Clinical Science: Invited Commentary

Acute traumatic stress among surgeons after major surgical complications by A. Pinto, O. Faiz, C. Bicknell, and C. Vincent

Lewis Flint, M.D., F.A.C.S.*

No. 633 North St. Clair Street, Chicago, IL 60611, USA

Pinto and coauthors have completed an important study that is a first step in the process of understanding potentially destructive as well as helpful behaviors for surgeons who are seeking to deal with the emotional turmoil that follows a major surgical complication that results in significant patient harm or death of the patient. Anyone who has practiced clinical surgery knows that a major complication, particularly one that is unexpected and produces major harm, is the prototypical “gut-punch” for the responsible surgeon. For those fortunate enough to have had constructive mentoring during residency training and during a clinical career, systems for dealing with such events have been developed. The most important mentor in my career offered this advice: “Don’t forget the event, think about it, talk about it, learn from it, decide what you can do to make sure it doesn’t happen again, then get back in the game.”

The data from the surveys conducted by these authors suggest that such an approach is useful. Surgeons who discussed complications with colleagues and sought to use the experience as an opportunity for self-improvement had fewer symptoms of post-traumatic stress and symptoms that were present were less severe. The report indicates that the use of self-distraction is associated with increasing severity of symptoms of post-traumatic stress. Self-distraction was a famous characteristic of Scarlet O’Hara, the character from Margaret Mitchell’s novel Gone with the Wind, and was typified by this quote: “I won’t think about this today, I will think about it some other time.”

Other factors that contribute to increased risk for and severity of post-traumatic stress identified by these authors were an institutional culture of blame and fear on the part of surgeons of criticism, punishment, and being ostracized by colleagues. These cultural characteristics were also identified in a recent study by Gianetti1 as contributors to healthcare provider isolation and failure of healthcare institutions to eliminate system issues and behaviors that are potentially harmful to patients.

All of us remember that the culture of Surgery is not to ask, “what happened?” but to ask “what did you do wrong?” when a complication occurs. Pinto and colleagues suggest that this manner of dealing with the aftermaths of surgical complications, especially those that are unexpected, can hinder the development of useful care processes and system changes that will reduce the risk of similar complications in the future.

We might also wonder why it has taken us so long to recognize the presence of this important syndrome of psychological damage in our colleagues and ourselves. In my view, one reason is that we saw the problem but we did not know what to call it. Overt psychological symptoms following stressful events is not a new phenomenon (“shell-shock” was the term used after World War I and II) but evidence-based descriptions of symptoms and natural history in veterans of the Iraq and Afghanistan conflicts have been published more recently. The first practice guidelines document produced to guide clinicians caring for patients with post-traumatic stress disorder in the
Veterans Affairs Health System appeared in 2004 (www.healthquality.va.gov/). The symptom complex that is now recognized as post-traumatic stress disorder began to be recognized in surgeons who served in the Vietnam conflict. The flashbacks, nightmares, anxiety, and mood swings typical of the syndrome were noticed but their damaging effects were underestimated. With the increasing recognition of these symptoms in military personnel, including surgeons and other medical professionals, who have served in Iraq and Afghanistan, a system of terminology and several approaches to management have been developed. Of interest is the fact that one useful therapeutic approach is to have the patient revisit the event or events that triggered post-traumatic stress to learn from the experience(s). This approach seems to reduce the levels of psychological harm. We have also begun to understand that this syndrome contributes significantly to problems of alcohol and drug abuse as well as self-destructive behavior in military personnel and nonmilitary healthcare professionals.

As with all good research, the contribution by Pinto and colleagues uncovers more questions than it answers. For example, why was clinically significant post-traumatic stress less common in vascular surgeons than in general surgeons? The majority of surgeons in the cohort responding to their survey were trainees. Is there a maturation process during and after training that helps surgeons learn to deal with and minimize the effects of post-traumatic stress? Finally, was there a relationship between patient comorbidity patterns and operative risk and the psychological responses to the complication events?

Hopefully, this group and other investigators will continue the search for pathways to minimize the mortality and morbidity of surgical complications and the attendant psychological effects on patients, families, nurses, surgeons, and others. Because research into events that result in patient harm has confirmed that the majority of errors are related to failures of systems of care and not to the behaviors of individual caregivers, what we can do now is work hard to eliminate the “culture of blame” so that using open discussion and the techniques of root cause analysis, we can learn more about complications and the ways to minimize them.2–4

References