Peer Support: Mitigating the emotional toll on physicians

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Relationships with financial sponsors:

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Deep Bow
My story

Evolving understanding
Institutions are...

“where the human heart either gets welcomed or thwarted or broken.”

Requires a fundamental *culture* change, because our culture has let us down:

- isolating
- blaming
- disempowering
- lacking humanity towards us
This is, fundamentally, a *culture* change

“The organization's culture consists of patterns of relating that persist and change through ongoing interaction.”

- Tony Suchman, MD
Not really this separate

In medicine, every one of us has faced a major challenge, one that had the potential to take a huge emotional toll.

None more intense than when we have made an error that harmed a patient.

*How can we talk about trust and wellbeing if we are not there for each other at such times?*
Reflection

Think of a time when you were involved in a medical error that caused patient harm.
Emotional impact of errors on clinicians

- Sadness
- Shame
  - Self-doubt
- Fear
- Anger
- Isolation
Helmreich’s observations:
Similarity between medicine and aviation

“...[both stress] the need for perfection and a deep perception of personal invulnerability...”

Physicians in particular

• High value on putting our head down, getting our work done: *do your job*
• It’s not supposed to hurt: *walk it off*
• We usually can *fix* things
Emotional impact of errors on clinicians

- Sadness
- Shame
- *Fear*
- *Anger*
- Isolation
We’re hoping for this:

“That’s OK. I know you always try your hardest and that you were only trying to help me.”
Fantasy

No more shame and blame
Following patient death

- Referrals dropped by 54% for female surgeons
- Only a small stagnation of referrals for male surgeons
Internal and external regulatory judgment and punishment

- Event analysis: M&M, RCA
- Department of Public Health
- Board of Registration in Medicine
- Inspectorate
- Royal College of Physicians and Surgeons
- Court of law
- Media
Emotional impact of errors on clinicians

- Sadness
- Shame
- Fear
- Anger
- Isolation
Many people may be significantly impacted

- Patient
- Family
- Physician
- Healthcare team
- Institution

Everyone should have access to support
Normal reactions to abnormal events

But sometimes recovery is thwarted...
3,171 MDs surveyed in US and Canada

**Figure 1.** Physicians’ lives were more likely to be affected as error severity increased. *Chi-square tests; p < .001 level.*

U.S. vs. UK: MDs and RNs

Following medical error

~30%

Experienced some negative impact on

Work performance or personal life

Colleague relationships

Factors associated with perceived medical errors

**TABLE 5. Factors Independently Associated With Perceived Medical Errors on Multivariate Analysis**

<table>
<thead>
<tr>
<th>Characteristic and Associated Factors</th>
<th>Odds Ratio*</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive depression screen</td>
<td>2.217</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Burnout</td>
<td>2.016</td>
<td>&lt;0.0001</td>
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</tbody>
</table>

Shanafelt et al, Annals of Surgery, 2010
Errors → Burnout → Errors
Suicidal ideation in MD’s correlates with recent errors

12.7% Of MDs reporting recent errors had SI (n=691) vs.

5.8% Of MDs who did not report recent errors had SI (n=5895)

Physician Suicide

40%↑ The suicide rate among male doctors than among men in general

130%↑ The suicide rate among female doctors than among women in general

Schernhammer E. NEJM 2005
So, how do we facilitate coping and resilience after adverse events?
Factors associated with resilience after adverse events

- Talking about it with colleagues
- Disclosure and apology
- Forgiveness
- Dealing with imperfection
- Learning from the error/understanding how to prevent recurrences
- Sharing that learning with colleagues and trainees

Sources of support

- Physician Colleagues: 88%
- Mental Health Professionals: 48%
- EAP: 29%

So, how do we facilitate coping and resilience after adverse events?

Group peer support

Sometimes an entire team is affected
Barriers to seeking support

• Lack of time (89%)
• Stigma (77%)
• Lack of confidentiality (79%)
• Access (67%)
We also offer 1:1 peer support

Group peer support

1:1 peer support
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Communication Coaching
When else should we offer peer support?

• Adverse events
• Communication with patients after AEs
• End of life care
• Board of Registration complaints
• Litigation
• Chronic stress
• Patient aggression: physical, verbal, social media
• Care of trauma victims
• Global crisis relief work
Factors associated with resilience after adverse events

Talking about it with colleagues

Disclosure and apology

Forgiveness

Dealing with imperfection

Learning from the error/understanding how to prevent recurrences

Sharing that learning with colleagues and trainees

Safety culture: Learning and growth mindset

- All feel safe talking about error
- Do not punish for human error (or for choices made in the face of legitimate competing priorities)
- Find and fix vulnerabilities in our systems and behaviors

Communication & Resolution Programs (CRPs)

• Transparent with patients regarding adverse events
  – What happened/why
  – Was event preventable
  – How recurrences will be prevented

• Proactive and prompt offer of financial and non-financial resolution if unreasonable care
Peer support: 
**A powerful culture change tool**

<table>
<thead>
<tr>
<th>Shame and blame</th>
<th>Promotes Just Culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal invulnerability</td>
<td>Human factors</td>
</tr>
<tr>
<td>Expectation of emotional denial</td>
<td>Normalizes reactions</td>
</tr>
<tr>
<td>Isolation</td>
<td>Community/solidarity</td>
</tr>
<tr>
<td>Self care is selfish</td>
<td>Gets you back to what you do well</td>
</tr>
</tbody>
</table>

Helps us show up with compassion for our patients, each other and ourselves
Not victims

“we are not victims of that world, we are its co-creators.

…source of awesome responsibility…and profound hope for change.”


Thank you for your engagement and commitment
Shoulders
Let’s face values conflict

- Production pressure
- Patient satisfaction
- Personal accountability

- Safety and quality
- Unrealistic expectations
- Systems accountability
Can’t expect people who are feeling unsupported and isolated to deliver high quality patient care or to sustain their joy in work
Learning frame

Knowing what we know now, would we do anything different next time?

What would we repeat that went well?

Did we make any errors?

Is what we did unreasonable?
(standard of care)
Trust

“The deepest principle in human nature is the craving to be appreciated.”

William James
CHANGING TIDES: SHIFTING CULTURES AND CREATING SAFE SPACES