Society of Hospital Medicine

CARE FOR CAREGIVERS:
EXECUTIVE SUMMARY

In 2010, seasoned ICU nurse Kimberly Hiatt made an error, giving a tenfold overdose of calcium to Kaia Zautner, a critically ill infant. Kaia died, leaving Kimberly devastated. Although Kimberly disclosed her error immediately, she was punished. She was escorted from the hospital, placed on administrative leave, and fired within weeks, compounding her distress. Seven months later, she took her own life, leaving behind her partner and two children, and highlighting the risks faced by "second victims."[1] The term, coined by Albert Wu, MD, refers to a healthcare worker who suffers distress because of their involvement in an adverse event, medical error, or patient injury.[2] Although healthcare workers may contribute to an adverse event without fault (e.g., if given a mislabeled medication to administer), some victims of adverse events disfavor the term "second victim" because it can steal the focus away from their experience.[3] And there doesn't need to be a "first victim" or an error; providers can suffer from merely witnessing distress, as the COVID-19 pandemic highlighted. Hospital-based providers have seen unusual amounts of suffering and death and at times have had to care for stricken friends and colleagues. Thus, reference to "care for caregivers" or "peer support" has been suggested.

CONSEQUENCES OF ADVERSE EVENTS & MEDICAL STRESS

Burnout: According to the ICD-11, burnout is a syndrome of "unsuccessfully managed, chronic workplace stress which consists of fatigue, a distant or negative work attitude, and reduced work effectiveness." Front-line providers, including internists and hospitalists, are at increased risk. Burnout is associated with cardiovascular disease, reduced life expectancy, risky alcohol habits, and broken relationships.[4]

Patient Safety Risks: Providers with higher levels of burnout symptoms more often report being involved in adverse events. A 2019 review of 21 studies found a significant association between levels of burnout and reduced patient safety.[5] In a study of 54 ICUs in Switzerland, unit-level burnout was associated with higher patient mortality at baseline. Over time, burnout spread in units and reduced teamwork, further impairing safety.[6] Burnout is associated with subsequent medical error among trainee physicians for at least several months,[7,8] independent of fatigue.[7,8] Thus, there's likely a bidirectional cause/effect relationship between burnout and safety events.

Burnout can also worsen patient experience by inducing compassion fatigue—a reduced capacity for empathy or bearing the suffering of others. Studies have documented that burned-out providers communicate more poorly with patients and that burnout reduces patient satisfaction.[4,9,10]

Systems Costs: NHS resident obstetrician Adam Kay quit clinical medicine several months after his patient experienced catastrophic bleeding and fetal death from placenta previa; he received minimal support or time off after the event.[11] Thus, the NHS invested substantial time and funding on training a clinician only to lose an entire career's worth of potential. This is not an isolated example. Physicians who suffer from burnout and who have been emotionally harmed by involvement in adverse events may change their work commitments, change fields, or quit/retire altogether. Among Mayo Clinic providers, one point changes in burnout or satisfaction scores on 5-7 point scales were strongly associated with subsequent reductions in clinical FTE.[12] Data from Stanford suggest a twofold increase in turnover among burned-out physicians.[4] Replacing physicians is costly—each burned-out physician replaced can be expected to cost two to three times the MD salary, and Atrius health reported total costs of $500k-$1M.[13,14,15,16,17] That's before considering the impact of turnover on morale, and the costs associated with the potentially more limited experience of replacements (either institutional-specific skills or total experience, plus teaching and mentoring capacity of senior physicians). Exhaustion and negative feelings about work can also be expected to reduce the effort and quality of scholarly and hospital systems work produced by hospitalists.

PEER SUPPORT PROGRAMS (PSPs)

Peer support programs (PSPs) connect people dealing with stressors to trained peers who have dealt with similar challenges. Such programs are important because providers have historically felt poorly supported after safety events, with only 10% reporting adequate support.[18] Participants benefit from having someone who can offer empathy and personal experience, as well as privacy

(versus a group therapy setting). Peer support programs increase awareness of provider suffering and improve perceptions of support. Peer supporters themselves may also find the experience therapeutic and rewarding by making a difference for a colleague. The Brigham and Women's Hospital was an early adopter of the PSP model, describing their program's initiation in a 2008 paper.[19] Another early model was Resilience in Stressful Events, or RISE, offered by The Johns Hopkins Hospital. RISE serves as the foundation for PSP training opportunities.

Find more details on setting up a PSP at the Roadmap to Peer Support, offered by the Armstrong Institute for Patient Safety and Quality at Johns Hopkins:
https://www.hopkinsmedicine.org/armstrong-institute/peer-support-roadmap

Specific training for implementation can be accessed here:
https://www.hopkinsmedicine.org/armstrong-institute/training-services/caring-for-the-caregiver

The University of Maryland offers a peer support programs based on RISE as well:
https://marylandpatientsafety.org/caregiver/

CARE FOR THE CAREGIVER PROGRAMS

Care for the Caregiver (C4CG) programs can include PSPs but are broader in scope, with more options available for supporting caregivers in crisis. For example, the Agency for Healthcare Research and Quality (AHRQ) Care for the Caregiver Implementation Guide[20] describes three tiers of support:

Tier 1 - Local unit/department support, which would be provided by a fellow team member, chair, manager, or supervisor.

Tier 2 - Trained peer supporters and patient safety and risk management resources.

Tier 3 - Expedited referral network, which may include chaplain, clinical psychologist, social work, employee assistance program, and holistic nursing support, ensure availability and expedite access to prompt professional support/guidance.

These expanded resources require a greater organizational commitment of resources, so it's important to be able to clearly describe the need and potential return on investment.

MAKING THE CASE FOR CARE FOR THE CAREGIVER PROGRAMS

Setting up or improving peer counseling and other physician support programs at your institution can be a complex and difficult task. According to an excellent summary of the case for improvement, many institutions stall at early and ineffective levels of support.[4] However, plentiful information exists to justify well-resourced C4CG programs. Pitches to your organization should stress a moral imperative as well as a business and quality case.

Moral Case: The information presented above indicates that burnout and distress related to involvement in adverse events are serious problems. Healthcare institutions have a moral imperative to care for their clinicians, who face exhaustion, depression, dissatisfaction, broken relationships, risk of suicide, and other health consequences from their work stress. An impactful personal story, like that of Kimberly Hiatt's tragic suicide, can drive home this moral imperative. A local story may be even more impactful—if appropriate.

Quality Case: Burnout is associated with subsequent medical error.[21] Emphasize the evidence that burnout has been associated with mortality—a hard outcome of unquestionable importance as well as a driver of quality rankings.[6] Burnout similarly reduces nurse efficacy in prevention of healthcare-associated infection.[22]

Business Case: As a single major safety event could result in regulatory consequences, fines, and large malpractice settlements or negative media exposure, C4CG programs could have large benefits as well. Institutions may want to improve care for the caregiver programs simply out of financial self-interest to avoid both direct and hard-to-measure costs associated with physician turnover, reduced effort, impaired performance, and loss of expertise. To assist you in making this point, cost calculators can drive home the enormous expense associated with physician burnout. A worksheet can be used to estimate the ROI for care for the caregiver work.[4]

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