

Hey Doctor, Is That You in There?

WILLIAM S. ANDERECK, M.D., FACP

If you're lucky, you haven't had to go to the doctor recently. If you have, you may have noticed that he or she seemed a bit flat—distracted, rushed or less interested. If so, you're not alone. According to a recent poll by the website Medscape, nearly half of the physicians in the U.S. are suffering from "burnout." The feeling seems to peak mid-career and affects more women than men. Unfortunately, it's also more common in primary care physicians, the doctors whom you probably see the most often.

This is not the first time we're hearing about physician burnout; what's astonishing is its scope. Recent articles in the *New England Journal of Medicine* chronicle a Mayo Clinic study led by Tait Shanafelt, M.D. He and his colleagues define burnout as "emotional exhaustion, depersonalization or a diminished sense of personal accomplishment due to work-related stressors." They found that nearly 55 percent of the internal medicine specialists they contacted in 2014 felt burnt out, a 20 percent increase from 2011. And it's affecting their general well-being. The number of doctors who said they were dissatisfied with their work/life balance increased from 37 percent in 2011 to over 45 percent just three years later.^{1,2}

We last addressed the causes of burnout in *Ethical Times* five years ago when Stanford philosopher Mary Rorty reported on our experience with CPMC's hospital-based physicians. And yet little seems to have changed. The recent Medscape study found that doctors complain bitterly about the electronic medical record, and over half of them cite the administrative/paperwork overload. Doctors also blame other familiar factors for their burnout, such as too many work hours (39 percent) and low pay (24 percent). Complaints about long hours and insufficient pay are nothing new. And the

frustrations with the confounding computer system have merely replaced the confusion and redundancy of the paper system.

Doctors have always had something to gripe about. I've listened to my colleagues for almost 40 years, and I can never recall a time when there were no complaints. But now, for some reason, the situation seems different. I didn't have a way to describe it until I came across an article published in *JAMA* by Scott Berman, M.D., entitled "Grippers and Whiners."

Grippers, he says, are the products of the survivors of World War II. When faced with a seemingly impossible task, doctors gripe to blow off steam. They face the incongruities of life with defiance. But when the job is at hand, we can count on the grippers to do their duty—think *Mash* when the helicopters arrive and everyone is at their stations.

Whiners, on the other hand, have a different attitude. Yes, they too complain about the current state of affairs, but they replace defiance with resignation. They've moved from a position of strength to one of submission, from a gripe to a whine.

I worry that the complaints that I'm hearing today have the tone of the whiner.

What force could be so powerful as to take the fight out of the medical profession? Gripes about money, work hours and bureaucratic nonsense have always been present and real. But they are, to a certain extent, directed at external forces. They do not eat away from within.

Of the reasons physicians now give for burnout, there are two that stand out. More than 20 percent of doctors cite "loss of autonomy/control" and "feeling like a cog in a wheel." Professional depersonalization and lack of agency bring a different challenge—one aimed deep into the heart of medicine.

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▶ If you would like to receive this newsletter electronically, please email us at ethics@sutterhealth.org.

¹ Shanafelt et al. *Archives of Internal Medicine* (2012).
² Shanafelt et al. *Mayo Clinic Proceedings* (2015).



The Ethicist Is In: Did We Do the Right Thing?

ALEXANDRIA P. LESCHER, D.BIOETHICS, AND SHILPA SHASHIDHARA, PH.D.

The Case:

Ivan is an 84-year-old man who was brought to the hospital after falling at home. In the emergency room, doctors found several injuries, including multiple neck fractures that were compressing his spinal cord and paralyzing him from the shoulders down. He was also in respiratory failure and needed to be intubated.

From the time of his admission, it was unclear if Ivan could make decisions for himself. He would only respond to “yes” or “no” questions with head motions, and his answers were not always consistent. His advance directive did not indicate any specific healthcare preferences, except that he did not want to be kept alive on machines long-term. He did not have a surrogate; in fact his directive specifically stated that he did not have anyone he could trust to make decisions on his behalf. He weakly but consistently nodded his head “yes” when asked if he wanted his medical team to make decisions for him.

The neurosurgeon indicated that Ivan’s only option for recovery was extensive reconstructive spinal surgery. If successful, it could decompress his spine and help him regain some of his function. However, he could still have impaired fine motor skills. He could return home, albeit with some neurological deficits, after a prolonged period in a rehabilitation center.

Based on the neurosurgeon’s guarded optimism and no one to object, Ivan’s medical team felt it was best to operate.

The Ethicists:

In accordance with CPMC’s Unrepresented Patient Policy, the ICU team asked the ethics consultation service to assess whether the surgery was appropriate.

The ethicists mostly considered Ivan’s potential outcomes with and without surgery. In Ivan’s case, surgery was necessary if he was ever going to breathe on his own again, and he would die without the procedure. His advance directive showed that he did not want to be dependent on a ventilator long-term, but not offering surgery would have required us to leave him on one. The other option was to remove his breathing tube, but that would result in his death.

Meanwhile, there were positive signs that Ivan would recover if he had surgery. Before his injury, he had been healthy with no chronic medical problems, and his mental status had improved slightly after he was intubated. His care team felt that he could have a promising future, even though rehabilitation could take months, or even years, in an assisted living facility.

Since Ivan’s advance directive did not name a surrogate decision maker, he had essentially become voiceless when he lost decision-making capacity. He had left the team with no clear idea of his preferences and unable to truly determine

which outcome he would prefer: death or a long period of life in a facility. Ultimately, the team felt the potential benefits outweighed the risks and the ethicists recommended surgery as an ethically appropriate course of action.

Following his surgery, Ivan’s breathing tube was removed. His mental status improved and he was able to communicate. Unfortunately, the surgery did not resolve his limb weakness and Ivan was now paralyzed. He would never walk or move on his own from the neck down. He would be dependent on others for even the most basic tasks for the rest of his life.

The ethicists saw Ivan a few days after surgery and asked him what he thought of his team’s decision to proceed with surgery. Ivan said that he felt conflicted. The ethicists then reminded him that he would have died if he had not been resuscitated and placed on a ventilator. They then asked him, “Did we do the right thing?”

Ivan shook his head and said, “No.”

The medical team is now expressing significant distress over the unexpected outcome and wondering, “Did we do the right thing?”

Moral distress has traditionally been defined as an intractable

conflict that arises when an individual knows what to do, but is unable to do it. A different, equally difficult conflict occurs when a procedure does not go as planned, and conflict arises between what one *actually did* and what one *would have done* with the knowledge one has now. This phenomenon is a form of survivor's guilt that we call "retroactive moral distress." Ivan's case is a prime example.

The team now has retroactive moral distress because of Ivan's feelings toward his new, permanent quality of life.

Quadriplegia is a potential outcome for many patients like Ivan. Had we known that would be the result, we may not have put Ivan through the surgery.



(Left to right) Ethicists Shilpa Shashidhara, Ph.D., and Alexandria Lescher, D.Bioethics

It's not unreasonable that we feel responsible for condemning Ivan to a life he does not want, but perhaps we're being too hard on ourselves. Even if we would have made different decisions knowing what we know now, we made the decision to proceed with surgery because we thought it was right given the information we had at the time, and that is all that can be expected of anyone.

Now we are all trying to come to terms with the role we've played in Ivan's uncertain and challenging future. Still, the questions linger: "Should we

have done something different? How do we deal with the distress among the staff?" And perhaps most importantly, "What will we, and Ivan, do from here?"



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Physicians now ask, "How can I give the best care to patients in a system that has reduced my authority?" It challenges the existential freedom of physicians to be the best doctors they can be. It's not intellectual; it's emotional...and draining. Prolonged exposure can turn gripers into whiners.

Burnout not only results in workforce turnover, but also in errors and omissions during patient care. If researchers found these levels of occupational injury in an automobile plant in Ohio, the federal government would shut it down. Yet doctors and other healthcare workers shoulder on, either too ashamed or hardheaded to admit defeat. Until recently, our healthcare institutions have also remained quiet enablers, benefiting from the hard work of their doctors despite their struggles. Sutter Health has recognized the problem and is taking steps to address it. But what is the proper response and how do we effect real change?

Our initial response could be to address the complaints. Giving doctors more time off, higher salary and more backup

staff would have some effect on burnout rates. There is hope on this front. The Mayo Clinic has a program that has significantly reduced physician burnout, but it has required an increase in support staff from a ratio of 1-to-1 to 2.5-to-1. Moreover, if doctors continue to feel like "cogs in the wheel" or powerless to provide the best quality medical care, merely getting them more help may not be enough to stem the tide of rising burnout.

If we don't address doctors' sense of empowerment—their existential freedom to do their best for a patient—we compromise professional identity and quality, cheapening the enterprise rather than raising it.

In his article, Dr. Berman calls physicians to task for not taking more strident action in defense of their professional standards. His words are aspirational, but they appeal to the intellect rather than emotion. Physician empowerment will need more than an intellectual effort; it will require significant investment. Otherwise, we will hear a lot more whining.

Save the Date: Summer Workshop XIII

Publication Spotlight

CALIFORNIA PACIFIC MEDICAL CENTER
PROGRAM IN MEDICINE & HUMAN VALUES

The Life Cycle of an Ethics Consultation: Defining and Refining Core Skills

SATURDAY, JUNE 9, 2018

8:30 a.m. – 4:45 p.m.

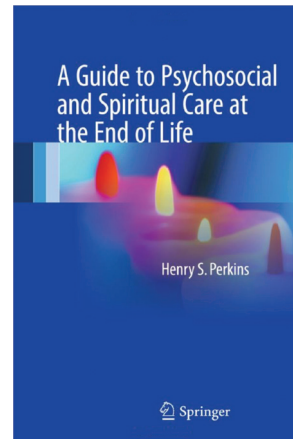
More details will follow.

REGISTRATION OPENS APRIL 1.

Registration will close when the workshop is full.



PMHV Medical Director William Andereck, M.D. (right), and bioethicists Robert Fulbright, J.D. (left), and Shilpa Shashidhara, Ph.D. (center right), were invited by Alix Rodgers, J.D. (center left) and Stanford Law Professor Hank Greely (not pictured) to speak at Stanford Law School's Law and Biosciences Workshop. This workshop seminar provides law students with the opportunity to examine and critique cutting-edge research and to work in the field of law and the biosciences. PMHV staff presented "Non-beneficial Treatments: Ethics, Policy and Law."



A Guide to Psychosocial and Spiritual Care at the End of Life

Henry S. Perkins, M.D.

REVIEWED BY:

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"A Guide to Psychosocial and Spiritual Care at the End of Life," by Henry S. Perkins, M.D., presents a clear, main message: Everyone involved in the drama of death must appreciate its physical, social, psychological and spiritual dimensions.

This impressive book uses many voices to deliver that message. Perkins is an experienced internist and bioethics consultant, but he calls on many others throughout the book—fellow physicians, nurses, chaplains, philosophers, scientists, dying patients and their loved ones. He weaves together their commentaries—from whispered words of resignation to shouts of "raging at the dying of the light"—into a lucid text, packed with information and case illustrations. The result is an indispensable addition to end-of-life literature.

Perkins begins his book by recalling a clinical ethics consultation of mine when I was his bioethics mentor some 40 years ago. He explains that that case about a dying, nonviable newborn challenged him "to step out of the narrow, strictly rational perspectives of scientific medicine and academic ethics." A new, broader perspective led him not only to have deep sympathy for the physical suffering of dying, but also to address nuanced but substantive issues of facts and feelings in end-of-life care. Accordingly, he divides his book into two parts. The first five chapters describe the physical dimension of end-of-life care, including an excellent chapter on the signs and symptoms of approaching death. The remaining 10 chapters describe the social, psychological and spiritual dimensions of that care, including notable chapters on advance-care planning and care of the family. Each chapter presents a case, summarizes pertinent empirical studies, explains key issues, and gives practical take-home points about care.

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Neuroethics News

GUILLERMO A. PALCHIK, PH.D. AND THOMASINE K. KUSHNER, PH.D.

Upcoming Publications



One of our goals at the Clinical Neuroethics Initiative is to promote the work of neurologists and psychiatrists at California Pacific Medical Center. To this end, we collaborate with clinicians on neuroethics literature. Look out for our upcoming publications, including the papers “Treating the Patient Who Has the Disease,” by Eric Deny, M.D., and “Doing the Most Good with the Least Harm in Cases of Suspected Malingering,” by Brian Andrews, M.D. Both papers will appear in the “Clinical Neuroethics” issue of the Cambridge Quarterly of Healthcare Ethics (Vol. 27, No. 3, October 2018, published by Cambridge University Press). San Francisco Medicine will also feature the upcoming paper by Dr. Andrews, “Less is More,” on the need for prudence in spinal surgery that might not be indicated.



We’re Going to France!

Mark your calendars. We’re working with the ICM, Institut du Cerveau et de la Moelle Épinère (Brain & Spine Institute), to coordinate the **5th Neuroethics Network meeting, June 20-22, 2018 in Paris, France**. The meeting features seminars on newly emerging ethical issues in neuroscience. Seminar themes for 2018 include: “Theory of Mind: Philosophical Considerations and Practical Implications,” “New Developments in Imaging Along with Legal and Social Concerns,” “Deep Brain Stimulation and Recording,” and “Consciousness: Building Bridges.” There will also be scheduled laboratory meetings with ICM researchers and discussions around current projects. For details, visit www.icmbioethics.com.



Welcome

We’d like to welcome prospective medical student Christopher Allen to our team. Chris will be volunteering, working on a variety of research projects and helping us prepare publications.

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Bioethicist

Publication Spotlight

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Although Perkins first intended the book for professionals caring for dying patients, he soon realized its contents would also interest patients and their loved ones. He has, therefore, adopted a language and style understandable to nonprofessionals. He softens the arcane language of health professionals, defines concepts when necessary, and elucidates his charts and graphs. He also divides the text into short, stand-alone segments to permit the reader a quick read on particular topics.

The result is a useful book for us all as we face death. This book offers sound wisdom about giving ourselves and others, in John Cardinal Newman's words, a death of "safe lodging, a holy rest and peace at the last."