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President's Page

Facing Disasters

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Ultimately, the secret of quality is love. You have to love your patient, you have to love your profession, you have to love your God. If you have love, you can then work backward to monitor and improve the system."
Avedis Donbedian [1]

"My PTSD is about a third better. You don't realize how stressful doctoring is until you're not doing it anymore." My friend and ex-partner, an echocardiographer, told me this 4 months after he retired. He self-diagnosed PTSD from his career as a cardiologist, and estimated it would last years into retirement, perhaps forever. As a fellow, he had wanted to become an interventional cardiologist, but he knew he could not take the stress.

We don't talk about the stress we experience as cardiovascular interventionalists, and a literature search turned up almost nothing on the topic. I suspect that stress, like Voldemort in the Harry Potter books, is That Which Must Not Be Named among interventional cardiologists.

Several factors prompt us to push stress under the rug. First, interventional cardiovascular medicine is (unfortunately) a male-dominated specialty [2] and men are famous for hiding stress behind a façade of bravado. Second, if one acknowledges stress then one must deal with it, and dealing with stress is difficult [3,4]. Finally, the frantic pace of professional life gives us no time to pause and acknowledge or deal with stress. If your patient dies on the table after prolonged resuscitation, how can you take time to de-brief yourself and the team when you have 5 more cases to complete in that day?

Cardiac interventionalists experience many types of stress, but three types are common. The first is the stress of treating patients, common to all physicians, that leads to high levels of burn-out and suicide within the medical profession [5]. It starts during training. Depression and burnout occur in 29% of all residents

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[6], 57% residents in internal medicine [7], and many cardiology fellows [8]. Early career cardiologists experience career dissatisfaction to a greater extent than mid or late-career cardiologists [9], but it remains a problem throughout all stages of a career. A Medscape survey indicates that 39% of cardiologists would not choose medicine if they could "do it over", and 41% would not choose cardiology [10].

Trainees are particularly vulnerable to stress from performing procedures. They are aware of their own lack of experience and skill. They are prone to mistakes, and when bad outcomes occur they may believe, right or wrong, that they are responsible. As a fellow, I recall tears after failing to promptly insert a balloon pump in a dying CCU patient. In retrospect nothing could have saved the patient, but I blamed myself. In addition, trainees are vulnerable to attendings who inappropriately place blame on the trainee. This has occurred in our cath lab, and as a result we have adopted a policy that ultimate responsibility always resides with the attending.

A second type of stress is experienced by interventionists in teaching programs when they supervise trainees, where trainees' inexperience and lack of skill can cause major complications for which the supervisor is responsible. A study of physiologic responses of attending cardiologists demonstrated that their anxiety was higher when supervising trainees than when performing procedures alone [11].

Finally, interventionalists make decisions and perform procedures that may result in disaster for individual patients. When that happens, interventionalists must live with the knowledge that they are to some extent responsible for the death or injury of a patient. Cath lab catastrophes impact different interventionalists in very different ways. Some seem to be unaffected. Others grieve and experience emotional pain and can recall decades later the names and details of patients who suffered adverse outcomes. Whatever their emotional impact, cath lab catastrophes should prompt examination of techniques and policies that lead to better care for subsequent patients. When I mentor fellows in the cath lab my advice is often accompanied by graphic descriptions of what happens when that advice is not followed, based on personal experience, in the hope they will not repeat my mistakes.

What can we do to help ourselves and our colleagues deal with these stresses? There is no shortage of recommendations in the literature [12–14]. Many of them seem sensible: exercise, eat right, develop a circle of friends and trusted counselors, find mentors, and so on. When I posed this question to our interventional fellows, I was struck by 3 of their observations: First, they remembered in graphic details the events surrounding catastrophes they had experienced – including where the family members sat as the fellow delivered news of their patriarch's death and what the family members said. Second, that how their attending handled the catastrophe made all of the difference in the world. One fellow recounted how he had been blamed in one circumstance and recalled the pain resulting from that, in contrast to another case where, after he had dissected the right coronary ostium, the attending matter-of-factly scrubbed in, stented the dissection, and then took responsibility himself for not adequately supervising the procedure. Finally – and this is a take home message for all of us – when I asked what attendings could do to make these situations better, the fellow said "Just ask us how we are doing. I probably wouldn't say anything, but just knowing you cared enough to ask would be huge". That is the lesson for all of us. When colleagues experience cath lab disasters, we should show empathy, ask how they are doing, and be willing to listen.

Avedis Donabedian, the pioneer in health care quality quoted at the beginning of this article, asserted that love is at the heart of quality health care. The children's book Fill a Bucket, asserts we are born with emotional buckets filled by acts of kindness and love, and depleted by negativity and disrespect [15]. We provide the best quality care for our patients when our buckets are full. Both Donabedian and the author of Fill a Bucket would agree that health care professionals have an obligation to fill each other's buckets. That is never more important than after a cath lab catastrophe. So when your colleague or trainee experiences one of those disasters, do what you can to fill their bucket again. Check in with them, show empathy, offer to talk it over, and remind them that better times are ahead.

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