BURNOUT IN EMERGENCY MEDICINE: HOW DO WE GET BETTER?

Research in healthcare has found that emergency department doctors report higher levels of burnout than any other medical specialty. In this article, emergency physician **Shannon McNamara** describes her own experience, and how a shift in perspective can help.

KEY POINTS

- **There are many sources of burnout, including workload, inefficiency, broken systems, interpersonal incivility, and exposure to traumatic stress.**
- **Exposure to secondary traumatic stress is ubiquitous in health care workers and is directly related to burnout and compassion fatigue.**
- **Distress caused by traumatic stress is treatable but stigmatised.**
- **A Safety-II perspective may reduce burnout and traumatic stress by highlighting successes, prioritising the perspectives and expertise of front-line workers, and limiting individual blame, thus improving wellness.**

In the past eight years as an emergency physician, I've experienced burnout multiple times. A recent study showed that three-quarters of emergency medicine trainees were experiencing burnout (Lin, 2017). I often wonder, why are so many of us so miserable?

The medical profession is now paying more attention to wellness and burnout. The prominent Stanford Well MD centre emphasises a three-pronged approach to wellness through addressing culture, efficiency of practice, and personal resilience. I've witnessed the detrimental effects of a dysfunctional and under-resourced practice environment. I've felt the sting of a toxic institutional culture that is rife with professional incivility and interpersonal discord. Both are clearly factors in the development of burnout.

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Whenever I see the framing of 'wellness' through personal resilience, however, I feel really angry. Though individual strategies may well be effective in some circumstances, framing a lack of wellness as a lack of personal resilience feels like shifting the responsibility. Clearly, if burnout is so prevalent, this is an environmental problem, not a personal failure.

Personal Resilience and Traumatic Stress

My anger comes after many years investing in my own 'personal resilience' without the support of the medical community. Our environment exposes us to a heavy dose of traumatic stress, but our profession doesn't have a systematic way of managing it. Unfortunately, acknowledging and treating work-related traumatic stress is still stigmatised.

After my first year as a physician, I sought the care of a mental health professional for a non-work issue. I didn't consciously know that I wasn't well. At our first meeting, the therapist assured me that the personal challenge that brought me to her would be simple enough to address. Then she asked how we were going to address my work trauma.

I worked in a busy, urban 'Level 1' Trauma Centre that provides the highest level of trauma care to critically ill or injured patients, with a bustling intensive care unit. In that first year, I lost count of how many people I watched die. I lost count of how many open chest resuscitation cases we did in the emergency department for victims of gun violence. And I lost count of how many families I notified of their loved one's death. I didn't know that this was trauma. I worked in trauma, I didn't experience trauma.

The therapist didn't use terms like 'PTSD' (post-traumatic stress disorder). She just helped me feel feelings again. I would sit on her couch, tell her stories from work, and cry. It took us years to work through the backlog of stories I carried and to process the new ones. I gradually stopped seeing intrusive imagery about death before bed. My moods and my relationships improved. By the time I graduated from residency (a stage of graduate medical education), I was still burned out, but at least I was sleeping well.

Since then, my exposure to traumatic stress has lessened. It will never fully disappear. My job as an emergency physician is to take care of everyone who comes in the door. There will always be people who suffer and who die. There will always be families who grieve. This is part of the job. I stay in therapy to keep the distress related to that traumatic stress at bay, and it helps.

Mitigating Traumatic Stress

My frustration with the healthcare industry's focus on wellness is the notable lack of conversation about how to manage the universal challenge of traumatic stress. We know that secondary traumatic stress is ubiquitous in the health professions. We know that this contributes to burnout. We know that professional support can help. And yet, we don't talk about it. Seeking help is still stigmatised. It's rare to hear physicians openly discuss seeking or obtaining professional support for coping with traumatic stress. It's rare for organisations to offer professional supervision to mitigate that stress. Instead, we joke about getting a drink after a tough day.

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As I pursued more professional development in quality and safety, I discovered that not only were we failing to address the problem of traumatic stress, we may be making it worse. At administrative safety and quality meetings, I noticed that those making the rules often didn't understand how the work was done. Front-line clinician expertise was rarely considered in seeking the so-called 'root cause' of the perceived failure, nor in crafting solutions for the problems uncovered. Shame and blame were ubiquitous: often subtle, but rarely absent. I wondered, why were we relentlessly focused on finding someone to blame, instead of trying to learn how we succeeded and how to do better next time?

Does Blame Make Us Safer?

When things go wrong, there must be someone or something to blame, right? In my own practice, I experienced similar burdens of hindsight. When an adverse outcome occurred, our team was scrutinised and often blamed for what happened. When a patient did well, we occasionally received positive feedback. Often the processes that lead to both good and bad outcomes were the same. When we were critical of a process or asked for more resources, our calls often went unanswered.

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Many years after residency, I realised that I was still feeling cynical, burned out, and exhausted under the weight of the stories that I carried. Despite seeking support, I unconsciously blamed myself for my own failures to rescue patients from death or from suffering. It wasn't hard to imagine how it happened – I was named in a malpractice suit and endured a few of my own cases going through the 'root cause analysis' process. There were people lining up to blame me when bad things happened.

As I talked to my colleagues, it was clear that my experience was actually well within the norm. Most U.S. physicians get sued. Everyone has bad outcomes. It's part of the job. We work in a high-risk field, and the risk to us is also significant.

Safety-I to Safety-II

Gradually, something shifted. I realised that I alone could never conquer death or suffering. How did I imagine that I could? I couldn't blame myself for every bad thing that ever happened. But I could keep doing my best. I could always keep learning, keep growing, creating more kindness, and more safety. But I needed to let go of the weight of the shame of failure and transform it into recognising the realities of my impact as an Emergency Physician.

I started learning about complex systems and how they fail, and about how safety sciences have accepted the reality of how and why things happen, while acknowledging that it is not always possible to know. I heard people ask, "knowing what we know now, how do we get better?" instead of pointing fingers at those in the

past who were doing their best with what they knew at the time. Instead of searching for 'root causes', I started wondering: *how do we identify and create conditions that create safety?* How do we stare the realities of uncertainty, danger, and mortality in the face, and still be well?

Making this shift to a 'Safety-II' perspective took me years and great effort. The shift happened outside of the context of the predominant medical paradigm that still seeks 'root causes' and fails to acknowledge the realities not-knowing. In medicine, we often avoid acknowledging that we are just as human as everyone else, just as vulnerable to uncertainty, to mortality, and to being wrong. By recognising the strengths and limits of our shared humanity, we can start to build environments where humans can thrive. Perfection may be unattainable, but we can always seek more good in the world.

Debriefing Death

It's still really difficult for me to watch someone die. Now, after I do, I make sure that someone on the team leads us through a moment of silence to honour the person whose life just ended. Afterwards we debrief what happened. What do we know, and what don't we know? What did we do well? What systems supported us? Where did we feel challenged?

As I stand next to a person that died, I struggle to ask, "How could we do better next time?" I fear that asking this question to a team there may encourage them to carry the full weight of responsibility for the patient's death on their shoulders. The reality is that even when we perform optimally, most of the patients who experience cardiac arrest will die. Not every failure to rescue is a failure – many rescues are impossible. We often never know which is which.

We get better from both less bad and more good. I know that debriefing on what went well alone helps us get better. By focusing on our successes, I hope that we can stay calm and carry on even in the face of a career where ultimately we will continue to watch people die.

Reference

Lin, M., et al. (2019). High prevalence of burnout among US emergency medicine residents: Results from the 2017 National Emergency Medicine Wellness Survey. *Annals of Emergency Medicine*, *74*(5), 682-690. https://doi.org/10.1016/j.annemergmed.2019.01.037

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