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Confronting a False Culture of Strength

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SGIM's 2017 Annual Meeting shone a bright spotlight on critical issues surrounding physician wellness and resilience. It is clear that just the day in and day out experiences of being a doctor in today's healthcare environment can cause burnout with serious implications for the affected clinicians, healthcare organizations, and our patients. Many factors associated with physician burnout, such as production pressures and difficult-to-use electronic health records, feel out of our control. Yet, we are in control of how we respond as individuals to these pressures. We also create the culture of medicine that is both a source of psychological stress and of inhibiting our willingness to access helpful resources.

An understanding of culture and its role in shaping societal behavior is essential to the effectiveness of all academic general internal medicine physicians, whether it is in research, teaching, administrative, or patient care. My favorite definition of culture is "the way we do things around here." Culture is the collection of individual and group norms that are as ubiquitous as the air we breathe, and, in many ways, as invisible. Seeking to change physician behavior without an understanding of the culture in which those behaviors exist is a recipe for failure. As organizational behavior experts note, "culture eats strategy for lunch." Cultures never develop by accident and serve to advance powerful (though not always positive) interests within a group.

Culture is especially apparent during residency training. For me, the dominant cultural norm during residency was one of being "strong." Not admitting a patient with borderline indications from the emergency room, succeeding at placing a challenging central line, getting a patient to agree to a DNR status, and discharging the patient who had been sitting on the service for a long time were all met with an enthusiastic "strong work!" (and sometimes a demonstrative high five) from our senior residents. Equally powerful was the desire to not do things that our peers considered "weak," such as waking up the senior resident with a clinical question that should have been obvious to us, admitting a patient for primarily social reasons, or not being able to cover your shift for any health-related reason that did not require you to be personally admitted to the ICU.

A culture of strength has important benefits related to ensuring high quality, compulsive patient care, appropriate resource utilization, and cohesive teams. Yet, the downsides are considerable, as I learned early on in my residency. We had admitted a middle-aged patient to the coronary care unit with chest pain. He had a history of coronary artery disease, and we believed his presentation was consistent with unstable angina. I reviewed his chest x-ray, which looked okay to me, and reviewed it with the radiology resident who concurred. So, we started the patient on heparin, an appropriate treatment for unstable angina. He continued to have chest pain on and off throughout the night, which we treated with morphine. The CCU was extremely busy with complex patients that night. The next morning on rounds we got a frantic call from the attending radiologist, who was reading films from the day before. He informed us that the patient was having a massive dissection in his ascending aorta. The radiology attending came by later to show us the dissection, which was not subtle—we just missed it. When the radiology attending called, we told him we wished we'd had that information sooner, because about two hours earlier the patient had coded and died.

Our team was in shock. We huddled on rounds to formulate a plan for what the attending physician was going to say to the family, who was sitting in the waiting room. Then, we put our heads down and moved on to the next patient. I figured that this was what professionals do, and we never spoke again about the case itself or how it affected anyone on the team.

Research that we and others have conducted on the emotional impact that involvement in adverse

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events and errors has on healthcare professionals has highlighted this important area of unmet need related to physician wellness.[1] The vast majority of physicians have been involved in cases like these, yet only 10 percent of physicians in one survey reported receiving adequate support from their institution. Interestingly, the severity of the emotional distress does not always correlate with the level of harm the patient experienced. For some physicians, involvement in a near miss, especially if it had potential to seriously harm the patient, evokes considerable emotional distress.

The consequences of this distress are equally apparent: anxiety, poor sleep, loss of confidence, and sometimes suicide. For some clinicians, the emotional response resembles PTSD, with persistent and bothersome intrusive reflections and flashbacks. Yet, the impact extends far beyond the affected clinicians—physicians who experience distress after an error are more likely to make subsequent errors. I have no doubt the patients we rounded on next in the CCU did not receive the attention they deserved from us.

Fortunately, in the decades since this case happened, important new resources and programs have been developed to support clinicians after adverse events and medical errors. Formal initiatives to "care for the caregiver" are being implemented, often as part of a more comprehensive Communication and Resolution Program. Many of these new programs are based around a peer support model, in which clinicians in various specialties are trained to offer support to their colleagues.[2] When the need for support extends beyond what these peer supporters can offer, formal processes are in place for referral to trained mental health professionals and fitness to work evaluations.

While these programs are a positive development, important barriers limit their impact. For example, some physicians question whether such support is effective and confidential or have difficulty taking time away from work. This culture of strength, where acknowledging the emotional impact of adverse events and errors on oneself and being open to support is seen as a sign of weakness, can prove doubly toxic. It can increase the probability of adverse events and errors, and also limits our ability to get support when such events occur.

Some peer support programs don't wait for the affected clinician to ask for help, but rather involve proactive outreach after adverse events and errors with an offer of support from a colleague. Yet, even active outreach has limited impact when clinicians reflexively respond that "they're fine" and brush off the need for support. Other professions involving first responders and other high-stress occupations that can be involved in accidents—such as law enforcement, firefighters, and air traffic controllers—take a much more proscriptive approach, mandating time off and clearance from a mental health professional before return to work.

Our choices in how we respond to adverse events and errors have important implications for our long term personal and professional growth. Peggy Plews-Ogan and colleagues interviewed 61 physicians who had been involved in significant errors to explore the factors associated with clinicians learning and adapting positively.[3] Physicians who reported positive growth after the harmful error were more likely to have disclosed the error to the patient and family, talked about what had happened with colleagues or others in a way that acknowledged the mistake and diminished their isolation, forgave themselves, and devoted energy to preventing recurrences and improving teamwork.

The culture of strength from my days as a resident had short-term appeal in terms of establishing comforting ground rules in a chaotic and disorienting clinical environment. But, over time, I came to see that in more productive and supportive medical cultures, true strength lies in a willingness to acknowledge the emotional impact that practicing medicine has on all of us, both on a daily basis and in the face of individual traumatic experiences. SGIM members can lead the way in reshaping "the way we do things around here," role modelling productive and supportive approaches to coping with dips in our emotional well-being.

References

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