Personal Psychodynamics of Complications

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Abstract

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Complications are an uncommon but psychologically difficult aspect to any procedural specialty. Being able to deal with the personal aspect of complications and having the tools to learn from and grow from complications are vital aspects of the practice of radiology. This article discusses the psychodynamics of complications that occur in interventional radiology and proposes some coping mechanisms to deal with these adverse events.

Every surgeon carries about him a little cemetery, in which from time to time he goes to pray, a cemetery of bitterness and regret of which he seeks the reason for certain of his failures.

– Rene Leriche

1985: a young interventionalist is performing embolization of a large pelvic arteriovenous malformation, the fifth in a series of planned treatments that hopefully will reduce the disease bulk and treat the chronic pelvic pain and high-flow cardiac output associated with the malformation.

Two hours into the procedure, a massive pulmonary embolism occurs, and the patient dies despite desperate resuscitation efforts.

Absolutely stunned by the event, he must gather himself and summon the emotional reserve necessary to inform the patient's husband and family of her death; the subsequent conversation is agonizing and wrenching.

In the aftermath the death and physician decision-making leading up to it are replayed over and over. He attends the autopsy seeking desperately to identify what went wrong and pores over the images repeatedly. Powerful feelings of remorse, self-doubt, and recrimination over the case continuously intrude on his waking thoughts and interrupt sleep for weeks on end.

The physician seeks out and asks other interventionalists and surgical colleagues about how best to handle the situa-

tion; most offer a few sympathetic platitudes or encourage him or her to "just get back in the saddle." None of these offer solace. Finally, a gruff and widely respected senior vascular surgeon, having heard about the event, offers these simple words: "Hurts like hell, doesn't it? Believe me, it will remain with you for the rest of your career. Use the experience to make you better at what you do."

The simple words of acknowledgment and validation of the remorse and pain the physician was feeling have an almost immediate effect—someone else has experienced a similar event and was similarly traumatized.

Nothing stands out so conspicuously, or remains so firmly fixed in our memory, as something in which we have blundered.

– Cicero De Oratore, I, 129

In the obviously autobiographical story I just related, I became sharply aware of the significant personal and professional dynamics of complications and their effects on the individual physician. Through my efforts to talk to others about how to deal with complications and poor outcomes including patient death, I understood just how poorly equipped I and other doctors were in general to understand how these events should be handled at an individual and collective level. I had little or no resources and no organized institutional method of dealing with the aftereffects of the complication. No one knew how profoundly I was impacted; I

had no model for reaching out or seeking help and colleagues had no empathetic models to use to speak with me. Unfortunately, 30 years later, my narrative remains an all too common one.

Complications and medical errors happen to all physicians; they are a ubiquitous part of procedural medicine. Medical errors and devastating permanent disabling outcomes are currently being prominently discussed in all areas of medicine; methods to reduce or eliminate both routine and catastrophic errors are being instituted at every hospital across America.

The physician experience is *sui generis* and not analogous to any other population of workers. The great responsibility and regard given to physicians by society as well as the peculiarly discordant messages of doing no harm but yet treating aggressively can leave physicians confused and anxious about how to respond to medical calamities. Doctors are expected to be wise, knowledgeable, and empathic—we are not supposed to actually hurt the patients who have entrusted their lives and health to us. One thing is certain: the intensely personal effects of complications on physicians are not well known and certainly less frequently discussed. The literature is limited but thankfully it is gradually expanding and our knowledge of these effects and constructive methods of dealing with them is increasing.

After my misadventure, I had the opportunity to discuss the topic of physician responses to complications and bad outcomes with many other professionals. I also performed a literature search on the topic of physician psychology and doctor responses. I was surprised; there is limited material in the medical or psychiatric literature on this topic except in what is contained in a fairly abundant writing on the effect of suicide on the psychiatrist/psychologist treating the patient. Psychiatrists' response to a patient suicide, for example, is fairly consistent: preoccupation with loss, excessive rumination on possible errors and increased caution with other patients, while curiously and somewhat paradoxically psychiatrists reported infrequent consultations about the case with associates or senior physicians. Among my hospital colleague surgeons and proceduralists, all told stories of physicians they knew who had been so damaged by a complication experience that they had limited their practices or stopped doing procedures altogether. Most physicians agreed that their personal response to complications was self-learned and never taught as they had received little or no training in psychologically healthy methods of handling these extremely stressful events.

A consistent finding stands out: doctors who experience major medical complications and tragedies show very similar emotional responses and reactions. Many become preoccupied by the loss, ruminating excessively over the event and many stated that they had become much more cautious to varying degrees with other patients. This response has been well documented. For example, Waterman and coauthors assessed the impact of errors on physicians' life domains. Major errors led to increased anxiety about future errors in 66% of those surveyed, decreased job confidence, decreased satisfaction, and increased sleeplessness in half of

respondents.¹ Harrison et al noted that 30% of physicians noted a moderate negative impact on work performance and personal life and strained colleague relationships.² Shanafelt et al found striking increases in burnout, depression, and emotional exhaustion following a recent major medical error.^{3,4} The phenomenon of burnout, physician stress, and the higher rate of suicide among physicians compared with the general population (40% higher for men and 130% higher for women) may be partially explained by the frequency of dealing with traumatic events.⁵

What has been termed the "second victim" phenomenon is now recognized as a major issue in physician wellness and response to medical errors. However, the problem of second victims can be a sensitive topic since medical errors are still largely stigmatized. Edrees and Federico noted that "little attention has been paid to creating systems that help second victims after an unexpected adverse event," and that there remains little research on the topic with reported second victim rates of burnout and depression of 10.4, 30 and 43.3%.⁶ Some institutions have done work in this area dealing with the signs and symptoms of second victims and suggesting models for helping these individuals.⁷ Other studies introduced frameworks, models, and roadmaps for how to meet second victims' needs.⁸

Plews-Ogan et al noted several factors that were associated with resilience after adverse events: talking with colleagues and sharing that learning with colleague and trainees so as to prevent recurrences, acknowledgment of imperfection, disclosure, and apology and forgiveness.⁹ Not surprisingly, these authors found that less than 10% of individuals they interviewed had received any training in coping with traumatic events.

Programs which have begun to take this issue seriously have noted that the first line of support for physicians is physician colleagues in a group peer support situation or 1:1 peer support. The University of Virginia has successfully piloted a program called "Medical Error Disclosure and Peer Support" which uses role playing and paired interviews to deal positively with the emotions associated with medical error.¹⁰

The cleansing effects of error disclosure and sincere apology to patients can also play a salutary role in achieving improved mental health for medical personnel who commit or experience serious complications. Hospitals such as Brigham and Women's, Kaiser Permanente, and Johns Hopkins have all embraced the second victim concept and developed formal support programs for staff.

The role of morbidity and mortality complications conferences can also be seen as a positive step in dealing with the second victim problem. I have personally been interested and involved in many of these conferences and generally participants are extremely positive about a nonconfrontational educational, often confessional aspect to these case-based meetings. Ingredients for successful meetings are small size (40 or less), individuals who are known to one another, and what I would call "equitability" in which all participants must present a serious complication that they (personally, not their partner) have had. I would add to the

above formula for successful complications conferences that they include frank discussions and acknowledgments of the personal psychodynamics for the physicians play out and how healthy responses can enable better physician health.

Probably the most sagacious comment I've read is the simplest. Albert Wu of Johns Hopkins in an opinion piece in the *British Medical Journal* admonished all of us: "I'll conclude with an assignment for the practicing doctor: think back to your last mistake that harmed a patient. Talk to a colleague about it. Notice your colleague's reactions, and your own. What helps? What makes it harder? Physicians will always make mistakes. The decisive factor will be how we handle them. Patient safety and physician welfare will be well served if we can be more honest about our mistakes to our patients, our colleagues, and ourselves."¹¹

Conflict of Interest

The author reports no relevant disclosures.

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Further Suggested Reading:

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