Leading with resilience, ethics, and a trauma informed lens to support self and staff

Elaine Beardsley
Clinical Resilience Specialist, Program Manager

Jessica Roumillat
Program Manager, Integrated Ethics

Leslie Leach
Program Manager, Staff Support

resilience | integrated ethics | staff support | engagement

**RISE is a subcommittee of the Quality and Patient Safety Committee and is established and operates as a "medical peer review committee," "medical committee," and "professional review body," as such terms are defined by state and federal law, and is authorized to engage in quality and medical peer review activities.*

Objectives

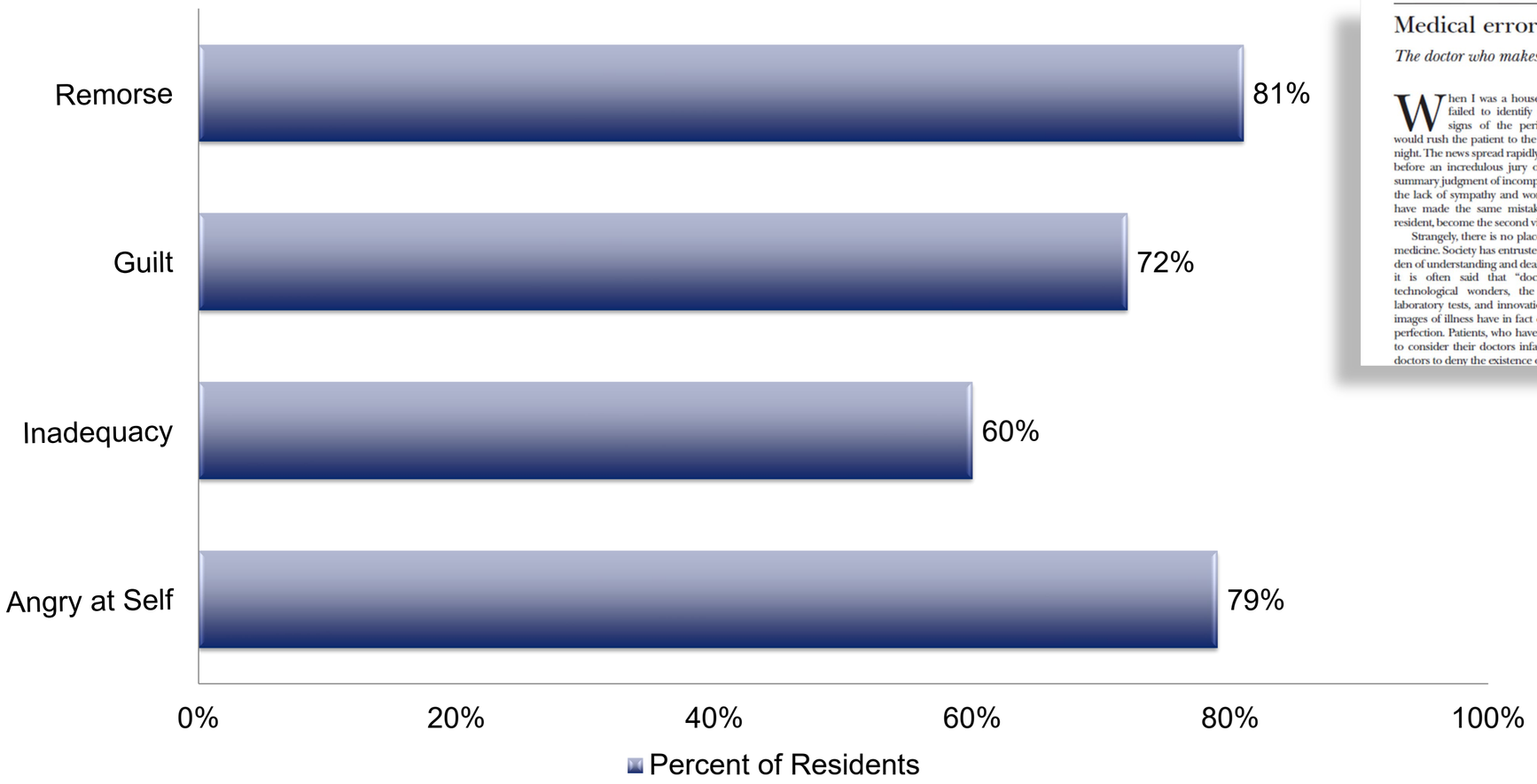
- Introduction to RISE
- Understand the second victim phenomenon and secondary traumatization in healthcare
- Explore strategies, skills and tips to support GME Residents
- The power of active listening after adverse events
- Define moral distress and explore strategies to mitigate impact
- Resilience Synthesis
- Tools for Promoting Resilience
- Facilitated Discussion
- Q&A
- Mindfulness Moment

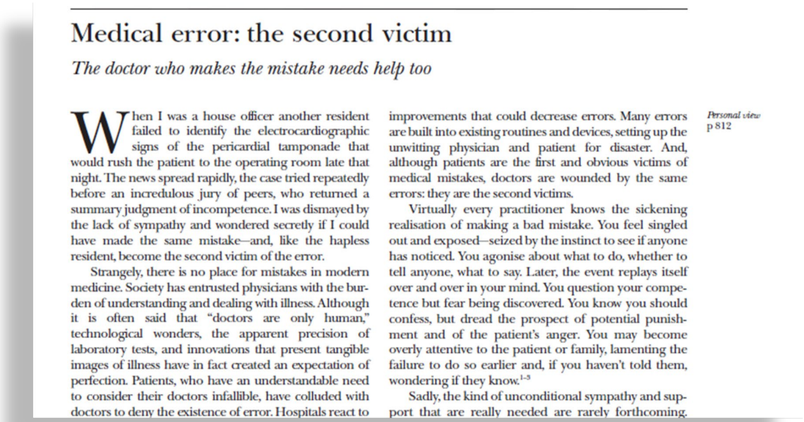
RISE Programs



- **Support the mission and values of Children's Health**
- **Promote resilience, integrated ethics, and staff support through programming, education, and research**
- **Enhance the ethical climate**
- **Create moral spaces**
- **Address secondary traumatization**
- **Mitigate burnout**

Resident Response after Adverse Events (Wu,2000)





Medical error: the second victim

The doctor who makes the mistake needs help too

Personal view
p 812

When I was a house officer another resident failed to identify the electrocardiographic signs of the pericardial tamponade that would rush the patient to the operating room late that night. The news spread rapidly, the case tried repeatedly before an incredulous jury of peers, who returned a summary judgment of incompetence. I was dismayed by the lack of sympathy and wondered secretly if I could have made the same mistake—and, like the hapless resident, become the second victim of the error.

Strangely, there is no place for mistakes in modern medicine. Society has entrusted physicians with the burden of understanding and dealing with illness. Although it is often said that "doctors are only human," technological wonders, the apparent precision of laboratory tests, and innovations that present tangible images of illness have in fact created an expectation of perfection. Patients, who have an understandable need to consider their doctors infallible, have colluded with doctors to deny the existence of error. Hospitals react to improvements that could decrease errors. Many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster. And, although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims.

Virtually every practitioner knows the sickening realisation of making a bad mistake. You feel singled out and exposed—seized by the instinct to see if anyone has noticed. You agonise about what to do, whether to tell anyone, what to say. Later, the event replays itself over and over in your mind. You question your competence but fear being discovered. You know you should confess, but dread the prospect of potential punishment and of the patient's anger. You may become overly attentive to the patient or family, lamenting the failure to do so earlier and, if you haven't told them, wondering if they know.[1-3]

Sadly, the kind of unconditional sympathy and support that are really needed are rarely forthcoming.



Wu,(2000)

What is the aftermath if no support?

Traumatized clinician	Isolation	Negative impact on teamwork (toxic work environment)	Low morale
Miscommunication or lack thereof	Turnover	Burnout	Compassion Fatigue
Impaired job performance	Empathy fatigue	Emotional exhaustion	What else?

Debriefing

Patient death debriefing sessions or checking in may improve residents' perception of support and coping

Debriefing frequently and consistently may foster a more open forum that normalizes a culture of support

Goal is to normalize emotional response, not relive each detail

Debrief sessions can last between 10-15 minutes if a small group

1:1 support is an option (checking in with each other)

Within 24-48 hours of event

The focus is on emotional reactions

It is important to acknowledge first deaths and first codes can be difficult

Know resources

(Journal of GME, 2015)

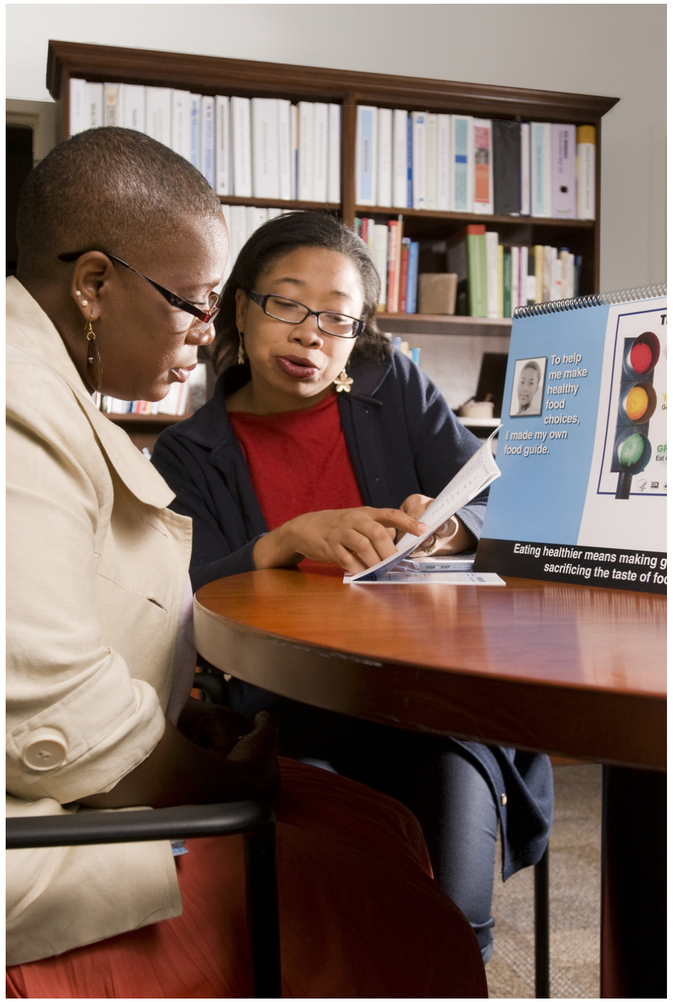


Tips for Active Listening as a Leader

- Create a calm, confidential, safe space
- Begin with an open-ended question
- Focus on the person and their experience
- Reflect what you hear the person say
- Avoid “fixing”
- Normalize. Avoid minimizing
- Maintain good body language and eye contact
- Silence is okay!

Phrases

- “What are you doing to take care of yourself?”
- “You are having a normal reaction to an abnormal/stressful event”
- “I can see how hard this is for you”
- “I am here for you”
- “It is okay to feel this way”



Takeaways

- There is no standard way to help GME Residents deal with the emotional impact of patient deaths, traumatic codes, medical errors and unanticipated patient events
- Showing up imperfectly is okay
- Asking “How are you doing?” goes a long way
- Articles:
  - Eng, J., Schulman, E., Jhanwar, S. M., & Shah, M. K. (2015). Patient Death Debriefing Sessions to Support Residents' Emotional Reactions to Patient Deaths. *Journal of graduate medical education*, *7*(3), 430–436.
  - Fatima S, Soria S, Esteban-Cruciani N. Medical errors during training: how do residents cope?: a descriptive study. *BMC Med Educ*. 2021 Jul 29;21(1):408.



Moral Distress: What is it?

Original Definition

- When one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action (Jameton, 1984)
- Hallmark = internal or external constraint



Image Credit: RACGP - Junior doctors working unsafe hours to 'earn their stripes'

A "Broadened" Definition

- The experience of a moral event,
- The experience of "psychological distress", AND
- A direct causal relation between the event and the distress (Morley, 2018)

Proposed Subcategories

- Fourie, 2015
  - Moral-constraint distress
  - Moral-conflict distress
- Morley et al, 2019
  - Moral-uncertainty distress
  - Moral-dilemma distress
  - Moral-tension distress

Moral Distress in the Age of COVID-19





- Three “Rs”
  - Rationing
  - Restriction
  - Responsibilities
- Balancing individual and collective interests
- Tensions surrounding "duty to care"
- Implications for defining "best practice"

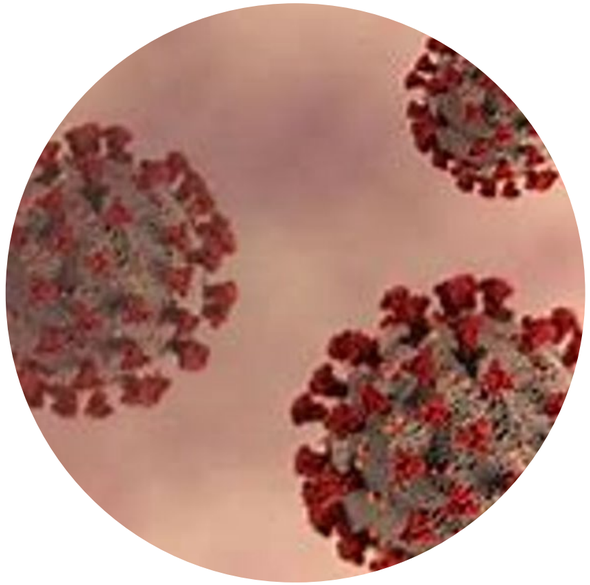






Image Credits: bing.com - COVID-19

Moral Distress: What to do?

Create safe, moral spaces for storytelling, processing, and unburdening

Name it

Speak up

Educate

Empower



Image Credit: COVID-19 Vaccination Clinical and Professional Resources | CDC

What does resilience mean to you?

Paradoxes

1. Does the personal/social interpretation of resilience at times result in increase suppression and emotional exhaustion?
2. Does connecting to meaning and purpose and belonging actually increase our expectations of self and soften our boundaries? (*self-worth, identity, etc*)
3. Does our own perception of what self care is in the moment over long periods contribute to depletion?
4. How can we process the difficult and detach without either increase stress or promoting suppression?
5. How can leaders support staff without increasing their own emotional exhaustion and “felt” stress?

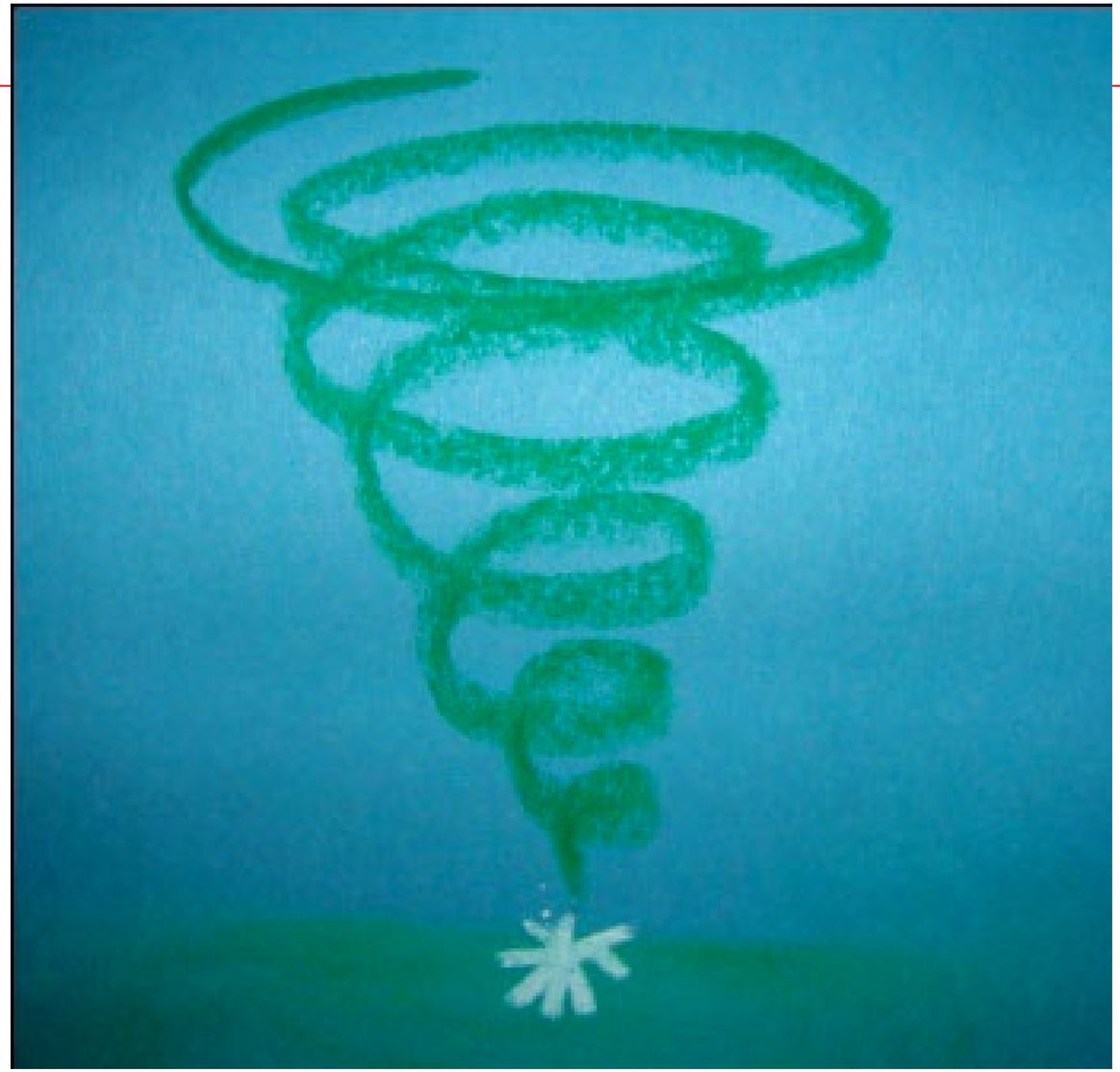
Key Concepts

- Resilience- definition
- Cumulative stress: multiple contributors contribute to allostatic load
- Burnout
    - Emotional Exhaustion; Depersonalization; Decreased feelings of personal achievement
    - Cognitive dysfunction, empathy loss, social retreat, anxiety/depression**

(Rajkumar , 2021; Tavella et al 2021)

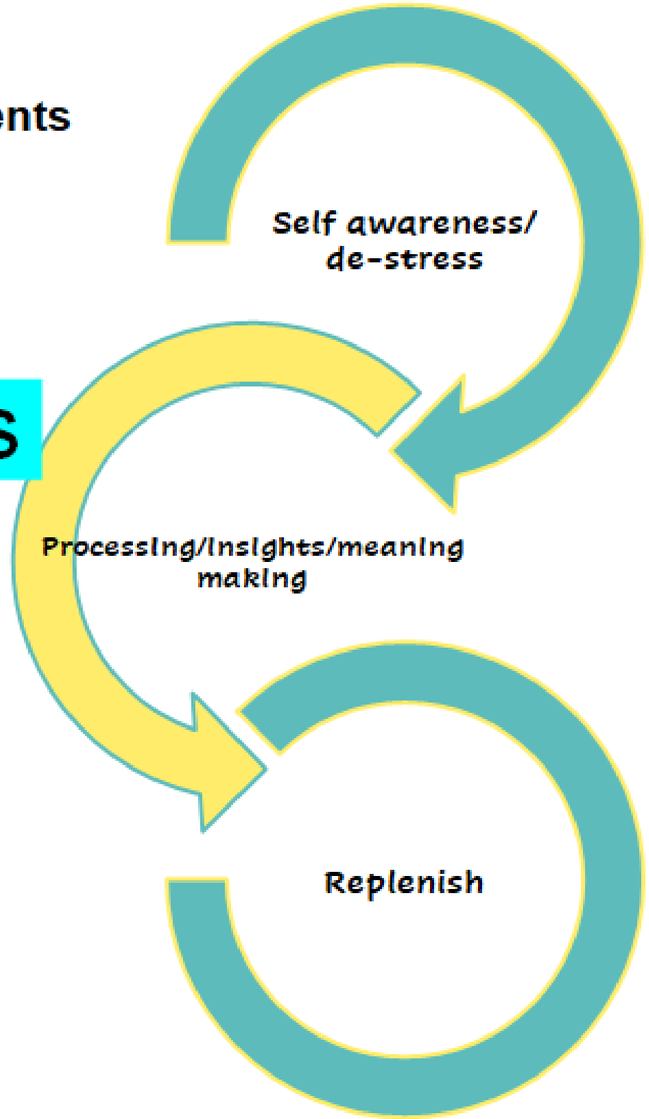
Conservation of Resource Theory

- We all have demands and resources (tangible and intangible) with different levels of meaning and priority
- Ideally, they should be balanced
- Some are worth more: self-worth, goals, meaning, connection, feeling valued and belonging, values



RESILIENCE Components

Self-compassion is throughout



Supportive Tools to Support Parasympathetic Recovery

Click to add text

STOP- Stop- Take a breath-Observe-Proceed

RAIN – Recognize-Allow-Investigate-Nurture (Brach, 2019)



Group Discussion

Questions?

Mindfulness Moment



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References

Brach, T. (2019). *Radical Compassion.* Penguin Publishing Group. Kindle Edition.

Hu, YY et al. (2012). Physicians' needs in coping with emotional stressors: The case for peer support. *Arch Surg.* 147(3):212-217.

Joint Commission (2020) *Promoting psychological wellbeing of health care staff during crisis.* Link: Quick Safety Issue 54: Promoting psychosocial well-being of health care staff during crisis | The Joint Commission

National Academies of Sciences, Engineering, and Medicine (2019). In National Academies Press (Ed.), *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being*. http://dx.doi.org/https://doi.org/10.17226/25521

Scott SD, Hirschinger LE, Cox KR, McCoig M, Hahn-Cover K, Epperly KM, et al. (2010). Caring for our own: deploying a system-wide second victim rapid response team. *Jt Comm J Qual Patient Saf*. May;36(5):233-40.

Tavella, G., Hadzi-Pavlovic, D., & Parker, G. (2021). Burnout: Redefining its key symptoms. *Psychiatry Research*, *302*, 114023. https://doi.org/10.1016/j.psychres.2021.114023

Yang, Y., & Hayes, J. A. (2020). Causes and consequences of burnout among mental health professionals: A practice-oriented review of recent empirical literature. *Psychotherapy*. http://dx.doi.org/https://doi-org.lopes.idm.oclc.org/10.1037/pst0000317