A PIECE OF MY MIND

A Death in the Family

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One Sunday in early 2017, my anesthesia coresident Will (not his real name) was brought to the emergency department of our hospital unresponsive. He was quickly triaged, intubated, and transferred to the intensive care unit (ICU), where a hypothermia protocol was initiated. I couldn't visit Will for two days. Those days came like rust, slow and hard. I went to see him with another resident. We met Will's family for the first time under the worst of circumstances. I went expecting to offer comfort, prayers, and time. Instead, Will's family gave me comfort, prayers, and all the time I needed.

The ICU is a place anesthesia residents visit daily, no more worrisome than the hospital cafeteria. However, standing in Will's room, I felt out of place and vulnerable. I wasn't a physician here, and Will wasn't my patient. This was my friend and I was a visitor.

Years of anesthesia training will never prepare you for the moment when you see a loved one intubated. In that moment, it all seemed new to me: the intravenous (IV) infusions, the ventilator, the electroencephalogram (EEG) leads stuck to Will's head like a skullcap. An endotracheal tube had never been so invasive. I spoke to Will and let him know I was there. Then I left, dumbfounded. There was a certain pressure in the room I couldn't shake. I realized later it was fear. Fear for Will. Fear for his family.

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As the days passed, friends and family from across the country came like fireflies to light up Will's bedside. For his coresidents, our days were punctuated by visits to Will. No matter how physically spread out we were, on different rotations at different hospitals, we all made the time. The nights were often the best time to visit. When the operating rooms had been lulled to sleep, I visited the ICU to watch Will's chest rise and fall. And when we were alone, after Will's family had fought back sleep for as long as they could, I would read him short stories, hoping somehow, through the fog of sedation, Will was hearing a familiar voice.

The days morphed into weeks; the sprint became a marathon. The first time I saw the chairman of our department in scrubs was the day he joined our associate program director at Will's bedside. Will needed an operation, and the two of them would perform the anesthesia. I drew strength from watching them transport Will to the operating room. They were taking care of their own. When they left, another resident and I stayed with Will's family. Despite having taken countless patients to the operating room, this was the first time I saw what was left behind. The room looked empty without the hospital bed. A room full of worry, a room not ready for the separation.

The weeks continued. The infusions, ventilator, and EEG monitor slowly disappeared. The sedation was turned off, and everyone waited. Will opened his eyes and moved his limbs, but the fog persisted. He was transferred to the general medicine floor and soon afterward left the hospital for a long-term care facility. A month later, surrounded by his family, Will died.

Will overdosed on fentanyl; one of many physicians with substance use disorder whose presenting symptom is a fatal or near-fatal overdose.[1] Smart, funny, charming, Will had a tireless work ethic; no one would have suspected that Will had a drug problem. His addiction slipped by everyone, as is too often the case. If this could happen to Will, it could happen to any physician. Substance use disorder is not limited to anesthesia. As a community, we must examine the factors driving increasing rates of substance use disorder among all practicing physicians.[2]

Physicians are not immune to stress and fatigue, although we sometimes pretend this is the case. While many are proficient at masking stress and fatigue, we often do a poor job of managing them. This manifests in serious ways: burnout, depression, and substance use disorder. Estimates suggest that more than half of practicing physicians in the United States are affected by professional burnout, and our profession has one of the highest suicide rates.[3,4] This is unacceptable. The medical community must acknowledge that these tragedies are a direct product of the environment and culture we have created. Just as firefighters are most vulnerable to the wildfires they fight, physicians are most vulnerable to the opioid epidemic we fight.

Our approach to physician burnout and substance use disorder must move beyond awareness and education. Recently, the Accreditation Council for Graduate Medical Education (ACGME), which oversees physician-training programs, made significant changes to core program requirements to promote trainee wellness. While this signals a shift in the culture, more must be done.

Trainees may be protected by ACGME guidelines and requirements, but what about practicing physicians? Who protects them? It is time to consider whether it is effective for the medical community to continue to self-regulate in this regard. The stakes are too high to continue to get this wrong.

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And unfortunately, the medical community is too fatally entangled to see it. Seeking the guidance of an external agency to detect, manage, and treat physician burnout and substance use disorder could be a major step toward promoting physician wellness and ensuring patient safety. Without guidelines and enforcement from an independent group to manage stress, fatigue, and general wellness (sleep, exercise, diet) what will remain is a patchwork of unconnected suggestions. Physician wellness must become a priority. We are much better at fighting for our patients than for each other. This must change, and we cannot do it alone.

We celebrated Will's twenty-six years the same way he lived his life, filled with love. As a profession, we should acknowledge every physician's death as our program did Will's, a death in the family. The ease of accepting it as another statistic must be replaced by the urgency to act. As a profession, now is the time to call a family meeting. We must look out for each other, because that's what families do.

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