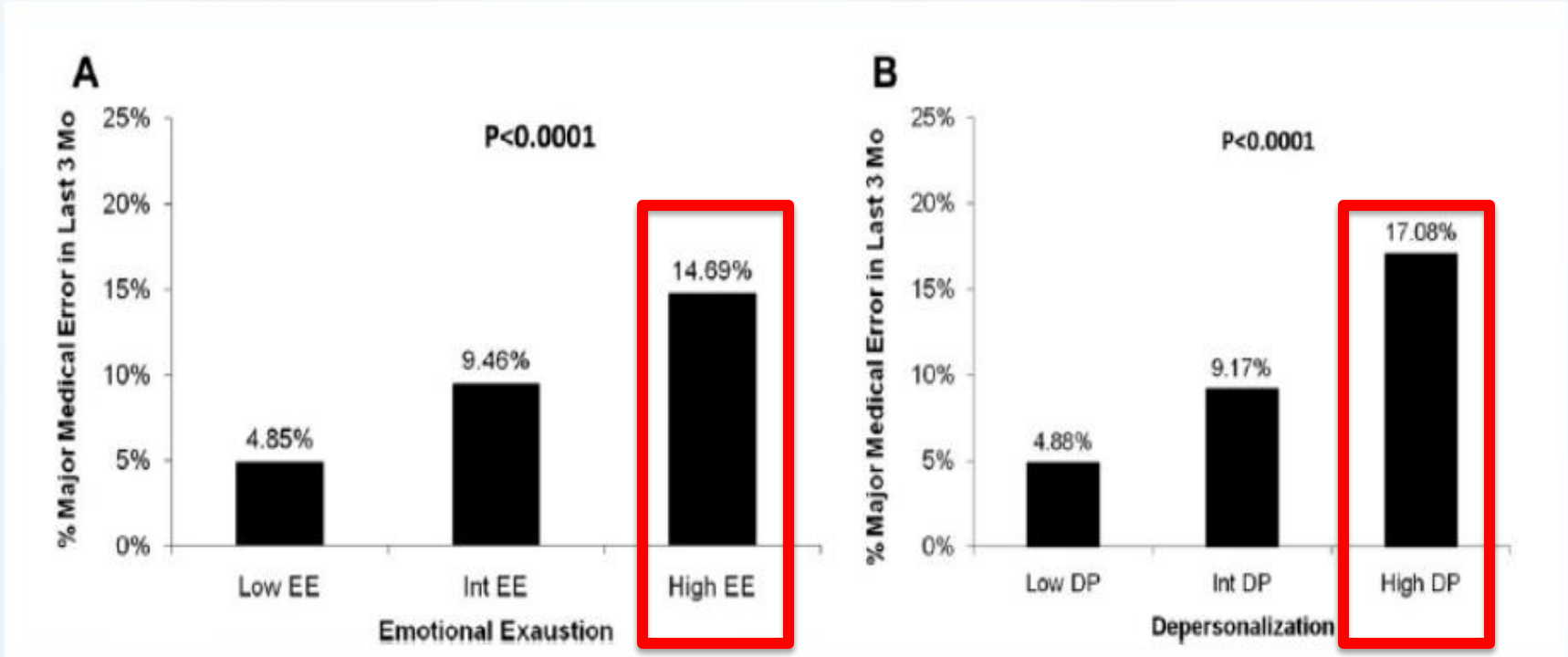
Distress Leads to Medical Errors

- West JAMA 296:1071

Variable	Instrument	OR of subsequent error	p
Burnout	MBI-DP	1.10	.001
	MBI-EE	1.07	<.001
	MBI-PA	1.08	.02
Depression	Positive 2-item screen	1.93	.08

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.

Pamela Wible MD

America's leading voice for ideal medical care

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What depressed doctors do (when nobody's looking)

Posted on July 9, 2017 | by Pamela Wible MD | ~ 70 Comments

What is the difference between depression and burnout? An ongoing debate

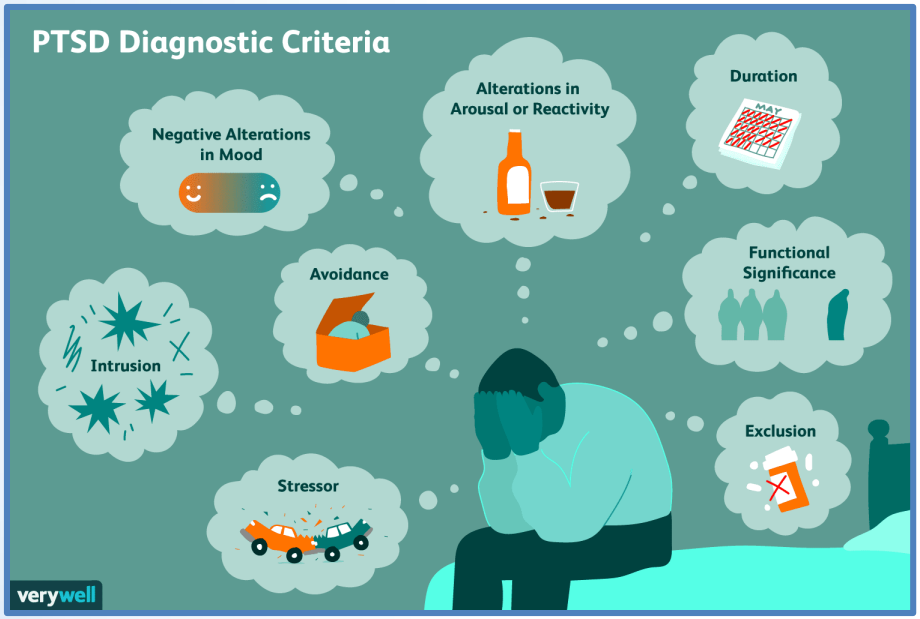
Qual è la differenza tra depressione e burnout? Un dibattito in corso

IRVIN SAM SCHONFELD[1]*, RENZO BIANCHI[2], STEFANO PALAZZI[3]
*E-mail: ischonfeld@ccny.cuny.edu

[1]Department of Psychology, The City College of the City University of New York, USA
[2]Institut de Psychologie du Travail et des Organisations, Université de Neuchâtel, Svizzera
[3]Unità 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 unresolvable stress.

KEY WORDS: depression, burnout, stress.



BURNOUT	COMPASSION FATIGUE	VICARIOUS TRAUMATIZATION
HALLMARK SIGNS • Anger & frustration • Fatigue • Negative reactions towards others • Cynicism • Negativity • Withdrawal	**HALLMARK SIGNS** • Sadness & grief • Nightmares • Avoidance • Addiction • Somatic complaints • Increased psychological arousal • Changes in beliefs, expectations, assumptions • 'witness guilt' • Detachment • Decreased intimacy	**HALLMARK SIGNS** • Anxiety, sadness, confusion, apathy • Intrusive imagery • Somatic complaints • Loss of control, trust & independence • Decreased capacity for intimacy • Relational disturbances (crossover to personal life)
SYMPTOMS • Physical • Psychological • Cognitive • Relational disturbances	**SYMPTOMS (mirror PTSD)** • Physical • Psychological distress • Cognitive shifts • Relational disturbances	**SYMPTOMS (mirror PTSD)** • Physical • Psychological distress • Cognitive shifts • Relational disturbances • **permanent alteration in individual's cognitive schema
KEY TRIGGERS • Personal characteristics • Work-related attributes • Work/organizational characteristics	**KEY TRIGGERS** • Personal characteristics • Previous exposure to trauma • Empathy & emotional energy • Prolonged exposure to trauma material of clients • Response to stressor • Work environment • Work-related attitudes	**KEY TRIGGERS** • Personal characteristics • Previous exposure to trauma • Type of therapy • Organizational context • Healthcare structure • Resources • Re-enactment

Contents lists available at ScienceDirect

Journal of Pediatric Surgery

journal homepage: www.elsevier.com/locate/jpedsurg

Canadian Association of Pediatric Surgeons' state of wellness

Ioana Bratu [a,*], Kurt Heiss [b], Claudia Mueller [c], Andrea Winthrop [d], Geoffrey Blair [e], Carol-Anne Moulton [f]

[a] Division of Pediatric Surgery, Department of Surgery, University of Alberta, Edmonton, AB, Canada
[b] Division of Pediatric Surgery, Department of Surgery, Emory University School of Medicine, Atlanta, GA, USA
[c] Division of Pediatric Surgery, Department of Surgery, Stanford University School of Medicine, Stanford, CA, USA
[d] Department of Surgery, Queen's University School of Medicine, Kingston, ON, Canada
[e] Department of Surgery, University of British Columbia, Vancouver, BC, Canada
[f] Department of Surgery, University of Toronto, Toronto, ON, Canada

Table 1
Pediatric Surgeons' Maslach Burnout Inventory Profiles.

Profile (n = 116)	Emotional exhaustion	Depersonalization	Personal accomplishment
Engaged 67 (57.7%)	Low	Low	High
Ineffective 19 (16.4%)	-	-	Low
Overextended 20 (17.2%)	High	-	-
Disengaged 1 (1%)	-	High	-
Burnout 9 (7.8%)	High	High	-

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?

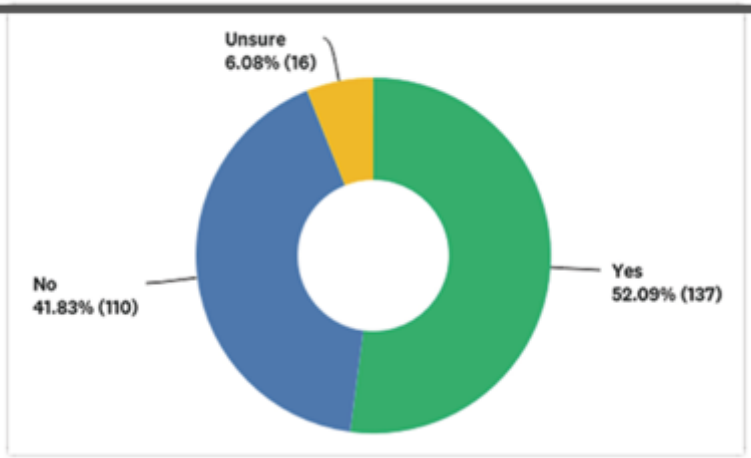


Figure 3. Were you resistant to talking about burnout because of the possible stigma?

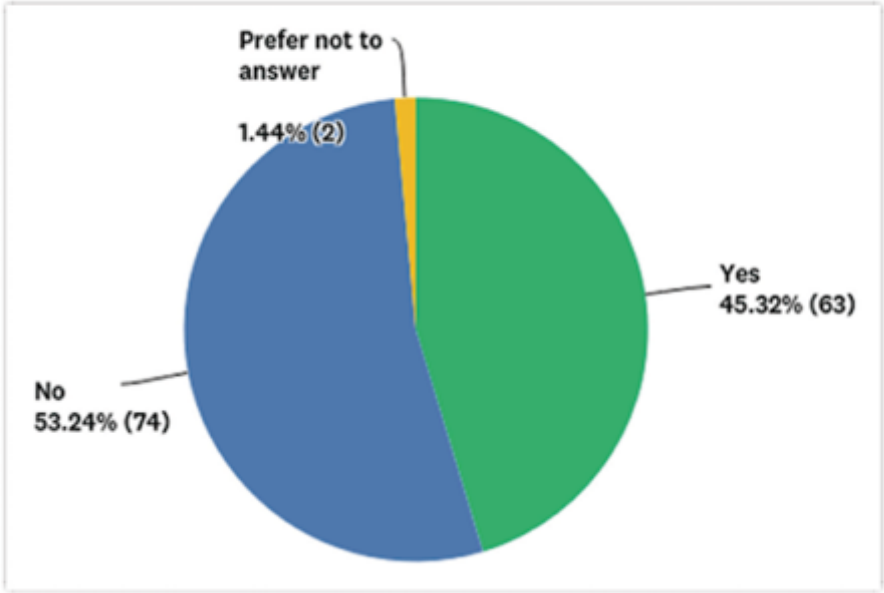


Figure 5. Have you witnessed a colleague experience burnout?

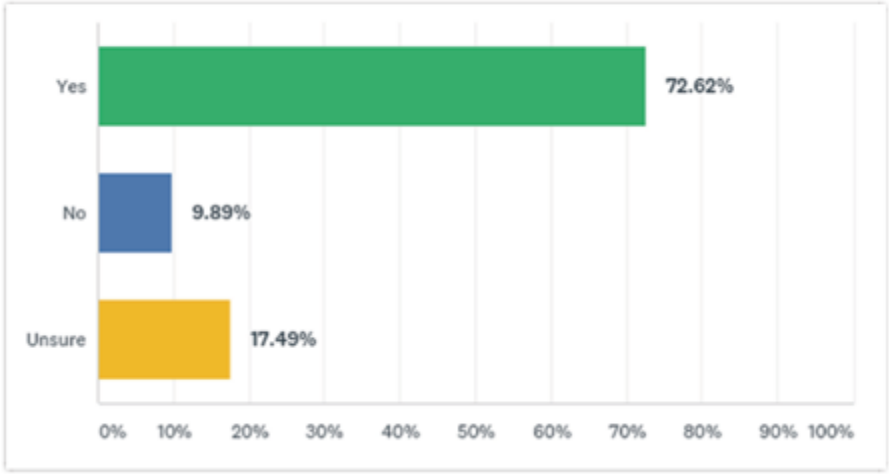
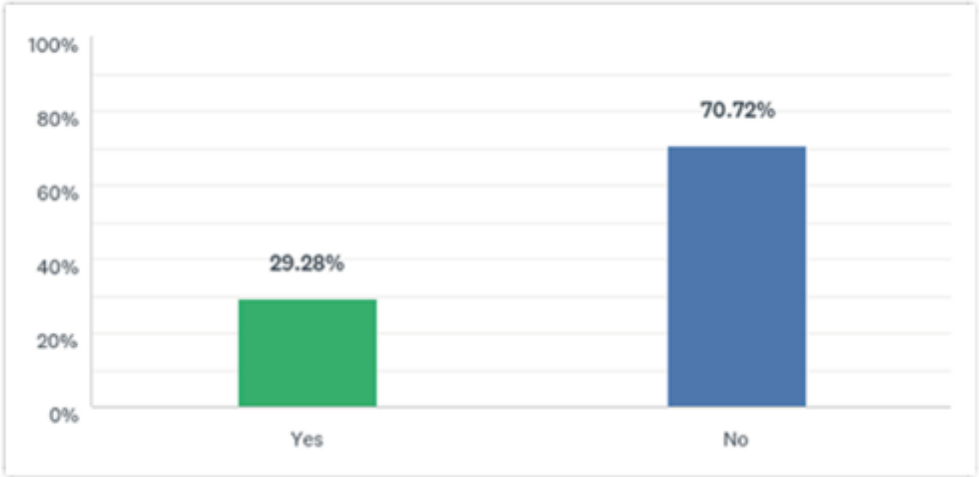


Figure 6. Are you aware of a surgical colleague who has committed suicide?

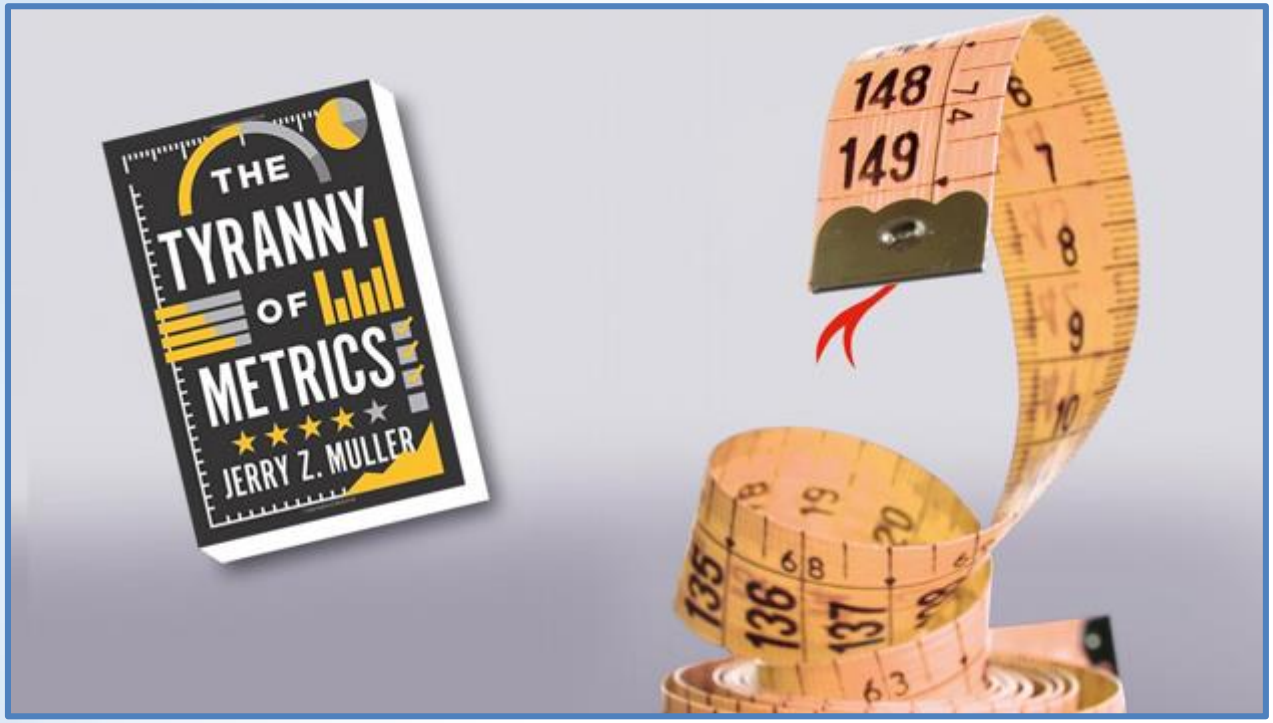


Overworked Overscheduled

Bombardment by EMR, Unnecessary Emails & Social Media= **Physician Frustration**

Documentation eats patient care for breakfast

Lack of Autonomy

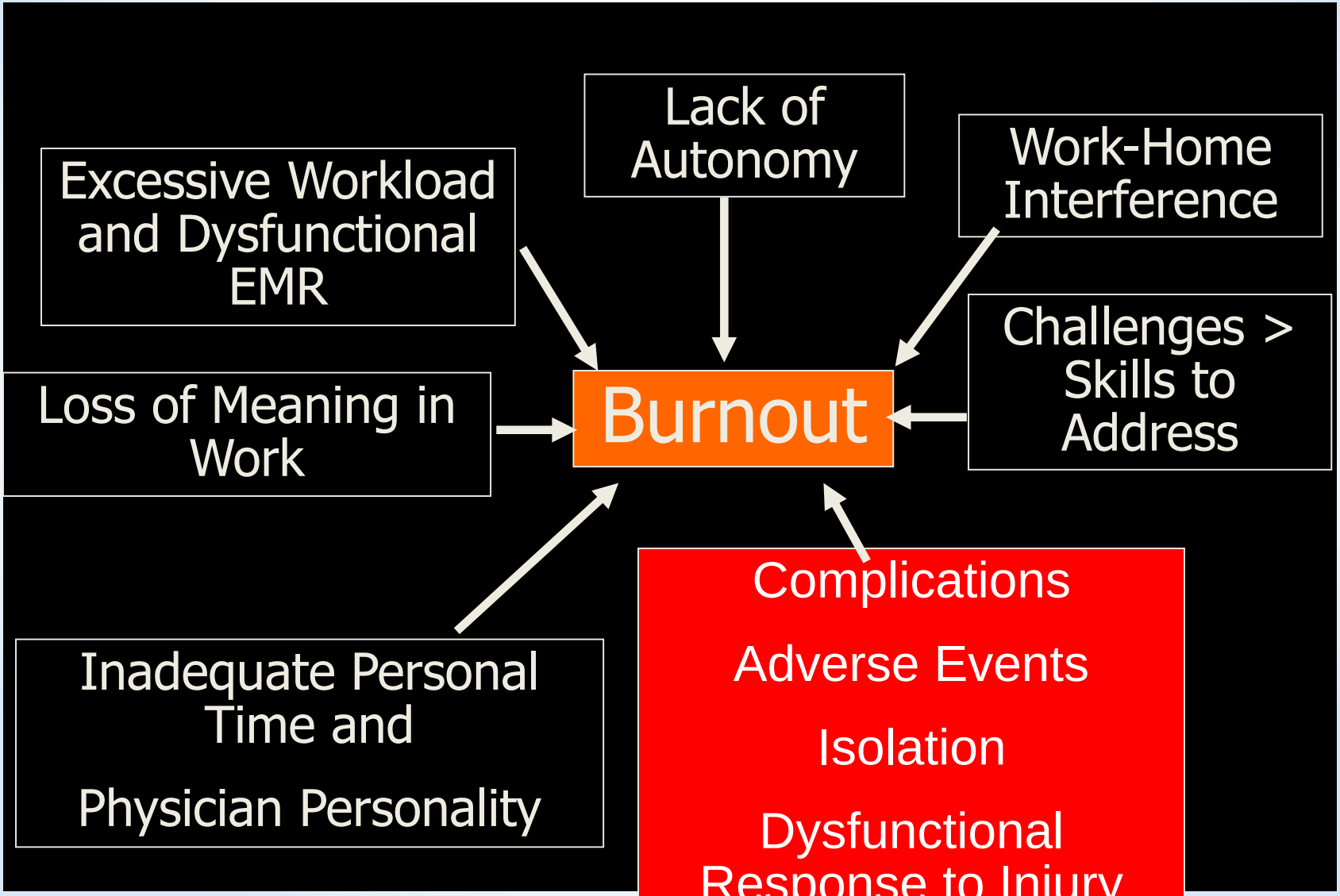


"In *The Tyranny of Metrics*, Jerry Muller has brought to life the many ways in which numerical evaluations result in deleterious performance: in our schools, our universities, our hospitals, our military, and our businesses. This book addresses a major problem."

—**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."

Work Life Balance in Healthcare


Lack of Autonomy
Excessive Workload and Dysfunctional EMR
Work-Home Interference
Challenges > Skills to Address
Loss of Meaning in Work
Burnout
Inadequate Personal Time and
Physician Personality
Complications
Adverse Events
Isolation
Dysfunctional Response to Injury

Why is the Second Victim Syndrome important?

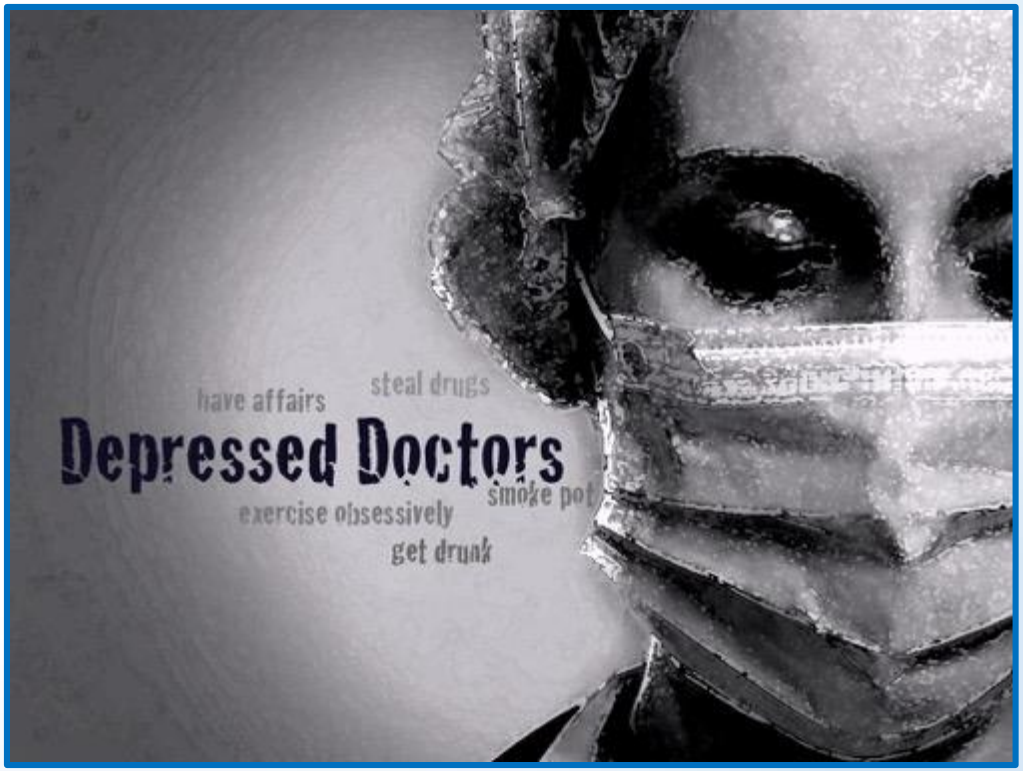
Second Victim Definition

"… 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?

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.

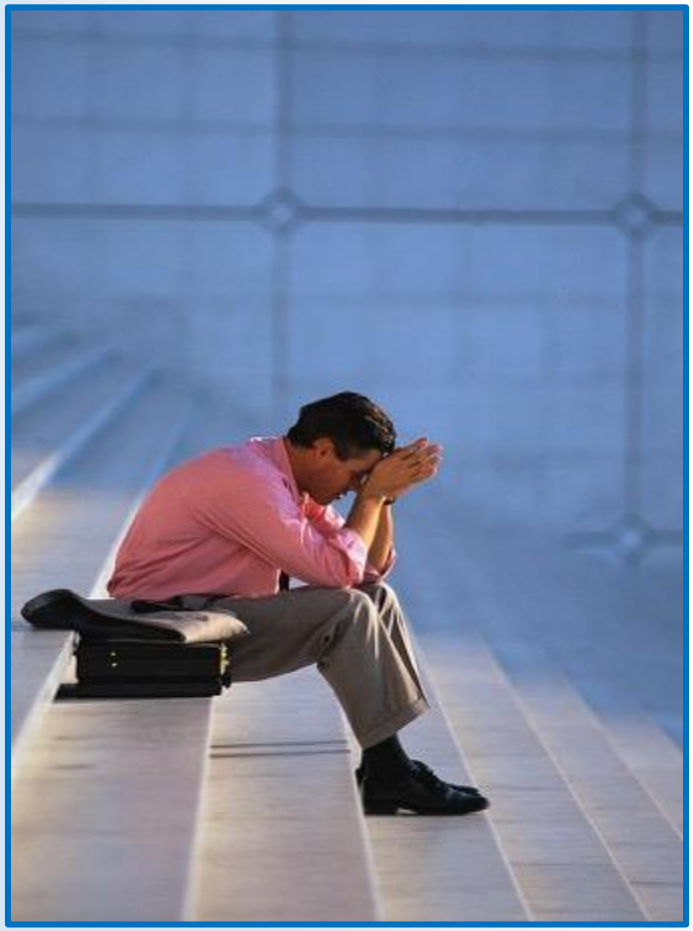
Strangely, there is no place for mistakes in modern medicine. Society has entrusted physicians with the bur-

improvements that
are built into existir
unwitting physicia
although patients
medical mistakes,
errors: they are the

Virtually every
realisation of mak
out and exposed—
has noticed. You a
tell anyone, what
over and over in yo

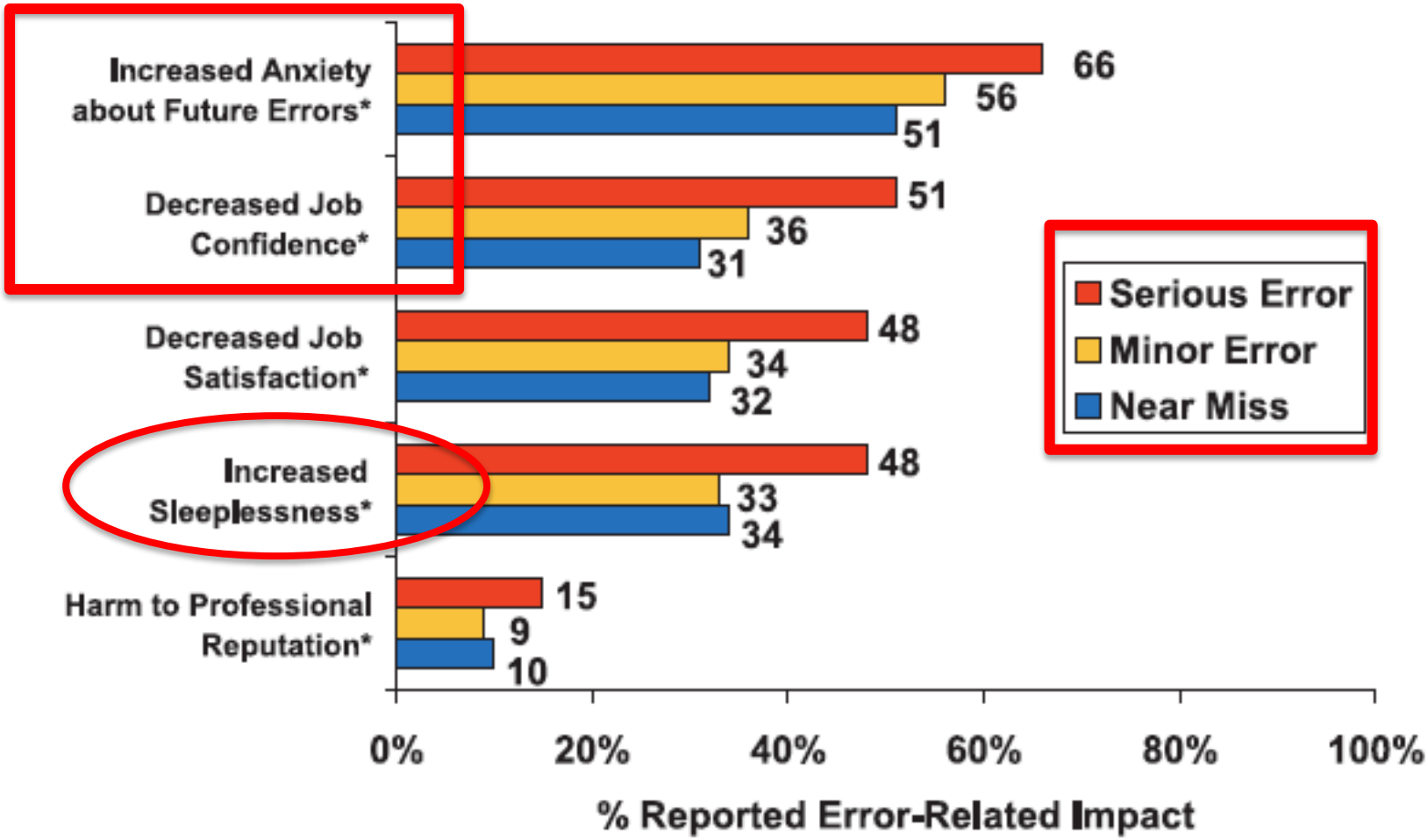
Wu. BMJ 2000:320:726-7.

Second Victim



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*



Do you want your Surgeon to have these symptoms…?

Physical symptoms	n (%)
Extreme fatigue	16 (52)
Sleep disturbances	14 (45)
Rapid heart rate	13 (42)
Increased blood pressure	13 (42)
Muscle tension	12 (39)
Rapid breathing	11 (35)

Psychosocial symptoms	n (%)
Frustration	24 (77)
Decreased job satisfaction	22 (71)
Anger	21 (68)
Extreme sadness	21 (68)
Difficulty concentrating	20 (65)
Flashbacks	20 (65)
Loss of confidence	20 (65)
Grief	20 (65)
Remorse	19 (61)
Depression	17 (55)
Repetitive/intrusive memories	16 (52)
Self-doubt	16 (52)
Return to work anxiety	15 (48)
Second guessing career	12 (39)
Fear of reputation damage	12 (39)
Excessive excitability	11 (35)
Avoidance of patient care area	10 (32)

Understanding Second Victims Trajectory

If this was a Jeopardy question for $500….

What is…?

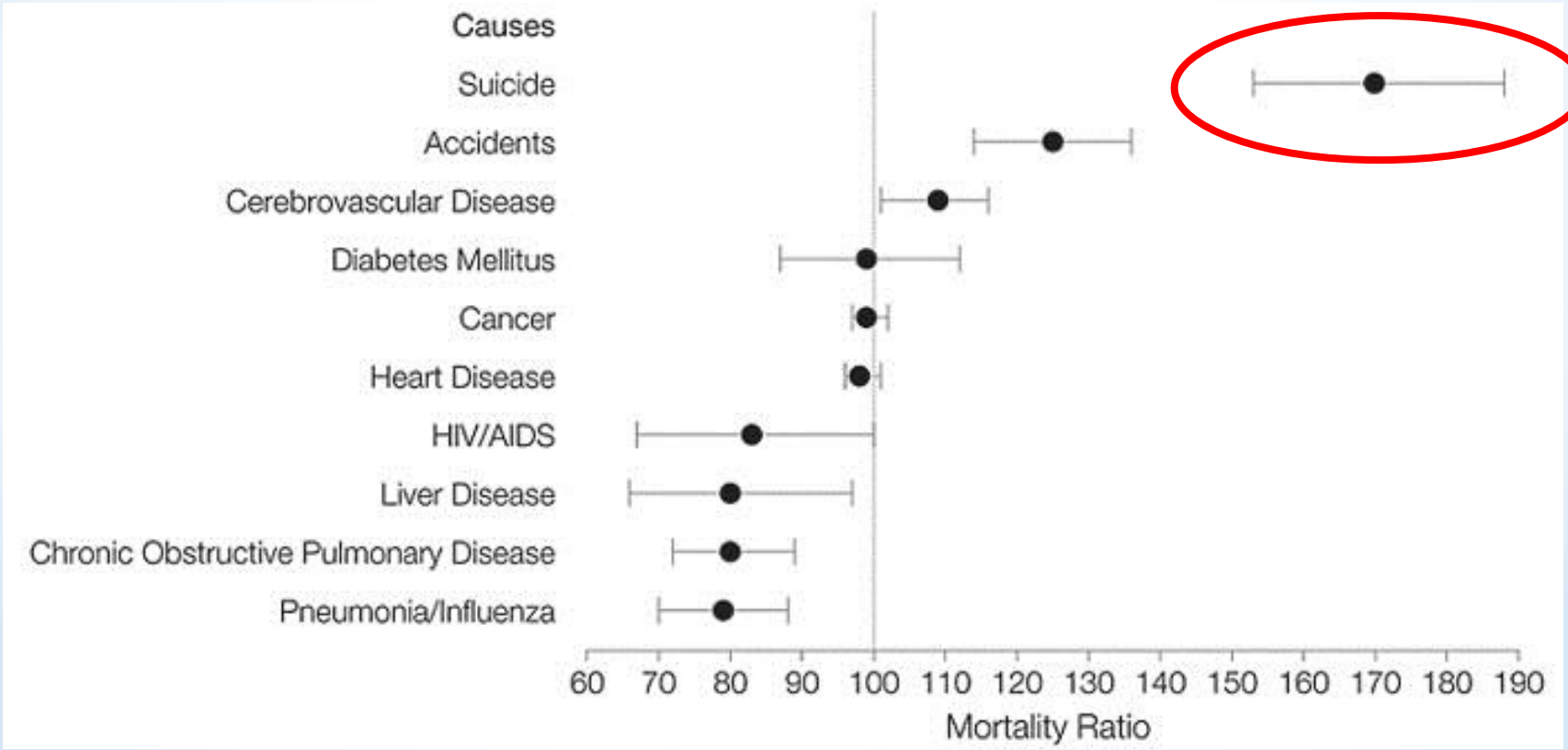
"One medical school class / year"

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**.

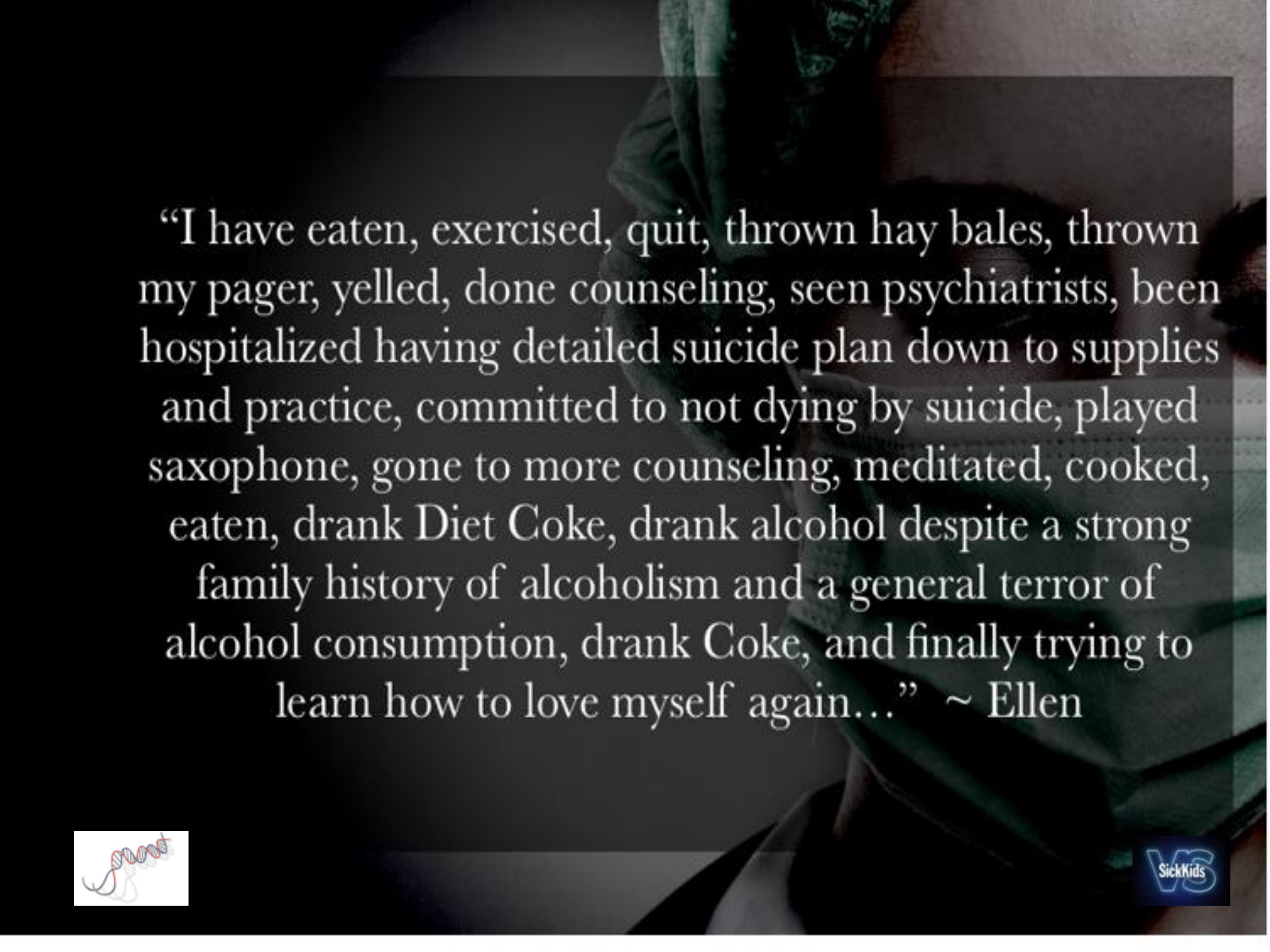
"I was told by the psychologist at my med school's campus assistance program, that 75% of the class of 175 people were on anti-depressants.
He wasn't joking. How broken is the system, that doctors have to be pushed into illness in order to be trained to do their job? ~ Jaya

Proportionate Mortality Ratio:

Male Physicians vs Male Professionals

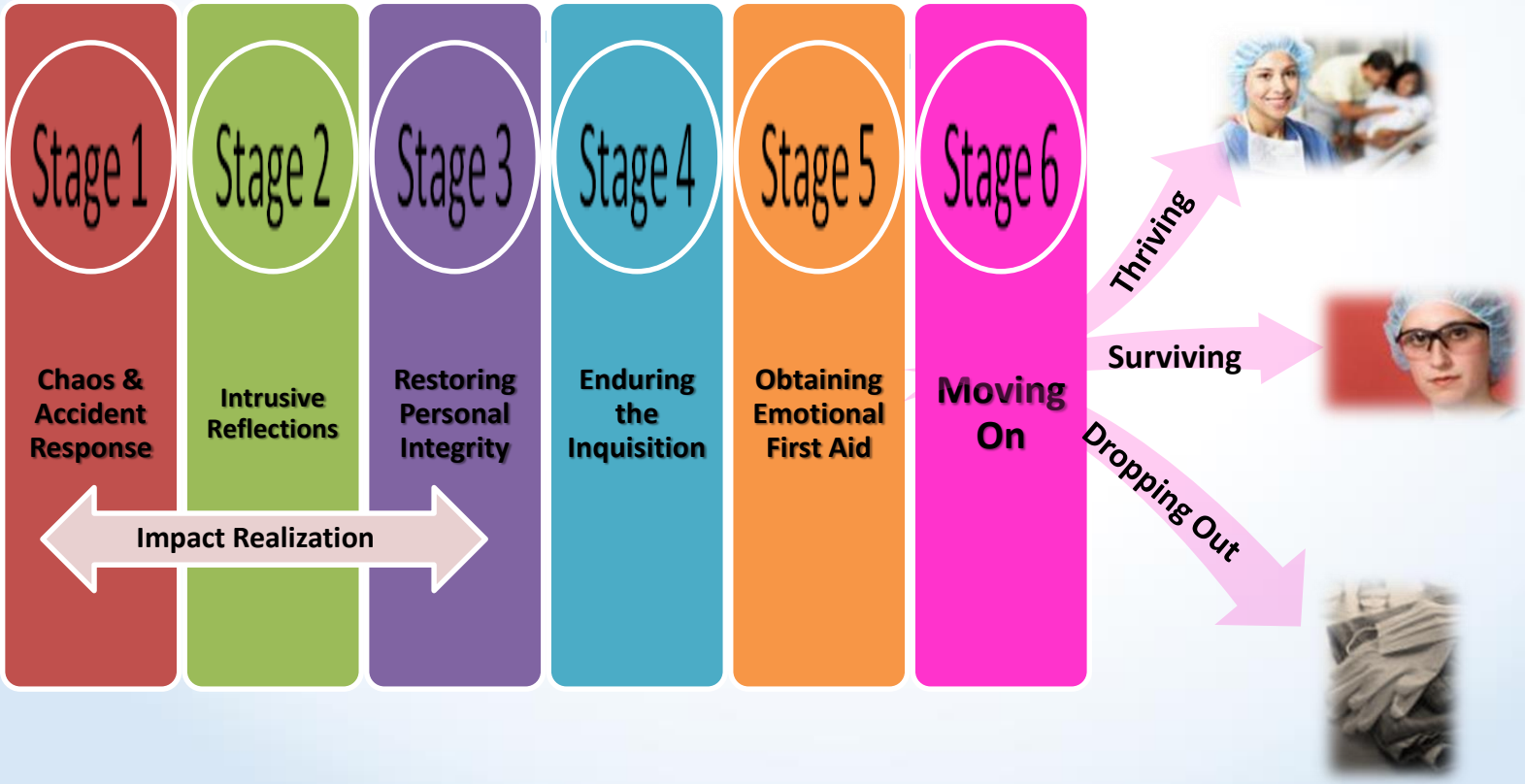


Center, JAMA.289:3161 (2003)


"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

Scott, S. D., Hirschinger, L. E., Cox, K. R., McCoig, M. M., Brandt, J., & Hall, L. W. (2009). The natural history of recovery for the healthcare provider second victim after adverse patient events. Journal of Quality and Safety in Health Care, 18, 325-330.

Stages of Healing: The Second Victim Recovery



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

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

STAGE 5:

OBTAINING EMOTIONAL FIRST AID

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

- 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

?

- **Is this the profession I should be in?**
- **Can I handle this kind of work?**

SURVIVING

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

?

- **How could I have prevented this from happening?**
- **Why do I still feel so bad/ guilty?**

THRIVING

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

?

- **What can I do to improve our patient safety?**
- **What can I learn from this?**

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

Learning about Resilience\Recovery

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

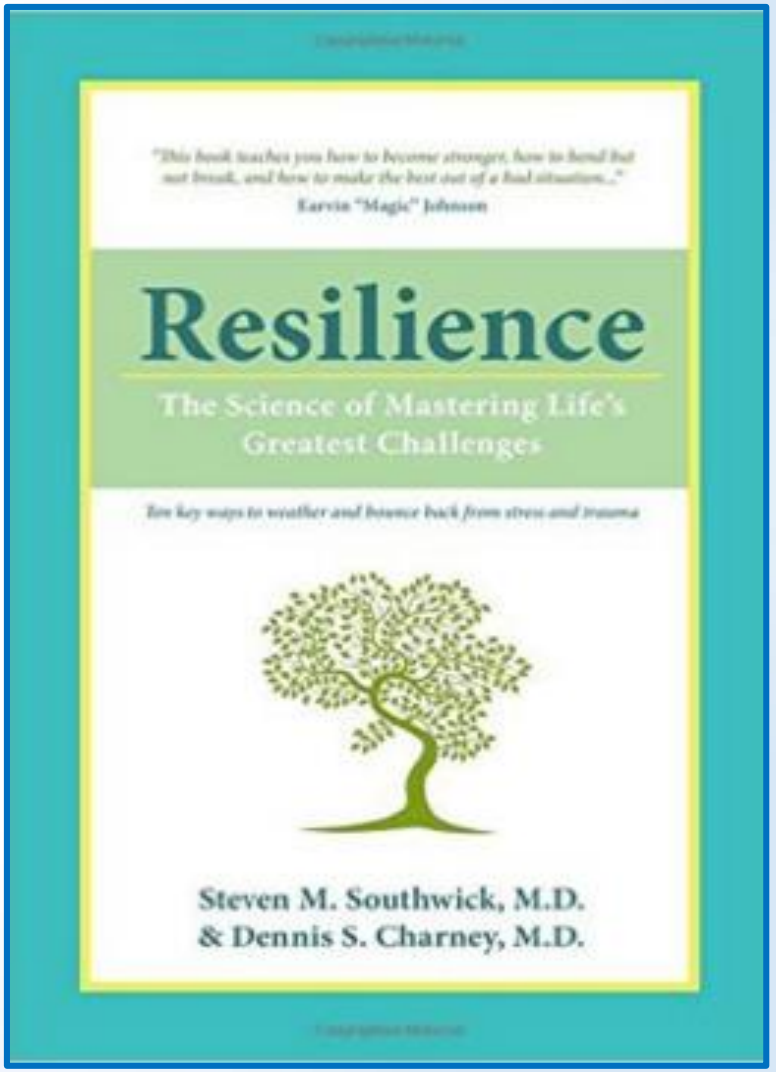
- Personal Resilience and Wellness
- System focus on Patient Safety
- Peer Support
- Leadership Imperatives

Resilience

Research Report

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

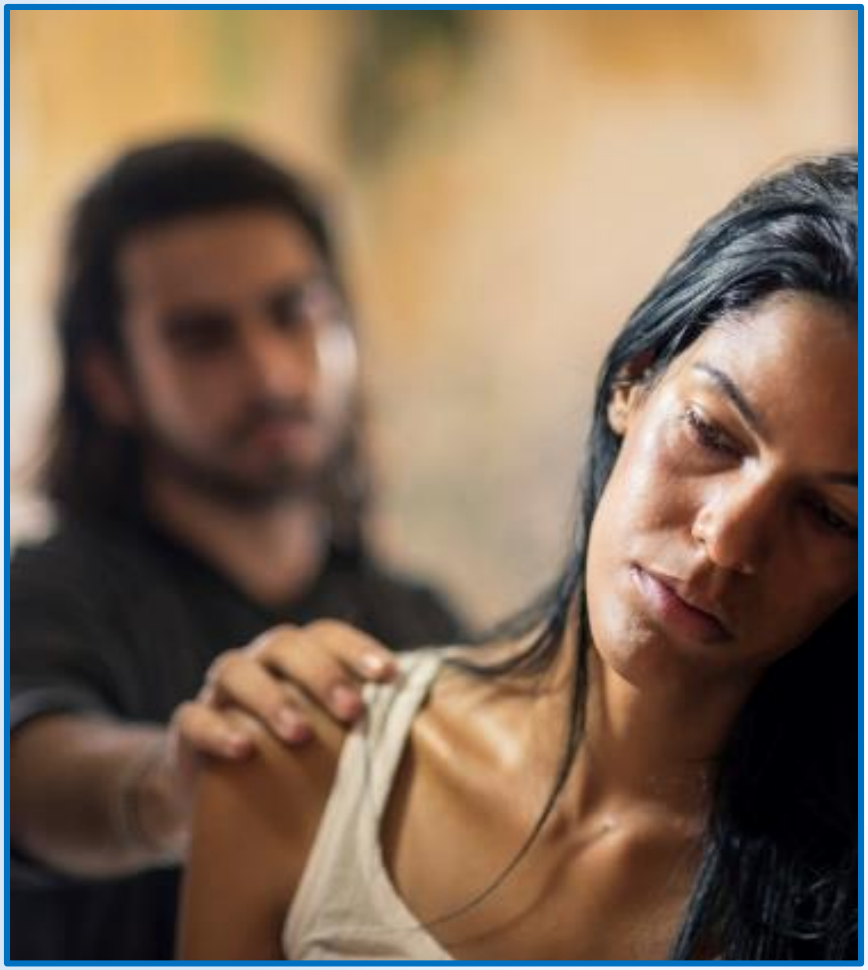
The Personal Health Habits and Wellness Practices of US Surgeons

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'

Shanafelt. Ann Surg 2012.255:625-33.

Navy Seals, Abuse Survivors



Developing Resilience….

- Fostering Learned Optimism
- Cognitive and Emotional Training
- Facing down Fear

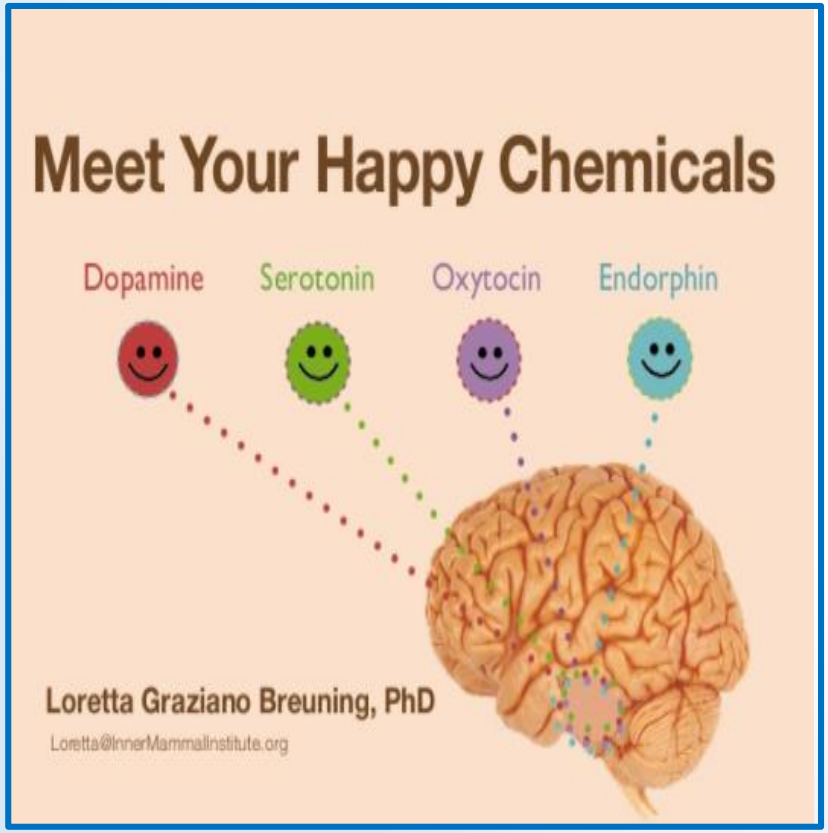
- Attracting & giving Social Support
- Imitating Resilient role models - Mentoring

- Physical Training & Wellness

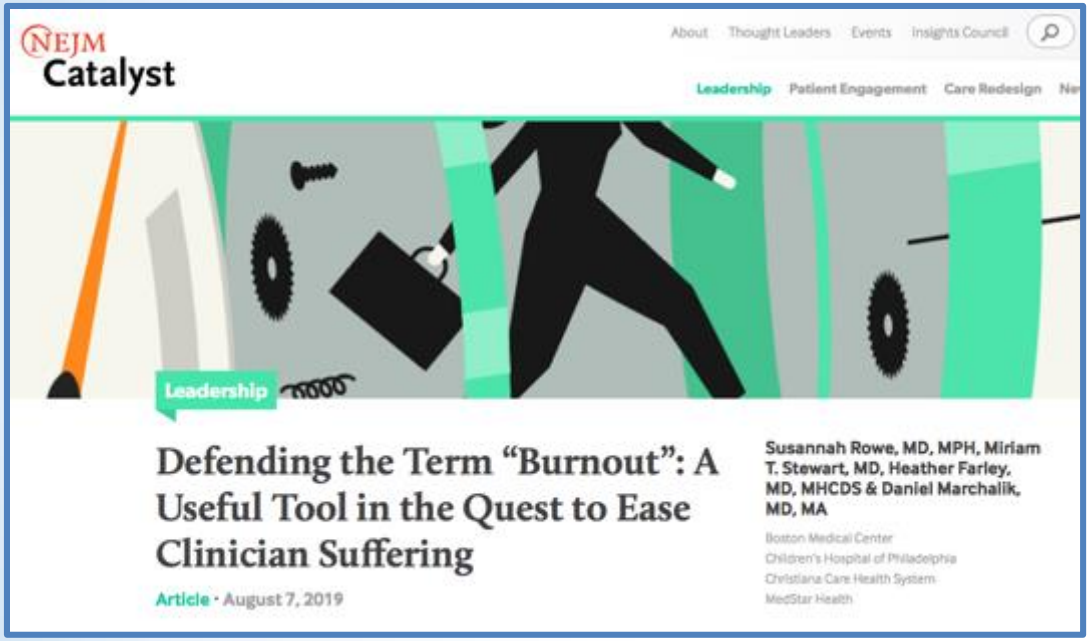
- Solidifying Moral Compass
- Practicing Religion/ Spirituality
- Focusing on Mission/ Purpose
- Finding Meaning, Purpose, & Growth

Attracting & giving Social Support

Wellness in groups



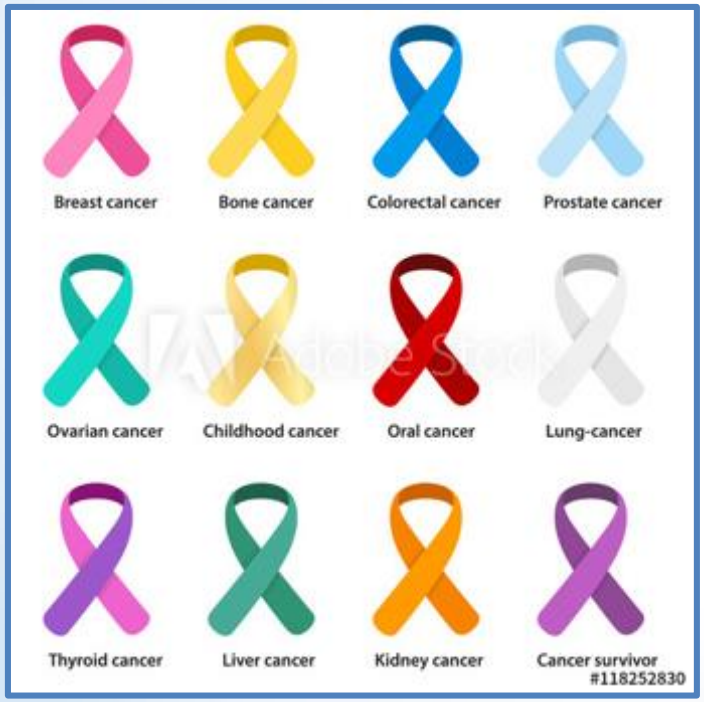
- Personal Resilience
- System focus on Patient Safety
- Peer Support
- Leadership Imperatives



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?



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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

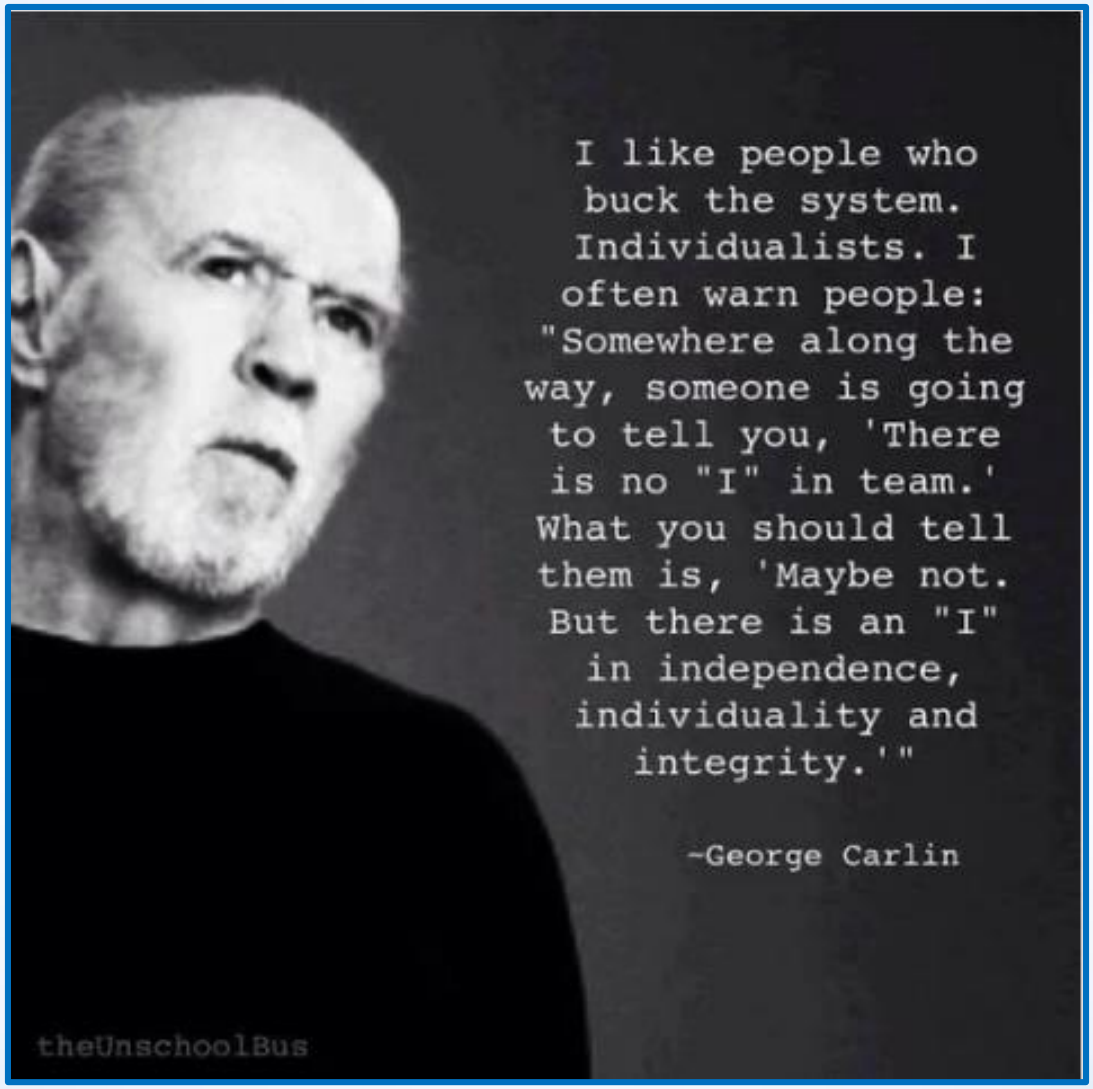
ONLINE FIRST

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

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
theUnschoolBus


If you want to go fast, go alone.
If you want to go far,
GO TOGETHER.
African Proverb
SickKids
VS

Culture Change

Culture Change

Always Reach Out

You may be thinking…	What a Second Victim is thinking…
"He probably wants some time to process everything."	"I feel so isolated and alone."
"We should probably lessen her case load."	"They have lost confidence in my abilities. They don't trust me."
"I don't know what to say."	"I wish everyone would treat me normally."
"I don't want to make her re-live the situation."	"I think about this situation all the time."

Always Reach Out

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"I don't want to make her re-live the situation."	"I think about this situation all the time."

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

Burnout should not be a silent epidemic

The views expressed in this editorial are those of the author and do not necessarily reflect the position of the Canadian Medical Association or its subsidiaries.

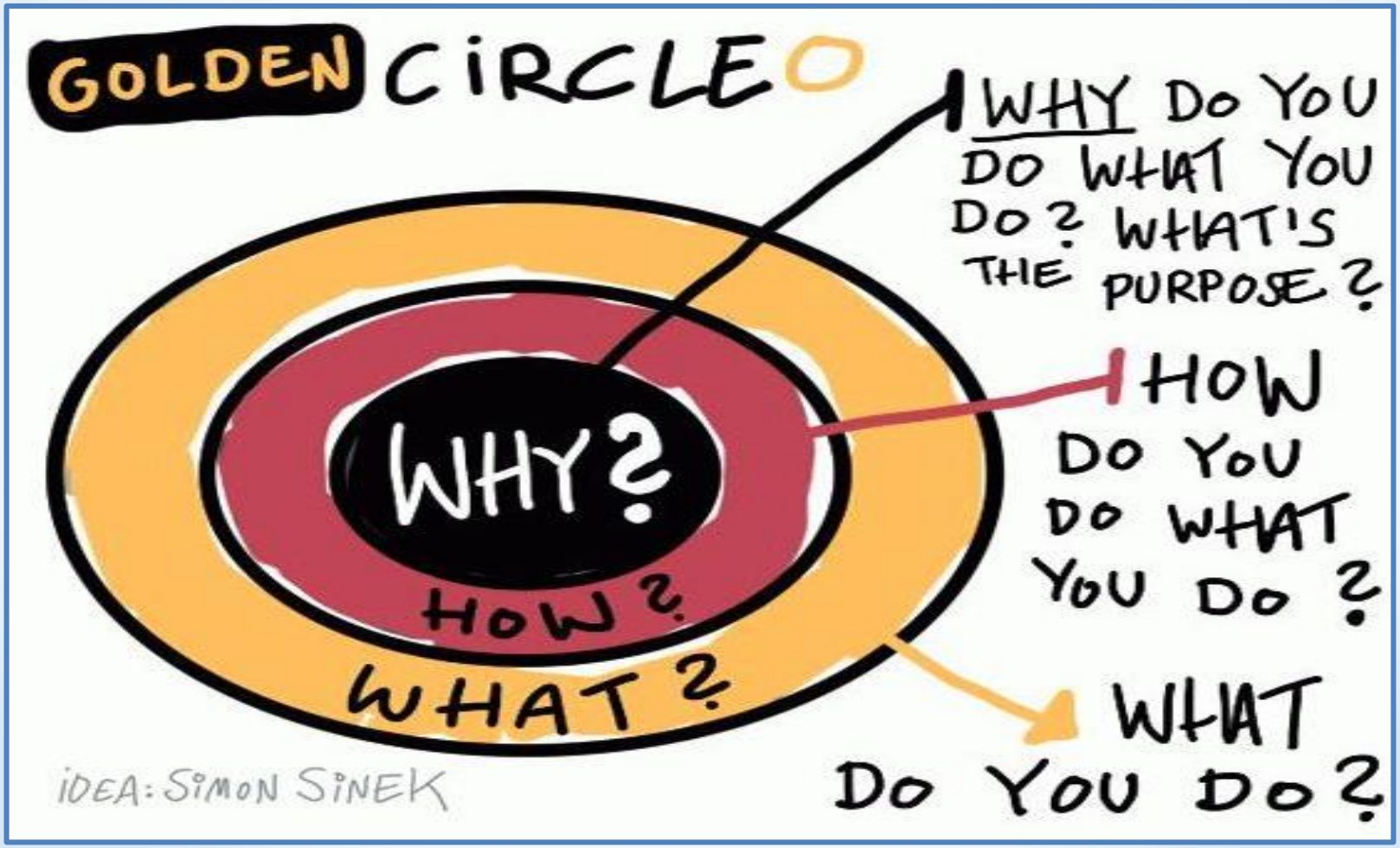
Canadian Journal of Surgery

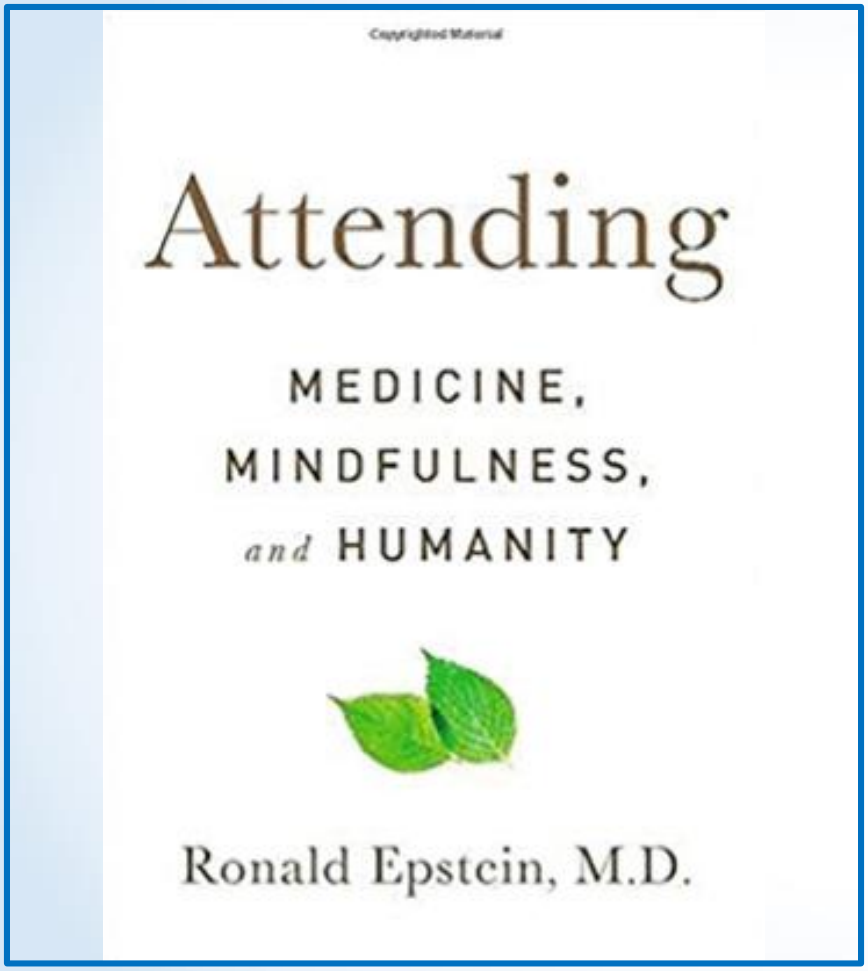
Currently, the plan for therapy varies greatly among cases, with no agreed-upon recovery program. Treatment protocols are not unified and definitely need to be. Like all other epidemics, we need to recognize the importance of physician burnout and meet the problem head-on. However, all these issues combined 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*


SUCCESS
TROUBLE
obstacle
difficulty
Failure
PROBLEM
CRASH

Start with “Why”

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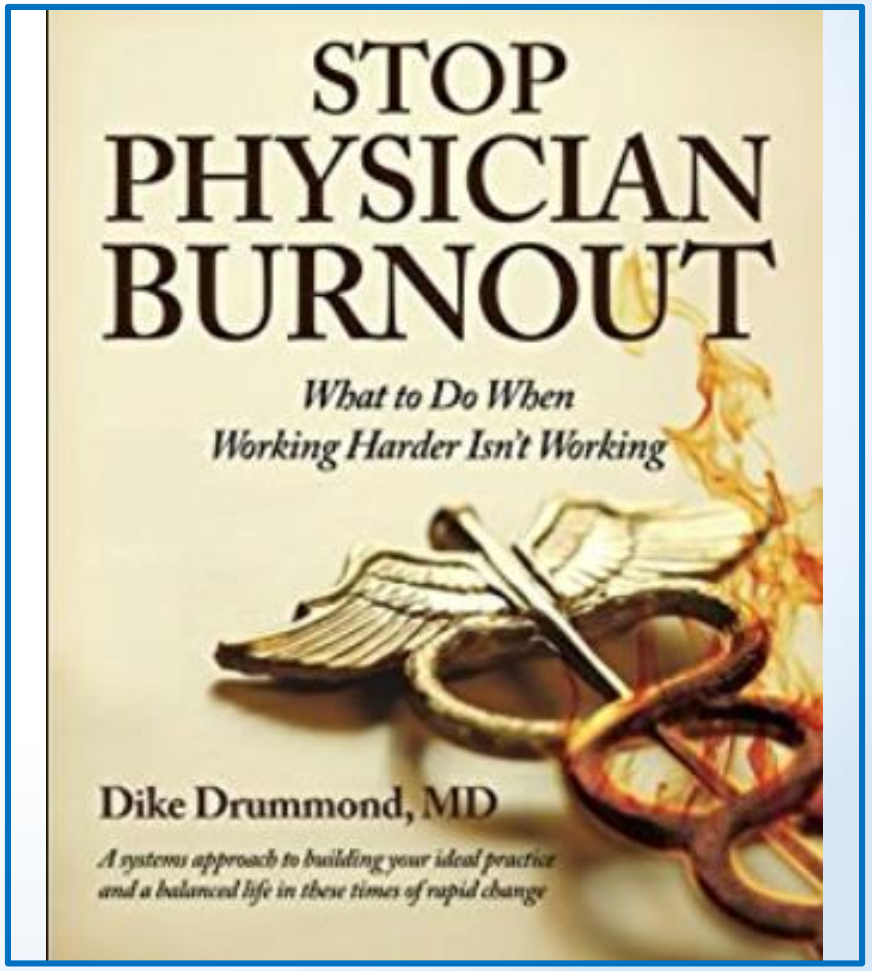
Ronald Epstein, M.D.


STOP
PHYSICIAN
BURNOUT
What to Do When
Working Harder Isn't Working
Dike Drummond, MD
A systems approach to building your ideal practice
and a balanced life in these times of rapid change

Features > 2018 ACS Governors Survey: Burnout—a growing challenge

2018 ACS Governors Survey: Burnout—a growing challenge

by DAVID J. WELSH, MD, FACS, HIBA ABDEL AZIZ, MBBCH, FACS, JUAN C. PARAMO, MD, FACS, PETER ANDREONE, MD, FACS, DAVID W. BUTSCH, MD, FACS AND JULIAN SMITH, MB, BS, FACS
PUBLISHED JUNE 1, 2019 • PRINT-FRIENDLY

Editor's note: *The American College of Surgeons (ACS) Board of Governors (B/G) conducts an annual survey of its domestic and international members. The purpose of the survey is to provide a means of communicating the concerns of the Governors to the College leadership. The 2018 ACS Governors Survey, conducted in August 2018 by the B/G Survey Workgroup, had a 91 percent (263/289) response rate.*

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.

Available Resources

- ACS Physician Well-Being Index
- American Medical Association Steps Forward
- Mayo Clinic Program on Physician Well-Being
- Mind Tools—Stress management techniques
- Resident and Associate Society Webinars
- Skills You Need—Personal skills
- Stanford Medicine—Stress and burnout


NATIONAL ACADEMY OF MEDICINE
Jo Shapiro
Director, Center for Professionalism and Peer Support, Brigham and Women's Hospital
Associate Professor of Otolaryngology, Harvard Medical School

The Royal Society of Medicine

Cultural perspectives in medical professionalism and wellbeing

The Royal Society of Medicine <events@rsmemail.rsm.ac.uk>
Martin Koyle
Tuesday, September 17, 2019 at 10:17 AM

Date: Tuesday 8 October 2019
Venue: Royal Society of Medicine, London
CPD: Accredited

Dear Professor Koyle,

This is your chance to attend a turly 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 porfessional - 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 Lndon

3:30pm

Tea and coffee break

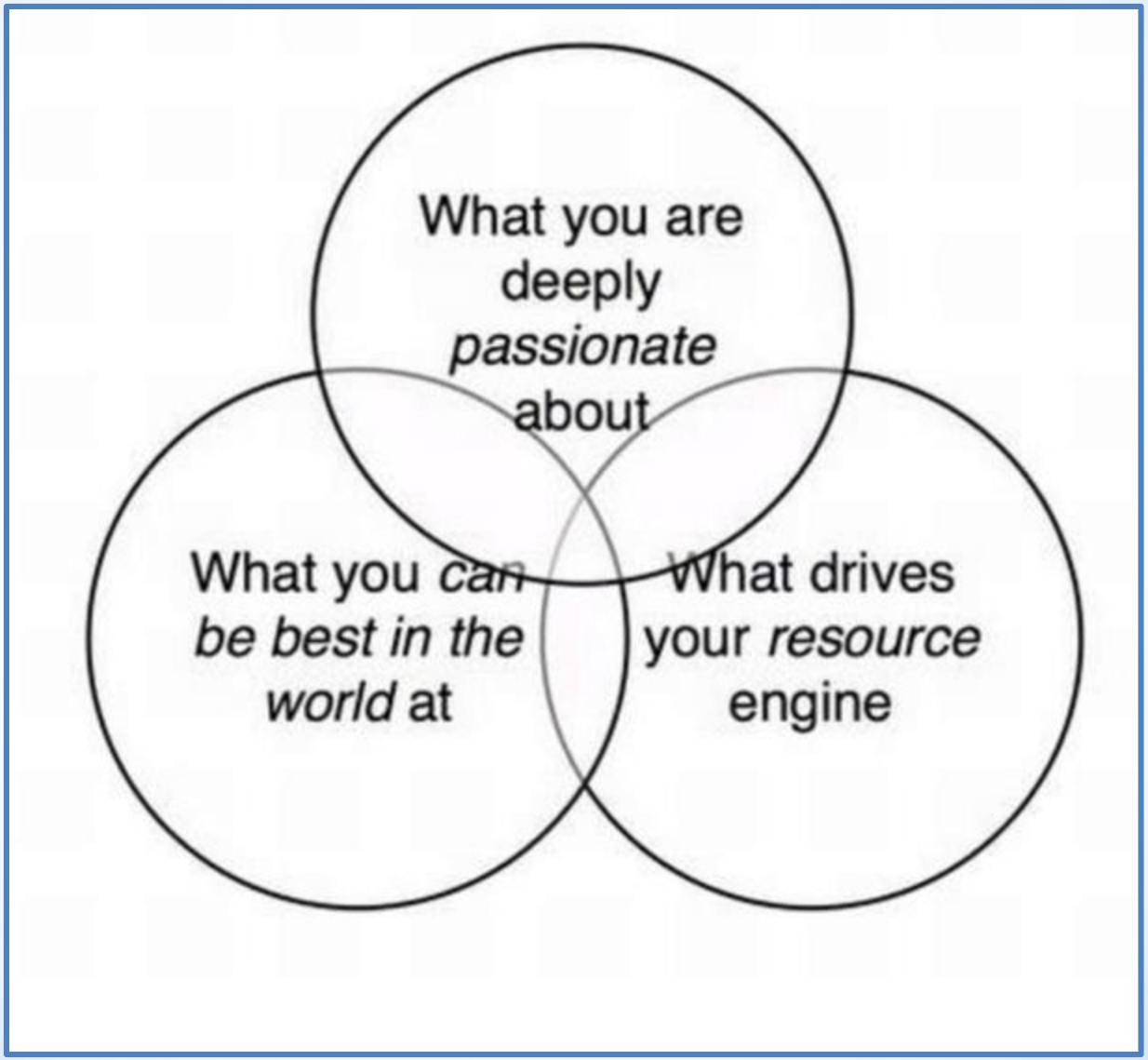
4:00pm

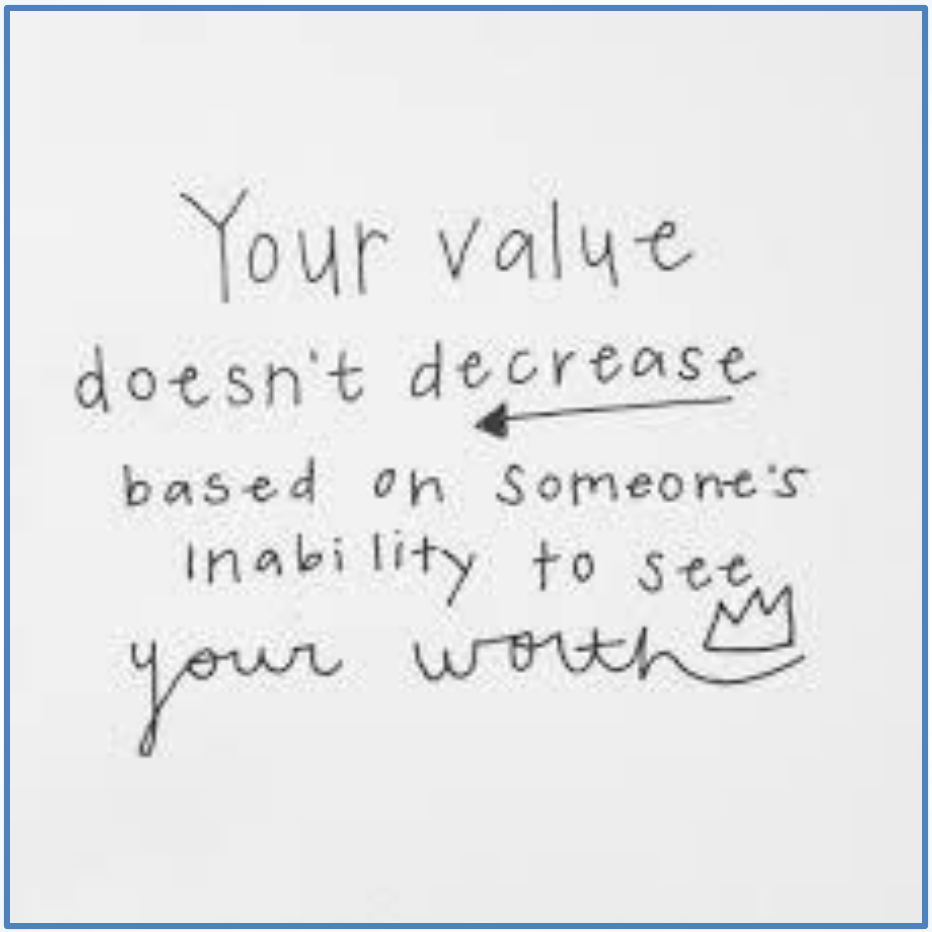
Panel discussion: What needs fixing – the environment or individual?

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

THE VARSITY

The University of Toronto's Student Newspaper Since 1880

A surgeon's account of physician burnout and depression

How the social dynamics of Canada's health care system may obstruct patient care

By Danté Ravenhearst
Published: 10:45 am, 11 August 2019

"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.

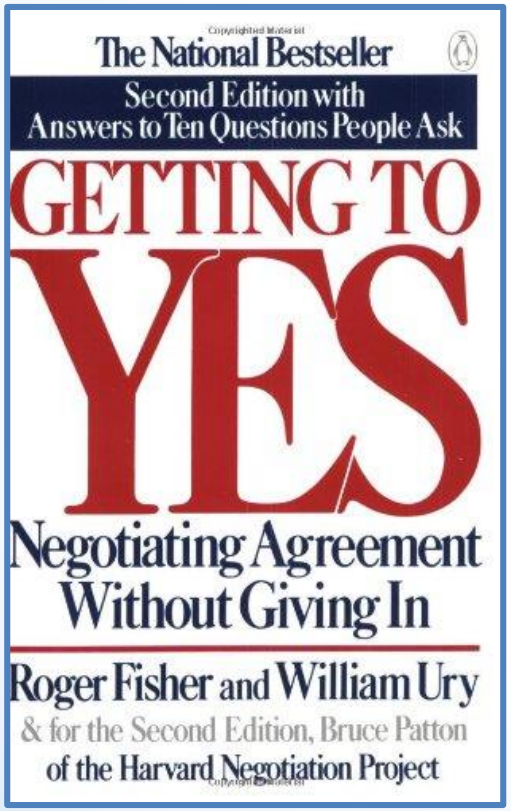
BMJ Quality & Safety Online First, published on 17 December 2014 as 10.1136/bmjqs-2014-003673

VIEWPOINT

A 'work smarter, not harder' approach to improving healthcare quality

Christopher William Hayes,[1] Paul B Batalden,[2] Donald Goldmann[3]

Getting to NO!!!!!!



Forbes

16,280 views | Jul 8, 2019, 9:00 am

The Unspoken Causes Of Physician Burnout

Robert Pearl, M.D. Contributor

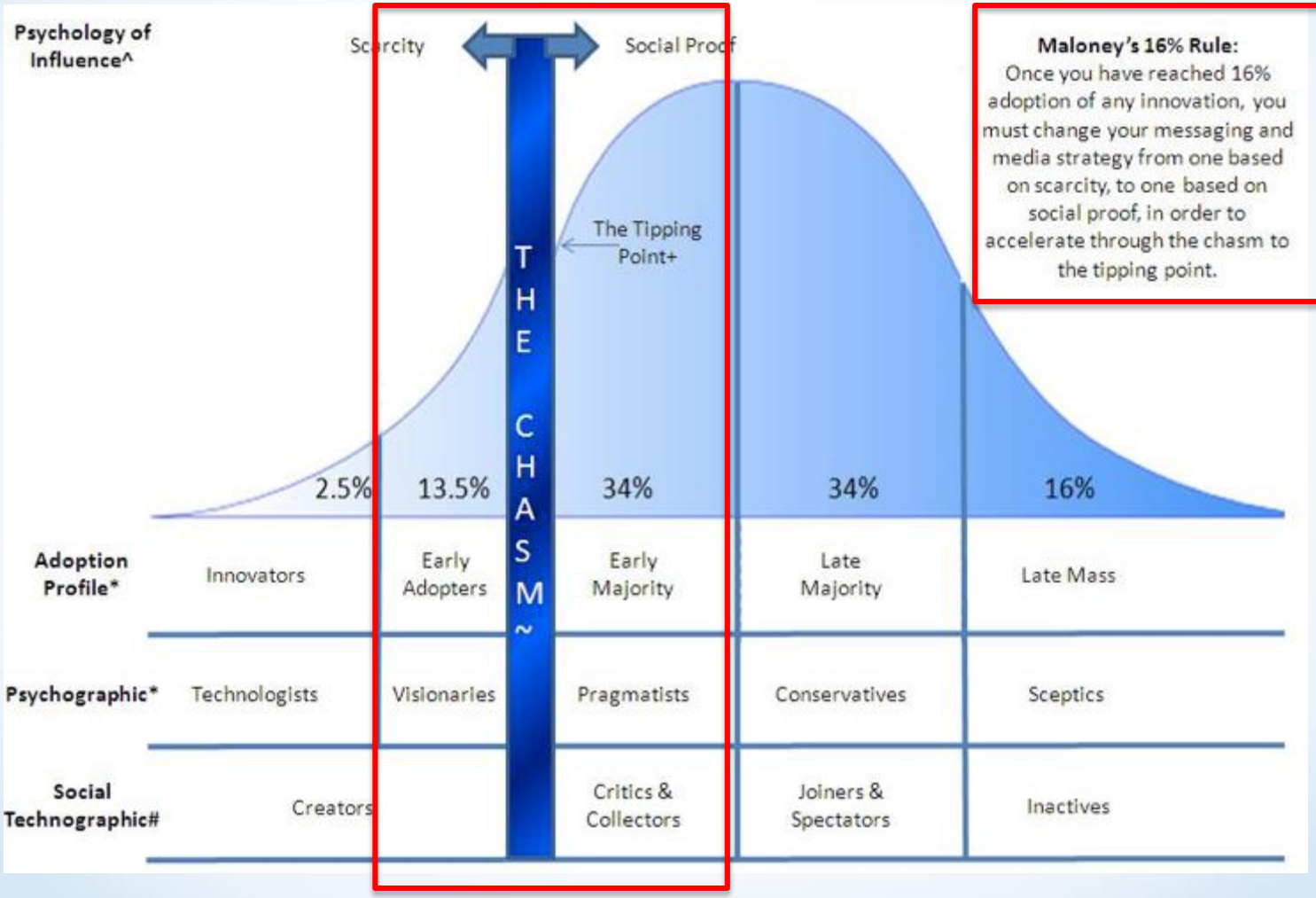
Healthcare

Granted, doctors are right to complain about cumbersome insurance forms, high patient volumes and other systemic barriers to better healthcare delivery. But as long as they see comparative data as nothing more than "metrics," and as long as physicians falsely interpret the rankings as measures of individual self-worth, the burnout problem will persist.

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.

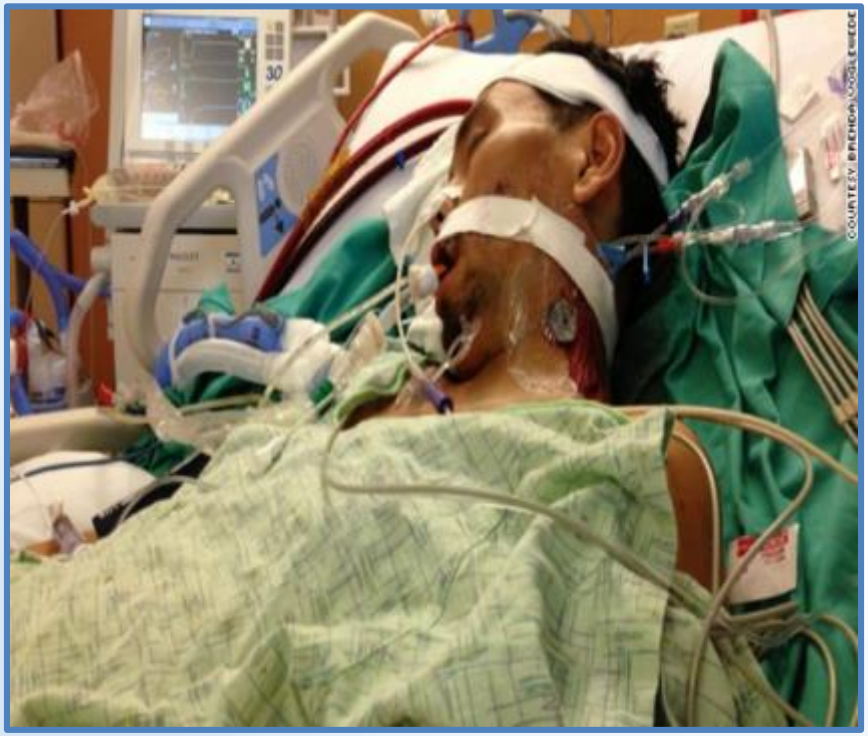
Robert Pearl, M.D. Contributor

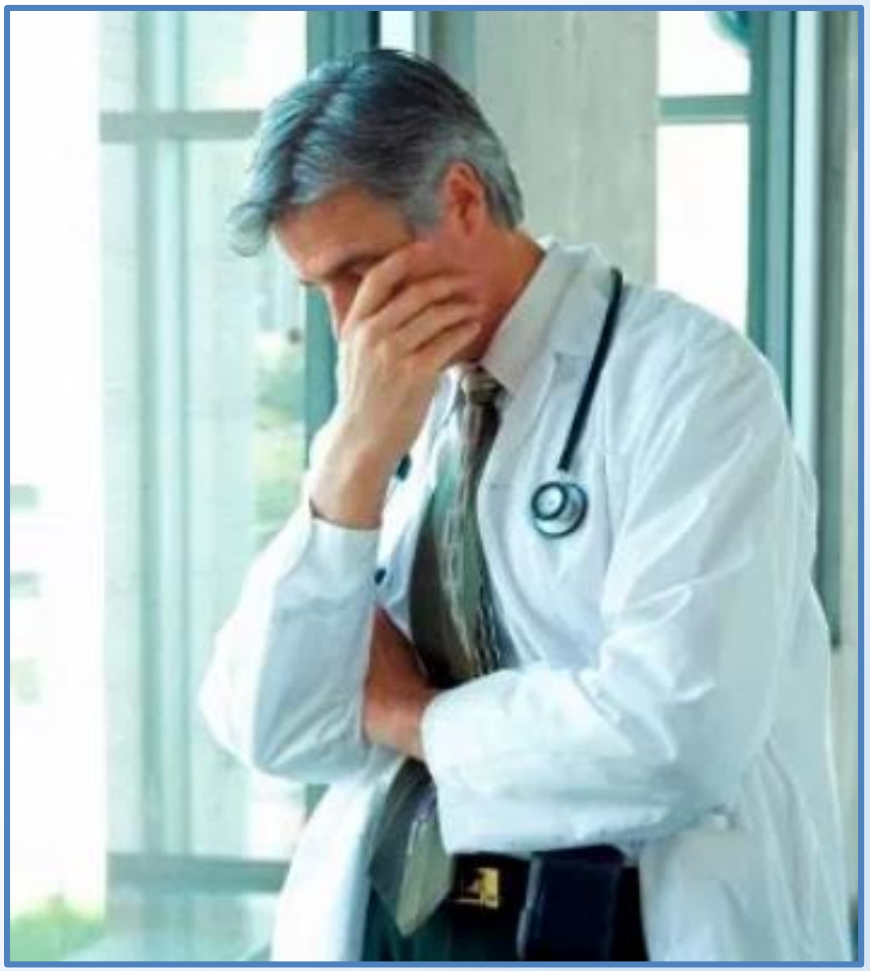

Psychology of Influence^
Scarcity
Social Proof
THE CHASM~
The Tipping Point+
2.5%
13.5%
34%
34%
16%
Adoption Profile*
Innovators
Early Adopters
Early Majority
Late Majority
Late Mass
Psychographic*
Technologists
Visionaries
Pragmatists
Conservatives
Sceptics
Social Technographic#
Creators
Critics & Collectors
Joiners & Spectators
Inactives
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…

REFLECTION

From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider

Thomas Bodenheimer, MD[1]
Christine Sinsky, MD[2,3]

[1]Center for Excellence in Primary Care, Department of Family and Community Medicine, University of California San Francisco, San Francisco, California

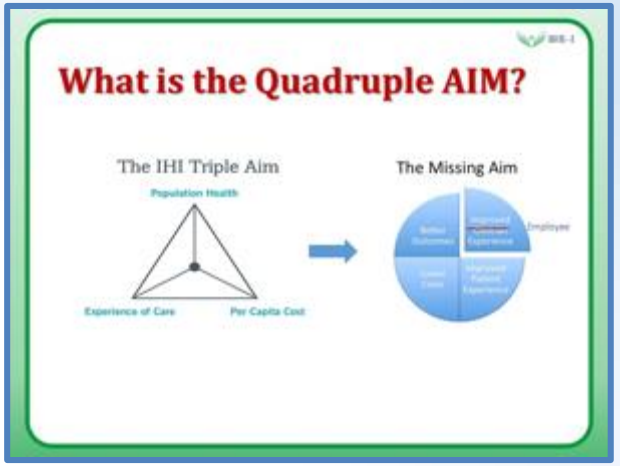
[2]Medical Associates Clinic and Health Plan, Dubuque, Iowa

[3]American Medical Association, Chicago, Illinois

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.

Ann Fam Med 2014;12:573-576. doi: 10.1370/afm.1713.



"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.