Chapter 19
As a Professional

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> *Your work is going to fill a large part of your life, and the only way to be truly satisfied is to do what you believe is great work. And the only way to do great work is to love what you do. If you haven't found it yet, keep looking. Don't settle. As with all matters of the heart, you'll know when you find it.*
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> *—Steve Jobs*

To succeed, intensivists must professional behavioural responses to workplace stressors. Adaptive and positive responses are helpful to their well-being. At other times maladaptive responses lead to burnout and depersonalisation [1, 2]. Most of the current literature that exists in the area has explored responses of those working in the adult ICU; there remains little data pertaining to the paediatric intensivist.

It is normal to have negative feelings when a bad outcome occurs, but especially when this occurs in a child. One of the most common things intensivists do is attempt to make sense of the events through self-reflection:

> *I mean firstly I think I probably just want some space or time where I'm not necessarily required to talk about it, or whatever. Like, I think I just like some thinking time. And I'm not even sure how long that is.*
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> *I need a little bit of immediate venting first-aid, then I need contemplative time, then I usually choose peer-based debriefing. So, peers that would understand. I am lucky enough to*

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D. Dennis et al. (eds.), *Stories from ICU Doctors*,
https://doi.org/10.1007/978-3-031-32401-7_19

be married to a nurse, who at least understands the mechanics, as well as the emotional reactions.

Taking time for sense-making is a very prevalent behaviour. Another often-mentioned behaviour was mentally rewinding and replaying the negative event and wondering how it might have played out differently if other things had occurred.

The 'if's' are there all the time. I question, 'If I would have done that, you know?' 'If I would have done it another way, the outcome may have been different?' You never know. But the fact is, that you are doing something, for the benefit of the child, but at the end, because what you have done, the outcome is very poor.

What led to the sequence of events that happened… Firstly that it happened. It shouldn't have happened. It shouldn't have been that way. Then, yes, I didn't communicate with the family well: They were at one point, and I was at another. We didn't understand each other. Also, the discussion was very emotional. When I understood what happened we all relaxed. I was also very stressed I did not understand the situation well. Only after I understood it all I relaxed a little bit. It was challenging to speak with them. It took days for them to relax. I understand that of course.

The personality of the intensivist likely plays a role in when and how they discuss the case with others. Extroverts likely talk with many people early in their processing of the negative outcome.

I talked it through with a lot of the staff that were affected, because we had all spent months. I think it's tough because they were young.

Whereas introverts often need more time to process and work through the details themselves.

Introverts try and make sense of it, and then only present it in a space when they feel safe and have processed it and packaged it to some extent, so we have a different way of dealing with it and I think we understand that. But we have a different philosophy as well, it's deeper than that, but we have a different way of dealing with those things, so there's a bit of that too.

Another interesting response is the degree of 'expectedness' of the clinical event. For example, some children die very sadly after an event, such as a prolonged cardiopulmonary arrest from a trauma or a drowning. Experienced intensivists begin to mentally and emotionally process this outcome the moment they get the referral call from the outside facility. They are preparing themselves for the very likely event of this child dying. Less-experienced intensivists and trainees however may not have the same mental model. This likely leads to a team disconnect when the child does die.

The team leader is potentially days ahead in emotional processing than the rest of the team. The intensivist may even come off as cold or not caring. Moral distress or moral injury may be experienced by other members of the intensive care team with closer bedside care proximity, less authority, or less control over clinical decision-making.

However, for deaths that are unexpected, the whole team feels the tragedy in a similar and dramatic way.

There's sort of like, the kid who dies who you're not surprised died, but you wonder if he would have died or the same thing would have happened if another…. people were saying 'Maybe we could have done this more than we did', and I wonder if that was an outcome that could have made a difference for this particular patient. That's more expected. I remember when that patient died, I didn't think much of it in that regard until I had more time to look back and think about it, and talk with other people and hear what other people had to say about it. And then that's hard!

The kid that you left thinking was fine, and you come in the next morning, and the teams like 'so-and-so exploded and this and this and this happened… And you didn't see it coming?

Most experienced intensivists commented on the importance of seeking solitude and taking time. This action is often not part of the intensive care training curriculum but instead modelled by older intensivists (mentors) to younger learners (mentees).

To deal with an adverse event I probably rely most around giving myself time and space to do so. I find that very useful, so that's what I do. It's not internalising, but that's just leaving me to my own devices to work through something and think about it.

…It's my internal root cause analysis of what happened.

…and then just taking a bit of time out and trying to focus on other aspects of my life - spending time with the kids

I usually need some time to… I still cry every time a child dies. And I need some time and space to do that. And many times, that's after whatever shift has ended for the day.

Transparency and open disclosure are important for excellent patient care and quality improvement. This area has changed in a good way over the last few decades. Timely, candid and honest disclosure of errors to patients and their families is important. It also can help the intensivist deal with knowing about an error, but not sharing it. It should be done honestly, focusing on facts and not judgements. Sharing with the family and patient what we do know and being honest about things that we do not know.

Most families find this helpful and often want to know what can be done in the future to prevent similar errors. They want to know steps are being taken to keep patients safer.

'Despite the treatment we gave to your child, there was a significant deterioration, and we did CPR, and we will figure out what happened, and we will come and tell you exactly what we think'. We are trying to be completely open to the families in every case. And generally, you can avoid after that, the anger of the family against the team. By being open. We do make mistakes and when you act you make a mistake also. But it is my opinion that we need to be open with the family and tell them all of the truths that we know.

I encourage honesty and openness to the behaviour of open disclosure. If bad things happen, I think it's very important, it's what I'm trying to teach… I mean I'm teaching that to my kids as well. Do not try and brush things under the table and I'd much rather be open. That is very important, to have open disclosure... lead by example

I think that when I was a younger, I would try to hide it. Try to - if I did a mistake - try to say that it maybe there was not a very bad mistake, or it's not my mistake. I think today, I know that the opposite is true: You should expose it, and the light, the sunlight is the best disinfectant.

More robust quality reporting systems and more engagement with risk management early in the adverse event process help protect the team and bring closure to the family. When errors are investigated with a focus on systems, and not individuals, more systematised learning can occur. People are less defensive and more likely to share 'near misses'. These near misses, when used for learning purposes, can help prevent future errors from ever reaching a patient. Recently, a prospective study in a large university paediatric ICU [3] identified 236 unique latent safety events in 188 h of observation time. Most of these events were attributed to system factors, with only 14% being attributed to an individual's error. In addition, there were zero events labelled as illegal—that is, with disregard for standard policies and protocols.

I'm very happy with the quality of reporting systems here. I teach here and elsewhere around open disclosure. So, I sort of understand the theory and practice behind that, and from what I see, the mechanics here… I mean I participate in the Deteriorating Patient Committee and that is gratifying being part of the governance structure to see the more immediate closed loops out of risk events and adverse events.

So, the culture changed over the years. And then risk management started to be, to infiltrate, the clinical aspect of medical care. Whereas before it was like a side arm, where the legal cases went to where they discussed it among themselves. Now they are more incorporated, they do courses, they do workshops, we have to send them reports every month or so about near mishaps or about clear mistakes and it's becoming more of the culture to discuss this within ourselves and with the patients and families.

Unfortunately, transparency does not always happen. This can be very difficult for an intensivist, as their patients' care journeys intersect many parts of the hospital, including the emergency room and operating room and often have multiple clinicians involved. When not everyone is being transparent with this collective approach to system improvement, the task is made more challenging.

But in some places around the hospital it doesn't happen. We had some fairly frosty conversations with outside specialists who don't think an error has been made, when we think they should be talking to the patient.

I think that at the end of the day, my feeling is that it is my responsibility is to be honest to the patients and their families. And I suppose that's how I rationalise my actions to myself, in that I am, in some ways, an advocate for safety and quality within the hospital for the patients, and not for, necessarily, my colleagues. And so, I'm not, like, pointing fingers in those situations, but explaining that this is what happened, these are the things that everybody tried to do, but this is unfortunate…

Improving the education and training of the entire critical care team is important for both better care of patients, as well as the team knowing what actions to take in a complex, time-limited, critically ill clinical crisis. This may be a situation where peer and or group upskilling would be beneficial. This can be done in traditional courses as well as using simulation-based education, especially with standardised patients in an interdisciplinary learning environment. It is vital that this training includes at least some basic information on delivering bad news, counselling, and debriefing, as there is very little of this training in more traditional medical education.

There is a course … for all of the medical students on how to deliver bad news with simulations using actors, etc... We try to involve the resident whenever we have serious discussions with the families.

In addition to group training, personal upskilling is also an important and common behavioural response of intensivists. Learning lessons from a tragic event helps healthcare professionals move forward.

That's something that also helps me, is to kind of come away with a lesson from it, if you will. It actually helps in a way if you can learn something from it. Even though it's terrible, and sometimes the price is steep. It seems like that might be one way to make that whole experience worth something, if you can come away with something that you learned from it.

'How do you live with that?' You have to try to take, I have to try to take a… an educational experience from the event to improve my response next time. That's what I would like to feel that I should do or have done…. Because as I pointed out, I personally feel I can get over things better if I can take something away from it. Some education out of it that will help me in the future.

So, we try to change something in our practice that would make us feel that we learned something from this event. Because if you don't learn anything from an event, it's like a disaster.

Finally, it is crucial to improve training in self-care. This may be a good situation to bring in professions who are trained in counselling. When continuing intense stressors are not dealt with, higher rates of mental illness and burnout can occur. Sadly, many intensivists do not access counselling regularly or proactively.

Well, I think the training itself in critical care - the professional training gives skills… and then just experience. The area gives you some skills, but I think the College itself can and should offer, just like they do for communication skills, which is one way to prevent things, is also being able to identify when you are not coping and having coping strategies, so all of this resilience side of things is the flipside.

…Whether that was taught to me specifically? Probably not that much. Other than a degree of self-directed learning – talking to others, et cetera. But I guess we don't have a… Well, we probably do, it's probably on the Intranet or something… I don't think we have a direct "this is what you must do, these are the steps you must take". We certainly got a critical incident notification system. But it's hard to sit down and go through a twenty-page intranet thing, with things going on, perhaps someone crying, the family upset, et cetera.

I haven't had any training to recognise any signs of post-incident stressors. So, there should probably be training around that, in how to actually recognise the signs of failure in that regard. And then also specific coping mechanisms and coping strategies to have in place. … How exactly that would be done I'm not sure. Maybe through help with… and seminars with psychologists, I guess they would have to deal with that a lot, there might be room for even psychiatrists?

No training at all. Really, no training at all.

So, I would certainly be a proponent of people making sure that they have done some sort of resilience training, and never feeling like, just the intrinsic skills that we have in life are all we can have.

I think learning in real-time with real events is the best way to learn. Given that you can't create that same experience for everybody because it's depending on who you happen to see

over the course of your Fellowship, what kind of experiences you have, I think simulation is the next best alternative. So, I think that a combination of both, making sure that you're taking all of the opportunities in real-time that exist, as well as using simulation to fill in the gaps, and making sure that there is some sort of consistency in what people are exposed to.

There are some obvious differences between the stressors experienced by practitioners of adult and paediatric intensive care. These included the differences in the relationships with staff and family, differences in patient features, and biases of individual intensivists. Also, patients' perceived responsibility for their illness may vary between adults and children. Paediatric intensivists mostly view their patients as innocent, whereas adult intensivists often view their patients as having had life factors leading to their illnesses.

Conclusion

Paediatric and adult intensivists reported very similar behavioural responses to the stressors of the ICU. Utilising reflective learning as well as learning from mistakes helps intensivists move forward from tragic events. Having better self-care skills and utilising professional counsellors more may help overall well-being.

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