Adverse Event Process / Crisis Management

Susan Gerber, MD, MPH
Residency Program Director and Vice Chair, Education
Departments of Obstetrics and Gynecology & Medical Education
Feinberg School of Medicine
Northwestern University
Background

• Medical training is a time of high stress
• Trainee wellness is a current ACGME focus
• Prevalence of depression and depressive symptoms among resident physicians ranges from 21% - 43%, significantly higher than general population
• Important implications for trainees and patients
Depression: Risk factors

- Female gender
- Young age
- Increased work hours
- Stressful life events
Gender and specialty choice
Internal data – Ob/Gyn (2011-2012)

• Incoming PGY-1 class (N=12)
• Surveyed at baseline, and monthly for depression, anxiety
• Total surveys = 156 (11/12 completed at least one survey)
• CES-D score >15 referred for counseling
• 8/11 subjects referred for counseling by the end of the year
• All scores returned to normal on next survey
Predictors of depression during residency: personality

• Baseline:
  - Higher baseline depression score
  - Lower self-esteem
  - Lower perceived social support
  - Higher trait anxiety
Predictors: environment

- Sleep hours – significant correlation ($r=-.32$, $P<.05$)
- Work hours – no significant correlation
Environment:
High risk vs. low risk rotations

![Graph showing STAI-state and CES-D scores across different rotations.](image)
Conclusions

- High rates of depression and anxiety among PGY-1 residents in Obstetrics and Gynecology
- Some predisposing factors may not be fixable
- Certain environmental risks can be identified
  - High risk rotations
  - Sleep
Stressful Events

• Expected
• Unexpected
• Specialty-dependent
• Nights, weekends, holidays
Lessons from Psychiatry: Impact of patient suicide

• Occupational hazard?
• Residents are a vulnerable population whose early experiences with suicide shape future behaviors and coping skills
• Residency exposes trainees to the sickest of patients, with the highest risk
• Chief resident survey – 19% reported feeling prepared for the aftermath of patient suicide
Lessons from Psychiatry: Collateral Damages

• Curriculum designed to prepare trainees for patient suicide
• Study participants – 240 trainees
  - 19.2% had already experienced patient suicide
  - Represented all PGY levels
• Outcomes – better understanding on post-test, but no real-world follow-up
Coping With Patient Suicide

• #1 – Sources of Support:
  - Call attending of record ASAP
  - Call PD and Chief Resident
  - Meet with faculty
  - Meet with colleagues

• #2 – Medicolegal Issues:
  - Resident group meetings
  - Consultation with faculty

• #3 – What happens next:
  - Critical incident or Quality Assurance Meeting (within 2 weeks)
  - Root Cause Analysis
Psychological effects of adverse outcomes - Ob/Gyn

- Board certified physicians in the Midwest (N=682, median age 58yo)
- Professional liability claims – 78%
- Evaluated impact on psychologic trauma, job strain, shame/doubt, active coping
- Three adverse events evoked most psychologic stress
  - Patient death
  - Fetal demise
  - Neonatal brain damage
Obstetrics and Gynecology residents – critical events

- Maternal death
- Unexpected neonatal death
- Poor perinatal outcome
- Medical error resulting in adverse outcome
- Anything that causes significant distress
Pre-protocol: well-intentioned, but not helpful?

- Give them some space
- Don’t wake them up
- “Get back on the horse”
Northwestern Ob/Gyn Critical Event Notification Protocol

Resident Response Policy

Catastrophic event occurs

Senior on shift or any resident emails PD & chief account with the following information ASAP:
- basic description of what happened without patient identifiers
- primary resident(s) involved
- other residents on service that shift
- attending(s) involved

Within 24-48 h

Chief Residents:
- Contact involved residents to check-in
- Offer to contact resident buddy or any other residents of event. Inform affected residents that seniors on service will be notified
- Contact senior(s) on service(s) to inform them of event and of affected residents
- Schedule appropriate follow up depending on resident needs (face to face, email check in, etc and at what interval)

PD/assistant PD:
- Contact involved residents to check-in
- Email uniform list of resources to involved residents*
- Offer to contact any of listed resources on behalf of resident
- Schedule appropriate follow-up depending on resident needs (face to face, email check in, etc and at what interval)
- Informs Risk Mgmt of event
Northwestern Ob/Gyn Critical Event Notification Protocol

In 1 week

Chief Residents:
- Contact involved residents to check-in, make sure receiving resources needed
 PD/Assistant PD:
- Contact involved residents to check-in, make sure receiving resources needed

In 1 month

Chief Residents:
- Continue to contact resident(s) promptly
- Ensure case is scheduled on M&M and involved residents/attendings are informed
 PD/Assistant PD:
- Continue to contact resident(s) promptly
- Offer support to resident if RCA is scheduled & have resident support person at RCA

*List of resources includes: mental health, risk/legal, life coach, involved attending, PD/assistant PD
Additional elements

- Collateral damage
- Time off if needed
- Debriefing – individual or as a group
- RCA participation
Take-home points

• Stressful / catastrophic events have significant impact on trainee well-being
• Effective management of these events may help
  - Contact immediately
  - Recognize potential for collateral damage
  - Be present / listen
  - Remind trainees of resources and encourage them to use them
Questions?