My eye – The importance of clinician well-being in 2020

It happened in an instant that morning. While working on my computer, a shower of specks erupted in my right eye, floating across my field of vision. From the time I was 10, I’d never had good eyesight and had muddled along with eyeglasses and mediocre vision. But I’d never experienced anything like this. Within minutes, it was like a scene from Star Wars in my right eye – like I was on the Millennium Falcon, navigating through dense and perilous asteroid belt. I was scared.

After walking to our hospital’s ophthalmology department, I was rapidly diagnosed as having several tears in my retina. Within the hour, I was in an exam chair, undergoing laser surgery to tack down those tears, which had apparently developed spontaneously. But by the next day the asteroids were back.

As much as clinician burnout and well-being seem to be on everyone’s minds, that plunge into the patient’s side of the medical system was a harsh reminder for me. It brought into sharp focus the importance of clinician well-being and its inseparable link to safe and high-quality health care. Because the asteroids soon dissolved into a cloud of debris that whitened out my eyesight. The prescription now was for surgery to remove the vitreous which was pulling the retina off the back of my eye, followed by direct lasering of the exposed flaps.

That surgery was uneventful, and I was restored to binocular, 20/20 vision. But after the operation, the doctor told me the unfortunate statistic: 60% of vitrectomy patients develop a cataract within the next six months. True to form, within a couple of months the acuity in what had historically been my “good” eye began to slip. The frightening prospect of losing vision in this eye, and perhaps both began to return. Six months later, the vision was approximately 20/700.

I was ready to confront cataract surgery.

The procedure was elective cataract extraction with subsequent implantation of an intraocular lens. I became actively involved in the planning. The first step was to identify my surgeon. I was in the fortunate situation of working at an institution where there are many outstanding choices. I settled for the ophthalmologist who is currently doing the highest volume of procedures in the health system. He also had a reputation for being the fixer for problem cases.

At the preoperative visit, I was greeted in the examination room by a young woman who introduced herself as a medical scribe. Cued by the electronic record, she asked me a series of questions off the screen about my history and medications. When the doctor came in, he was warm, animated, and collegial. He asked a few more questions, and the scribe typed earnestly to capture everything that was said. The doctor veered off briefly on a tangent about recent work travel before describing his intended plan for the surgery. He was happy and confident. And why shouldn’t he be? He was having an enjoyable conversation with an attentive patient on a topic for which he was an established expert. And, aided by a corps of scribes, he didn’t need to have anything to do documentation, scheduling, billing, or other activities attached to the electronic record.

When given a choice of what time to schedule the procedure, I picked the first case of the day, based on a mixed literature implying that problems in the operating room may be lower earlier in the day.

On the day of the procedure, I found myself keenly interested in my doctor’s physical and mental state. I wanted him to have had a restful night’s sleep and gotten up at his accustomed hour. I wanted him to have had a good breakfast, and enough coffee, but not too much coffee, because caffeine tremors have no place in the ophthalmologic operating room. I wanted him to be unperturbed by external stresses related to his spouse, family, or tax returns. I wanted him to be in an optimal psychological state – feeling happy, confident and in control, with full expectations of success. During the procedure, I wanted him to be “in the zone,” concentrated and focused on the task, vigilant, and determined and committed to delivering a peak performance.

During the actual procedure, I was in a twilight sleep. When I awoke, I was told that they had encountered a small rupture of the posterior capsule which had been rapidly recognized and successfully resolved. And my vision was again 20/20, which it is to this day.
I was grateful to have received such skillful, considerate, and responsive care.

Wouldn’t we all like the people taking care of us to be in the same peak physical and mental health as the doctor for my surgery? The literature relating psychological state to performance is primarily from the sports literature rather than medical. However, there are enough analogies between athletic performance and surgery to frame plausible hypotheses about the importance of clinician well-being to outcomes. This is why clinician well-being is important to patient safety and health care quality, and personally why it was important to me. It is understandable that this is not the state of health of all health care workers all of the time. To the contrary, there is a regrettably high level of clinician burnout in our institutions. But why can’t this still be an aspiration? And what can we do to move toward this goal?

In this issue of the Journal, several papers focus on clinical well-being and burnout. Hofert et al. describe a pilot study of mindfulness training for community hospital physicians, a group of clinicians who have received less study than their inpatient equivalents. They found that mindfulness-based stress reduction was feasible and could potentially reduce burnout and improve safety.

Connors et al. evaluated perceptions and attitudes about the RISE hospital staff support program. Their survey of staff nurses and nurse leaders found a high level of awareness and favorable perception of the program.

Swani and Isherwood report on a survey of critical care staff about team leaders who are approachable. They found that both individual and system level efforts are needed if an intensive care unit wants approachable leadership to become part of their organizational culture.

There are no health care institutions anywhere in the world that can claim to maintain their workers in the optimal state of well-being described in this paper. What can be done to advance us toward this state, which is really what we want for our own care?

An important first step is establishing clinician well-being as a national goal, as has been done by the US National Academy of Medicine in 2019. It is clear that institutions could do much more to move toward this goal. The turning point for me was gaining an individualized appreciation of clinician well-being and its importance to me. Perhaps a more personal understanding of the importance of well-being by those working in health care will help generate the motivation and energy needed to move in this direction.

References

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