Moral distress, burnout, resilience among healthcare professionals

Marc Moss, M.D.
Roger S. Mitchell Professor of Medicine
Interim Head
Division of Pulmonary Sciences
& Critical Care Medicine
University of Colorado School of Medicine

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Disclosures and Caveats to the Talk

• The following relationships with commercial interests related to this presentation existed during the past 12 months: None

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  • National Endowment of the Arts (?)

• Will integrate information about
  • Nurses and doctors
  • Trainees and attendings
  • Critical care and other types of medicine
Historical Tenets of Medicine

- Expected to dedicate to patient welfare above all other considerations
- Committed to the public good
- Impervious to financial temptation or other self-interests

As a result:
- Public respect and trust
- Autonomy and discretion in their work
- Delighted with their choice of profession
Is our profession out of balance?

“With altruistic intent, healthcare professionals may place professional responsibilities above personal responsibilities. Though admired, this may be self-defeating in the long run.”

“Role models range from academic superstars with impressive research credentials and international acclaim to committed clinician-teachers who are at the hospital seven days a week...their heroes lead lives that are desperately out of balance.”
Healthcare professionals always exposed to difficult experiences

- Walt Whitman and Louisa May Alcott
  - Volunteer nurses at army hospital during Civil War

  Whitman: “Feel sick and actually tremble at night, recalling the deaths, operations, and sickening wounds (perhaps full of maggots).”

  Alcott: “Found it difficult from weeping at the sight of several stretchers, each with its legless, armless, or desperately wounded occupants”. 
Changing healthcare paradigm: What happened?

- Less autonomy in work
  - Increase focus on documentation
  - Increase shift work

- Focus on quality measures and cost issues

- Patients are sicker
  - More chronic diseases and critical illness

- Increased patient/family expectations

- Decreased patient trust
  - 1966: 73% Americans has great confidence in medical profession
  - 2012: decreased to 34%

Added stress in academic centers:
- Decreased research funding
- Resident work hour limitations
Conceptual Model of Psychological Distress in Healthcare

Moss et al. Am J Respir Crit Care Med; 2016: 194: 106-113
Proximal BOS Triggers: Moral Distress

- Know the ethically appropriate action to take
  - But feel constrained from taking it
  - Nurses > Doctors

- Internal Constraints:
  - Self-doubt, anxiety about creating a conflict, lack of confidence

- External Constraints:
  - Power imbalances, poor communication, pressure to reduce costs, fear of legal action, lack of administrative support
Burnout Syndrome (BOS)

- Discrepancy between:
  - Employee expectations and ideals
  - The actual requirements of the position

- Work-related strain
  - Do not start a job with symptoms of burnout
  - Occurs gradually over time

- Best and idealistic employees
  - No prior psych history
  - Ones who care
  - Want to help people
Core Components of BOS

• 1. Emotional Exhaustion
  • Devoting excessive time and effort to a task that is not perceived to be beneficial
  • Continuing to care for a patient who has a poor chance of recovery

• 2. Depersonalization
  • Attempt to put distance between oneself and patients/families
  • Dismiss human qualities
  • Negative, callous, cynical, inability to express empathy or grief when a patient dies

• 3. Reduced personal accomplishment
  • Negatively evaluate the worth of one’s work
  • Feeling insufficient about abilities
Critical Care Physicians: Among Highest Burnout Rates

Medscape survey 2013
Consequences of Burnout

1. Individual Level

“When burnout was seen as a crisis of wellbeing – affecting healthcare workers personal lives and work satisfaction – it garnered little public sympathy and could be dismissed as the whining of the privileged class”

Epstein and Privieria: Lancet 2016
Prevalence of Disorders in ICU Nurses

- Post-mortem care
- Seeing patients die and involvement with end of life care
- Combative patients
- Verbal abuse from family members, physicians, and other nurses
- Open surgical wounds
- Massive bleeding
- Trauma related injuries
- Performing "futile" care to patients
- Performing cardiopulmonary resuscitation
- Stress related to feeling over-extended due to inadequate nurse to patient ratios
- Stress related to not being able to save a specific patient

Other Major Consequences

- Survey of 3500 physicians
  - Due to their choice of profession
    - Workload was too heavy (62%)
    - Family/personal life have suffered (55%)

- Divorce
- Broken relationships
- Substance abuse
- Suicide
  - 400 physicians annually: more than double the general population.

Doctor found dead at home in apparent heroin overdose

Doctor who killed himself at Froedtert had struggled with depression, relationships

The New England Journal of Medicine

Perspective

On Wednesday, August 17, 2016, at about 5:15 in the morning, Kathryn, one of our fourth-year medical students, ended her life by jumping out of her apartment window. She was found

dead to medical school with a suicide. The next 48 hours were a whirlwind. We put 24/7 emergency mental health services in place, had two town-hall-type meetings,
BOS effect on patient care: Diuresing your service?

115 internal medicine residents

Anonymous mailed survey

Questions about patient care practices

Stratified by MBI score: 76% met burnout criteria

Different Potential Solutions?

**Organizational-focused interventions:**
- Shortening length of rotations
- Changes in workflow: increased time for visits, scribes, voice recognition
- Improved communication: meetings with hospital leadership

**Individual-focused interventions:**
- Educational curriculum
- Stress management and self-care training
- CAVEAT: cannot place blame on the individual
Resiliency Can Be Learned

- A dynamic process in which individuals exhibit positive behavioral adaptation in times of significant adversity, stress, trauma, or tragedy.
- The capacity to bounce back after disruption.

<table>
<thead>
<tr>
<th>Domains</th>
<th>Exemplars Resilience</th>
<th>Exemplars PTSD</th>
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</thead>
<tbody>
<tr>
<td>Worldview</td>
<td><strong>”I also believe that I am not meant to understand why certain people die and certain things happen to people. I have to accept it, but I don’t have to understand it”</strong>.</td>
<td><strong>”Often times I do think, what could I have done differently? Did I miss something? Was there a better way to have handled the situation? I think I do play it over in my head, after the crisis has passed”</strong>.</td>
</tr>
<tr>
<td>Social Network</td>
<td><strong>”It was really good to sit down and talk about it rather than keep it to yourself and keep wondering what if”</strong>.</td>
<td><strong>”I think one of the job hazards we have is accumulated grief”</strong>.</td>
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Barriers to implementation: Requires a Culture Change

- **Survey of medical students at 6 schools**
  - 52% had symptoms of burnout (454/873)
  - 33% sought help in last 12 months: (154/454)

Sought Help in Last 12 Months

<table>
<thead>
<tr>
<th>Sought Help</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Family</td>
<td>70%</td>
</tr>
<tr>
<td>Friends</td>
<td>60%</td>
</tr>
<tr>
<td>MHS at school</td>
<td>50%</td>
</tr>
<tr>
<td>Outside MHS</td>
<td>40%</td>
</tr>
<tr>
<td>PCP</td>
<td>30%</td>
</tr>
<tr>
<td>School personnel</td>
<td>20%</td>
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Academic Medicine 2015; 90: 961-969
### Barriers to implementation: Stigma/Labelling/Discrimination

<table>
<thead>
<tr>
<th>Item</th>
<th>No. (% of 873)</th>
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<tr>
<td><strong>Item</strong></td>
<td><strong>Strongly disagree</strong></td>
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<tr>
<td>It is a sign of personal weakness or inadequacy to receive treatment for emotional or mental health problems.</td>
<td>315 (36.2)</td>
</tr>
<tr>
<td>Residency directors would pass over my application if they were aware I had an emotional/mental health problem (e.g., depression, anxiety).</td>
<td>26 (3.0)</td>
</tr>
<tr>
<td>My supervisors (e.g., faculty, residents, deans) would see me in a less favorable way if they believed that I had an emotional/mental health problem.</td>
<td>37 (4.2)</td>
</tr>
<tr>
<td>Fellow students would see me in a less favorable way if they came to know that I had received treatment for emotional/mental health problems.</td>
<td>32 (3.7)</td>
</tr>
<tr>
<td>Patients would not want me as their doctor if they were aware I had received treatment for an emotional/mental health problem.</td>
<td>28 (3.2)</td>
</tr>
<tr>
<td>Mental health care provided by my school/affiliated institution to medical students is truly confidential.</td>
<td>55 (6.4)</td>
</tr>
<tr>
<td>The dean at my medical school could access my personal medical record if he or she wished to do so.</td>
<td>212 (24.3)</td>
</tr>
<tr>
<td>Residency program directors at the institution associated with my medical school could access my personal medical record if they wished to do so.</td>
<td>244 (27.9)</td>
</tr>
<tr>
<td>If I sought care for an emotional/mental health problem it might end up in my academic record.</td>
<td>190 (21.9)</td>
</tr>
<tr>
<td>If I were to receive treatment for an emotional/mental health problem, I would hide it from people.</td>
<td>12 (1.4)</td>
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Take Home Points

1. **Address the stigma related to burnout**
   - Mental health problem
   - Making progress but still a ways to go

2. **Remove the blame from the provider**
   - Burnout is an occupational health problem

3. **Burnout is a complex syndrome:**
   - Different disorders necessitate different treatments
     - PTSD vs. BOS
     - Doctors vs. nurses (different triggers)
     - ICU vs. other settings
   - Can’t all be fixed by changing the EMR
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