Surgeons’ guilt after postoperative complications

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ABSTRACT: Surgery is an art, surgical dilemmas are not mathematical problems with rigid, straightforward solutions and the human mind/body is not a perfect science. In such circumstances, unexpected, sudden complications can happen during surgery. While better diagnostics and advanced techniques in surgery have minimised surgical errors to a large extent—the risk of postoperative death is currently as low as 3.6%—when complications do occur, the surgeon faces a huge backlash not only from the patient’s relatives, but from peers, hospital management, the media, and social media. The surgeon may also face violent retribution, not just consumer issues but the threat of arrest and legal battles. All these concerns make a surgeon the ‘second victim’ in the event of a postoperative complication, leading to changes in their practice, emotional turmoil and even serious mental issues like depression and suicide. In this era of instant judgement by a largely unregulated social media, it is urgently required to address this issue and to provide appropriate strength/support to the surgical community.

INTRODUCTION

With the incidence of postoperative surgical complications in the hospital being 8–12% across the globe, there is a constant threat of psychosocial burnout, emotional distress and behavioural change looming over the operating surgeon due to their direct involvement with patients. In such an unexpected circumstances, the surgeon suffers the stigma of being the ‘second victim.’ While in the year 1900 there was a 50% chance of dying after an operation, today this figure has come down to only a 3.6% chance of dying within 2 months of an operation; only 1 to 30 out of 100,000 patients suffer on-table intraoperative death [1]. One in eight (12.2%) surgeons felt that complications impaired their ability to perform their clinical job, with an increased tendency to be more conservative and risk-averse. Two per cent of surgeons avoided performing a surgical procedure because of complications [2]. It is time to recognise this problem and make an all-out effort to not allow the confidence and morale of the surgeon suffer after every inadvertent surgical error or intraoperative/postoperative complication.

SURGEON’S GUILT AFTER A COMPLICATION

Among the few reasons that predispose a surgeon to cause a surgical complication are a lapse in concentration, long working hours with ‘burnout,’ a personal conflict with family or friends, hospital administrative stress, poor physical health and a lack of adequate surgical acumen and skill. Women and junior surgeons suffer more from the ‘second victim’ syndrome after a complication occurs, especially during a routine elective surgery [3]. After any complication, the surgeon may feel worry and concern for the patient (91.5%), guilt (64.6%), anxiety (68.3%) and disappointment (63.4%). One third (36.2%) of surgeons have experienced acute traumatic stress. Ironically, it was found that 79% of surgeons with more than 10 years of experience reported no negative feelings after an inadvertent complication, and older surgeons were also less likely to report a complication, as seniors had access to a better professional support structure. Alcohol abuse and other substance use increased by 6.5% in the surgeons and 58.5% of surgeons felt that it was too difficult to handle the emotional effects of complications throughout their career; this did not improve with experience [2]. Some surgeons (7%) showed a tendency toward dissociation with withdrawal and 40% may suffer from burnout, having an effect on their personal life, including suicidal ideation, depression and divorce.

PHASES OF A SURGEON’S GUILT AFTER A COMPLICATION

After any surgical error, there are 4 phases which take place, each having a cognitive and emotive component [4]:

- 1st phase (the kick) – this phase involves feelings of failure (‘Am I good enough?’) accompanying a significant physiological response;
- 2nd phase (the fall) – during this phase the surgeon experiences a sense of chaos and assesses the extent of their contribution to the event (‘Was it my fault?’);
- 3rd phase (the recovery) – the surgeon reflects on the adverse event (‘What can I learn?’) and experiences a sense of ‘moving on’;
- 4th phase (the long-term impact) – the surgeon suffers in their personal and professional career due to the long-term effects of the complications. Surgeons also describe an effect on their clinical judgement, in both the case in question (minimisation) and future cases (overcompensation).

SUPPORT/SECURITY TO THE SURGEON AFTER A POSTOPERATIVE COMPLICATION

A study revealed that 10% of surgeons and the majority of the operating theatre staff felt that they had received inadequate support from the hospital administration and their managers or peers within their organisation following a surgical incident, and a few were reluctant to discuss incidents for fear of retribution [5]. Any inadvertent complication always makes the surgeon vulnerable to workplace violence in India, with the perpetrators of the violence mainly being the patient’s relatives, unknown sympathisers,
criminal offenders, and even politicians [6]. The fact remains that while in government hospitals, errors may occur which cannot be rectified because of inadequate infrastructure that the patient party does not want to condemn while in private hospitals, since the majority of patients do not have any medical insurance and pay for the surgery out of their savings. They do not want to even think of a postoperative complication, let alone death [7]. Every such incident makes ‘breaking news’ in print media and headlines in social media, destroying the moral and reputation of the surgeon.

MEDICOLEGAL ISSUES AFTER SURGICAL COMPLICATIONS

In a study on 2999 Australian physicians, it was reported that there were changes in practice due to medicolegal concerns, with 43% of doctors stating that they referred patients more than usual, 55% stating that they ordered tests more than usual, and 11% that they prescribed medications more than usual. One third (33%) of doctors were considering giving up their career in medicine, 32% were considering reducing their working hours and 40% early retirement [8]. The prevalence of second victims after an adverse event varied from 10.4% up to 43.3% [9]. Although 80% of surgeons spoke with their peers, in many instances the conversations were about the clinical decision-making and technical aspects of surgery that led to the inadvertent error rather than a free and frank discussion about the emotional impact the complications had on the individual surgeons. It was concluded that the emotional consequences of complications on surgeons’ health and well-being must be recognised not only by the senior surgeons and teams in the departments, but also by the management [10]. It was felt that a culture of blame and ‘macho culture’ in surgery was a major barrier in 25% of surgeons.

‘TOMOPHOBIA’ AND ‘NOSOCOMEPHOBIA’ FOR SURGEONS?

Tomophobia is the fear of surgical procedure or medical intervention. It is an anxiety disorder with an irrational fear of surgery which might also affect surgeons after a surgical error when they perform the same surgery again. Nosocomephobia is the fear of visiting the hospital, which can also afflict a guilt-stricken, stressed surgeon after a surgical error spoils their relationship with the patients’ families and colleagues. Dissociation, minimising social interaction, avoidance and self-blame were the major reasons behind these phobias [10]. Though there are not many studies in the literature on these phobias being experienced by surgeons after a complication, it is high time to recognise that it does occur and to treat these maladies. A study showed that surgeons have a higher risk of suicide compared with physicians if they are older, male, married or currently receiving treatment for mental illness [11].

MANAGEMENT OF THE PROBLEM

Every surgeon should avoid getting into a crisis and should make an all-out effort to minimise surgical complications by being more meticulous and methodical. There is a well-known quote: ‘10% of patients seem to get 90% of complications’. It is very important for the surgeon to investigate the complication by searching for the ‘why’ rather than the ‘what’. There should be a proactive professional support system for an erring surgeon, who should be guided in dealing with the problem. Most of the surgeons surveyed in one study felt that talking about the incident with a trusted senior colleague was beneficial [12]. It was also reported that doctors who have a mentor, exercise regularly, have a passion for a hobby and are less dependent on alcohol experience less burnout and are more suitable to tackle the stress from a postoperative surgical complication.

In addition to ensuring informed consent pre-op, after a postoperative complication the surgeon should tell the patient the truth, the whole truth and nothing but the truth. The discussion should be calm, unhurried and in no way evasive. It should detail exactly what happened, how it happened and what the consequences and prognoses are. Then the surgeon should explain what will be done next and what the ultimate outcome will look like. It is always preferred to seek a second opinion from another colleague in such circumstances [13].

In India, there is a problem of workplace violence with the immediate involvement of local politicians, who demand huge compensation for the patient with an out-of-court settlement by pressurising the operating surgeon and the hospital management. It is at that time a surgeon needs the maximum support and help from peers and law enforcement agencies. All surgeons should have robust Mediclaim policies so that legal issues do not weigh them down emotionally and financially, and so they can recover and learn from mistakes, which are bound to happen.

Just like in the airline industry before a flight takes off, a preoperative briefing involving surgeons, nurses and anaesthesiologists going over a surgery safety checklist of patient information and procedural issues was found to significantly decrease the number of communication failures and complications [14].

Another important aspect observed for patients having colorectal surgery at high-volume hospitals was that they are significantly more likely to recover and return home after surgery than individuals having operations at low-volume hospitals. This study is the first step to establishing that high-volume hospitals contribute towards desirable outcomes [15].

A study on the impact of gynaecological surgeon volumes on patient outcomes reported that gynaecologists performing procedures approximately once a month or less were found to have higher rates of adverse outcomes and intraoperative complications in gynaecology, gynaecological oncology and urogynaecology, with higher mortality in gynaecological oncology [16].

Finally, every surgeon should avoid getting involved in unethical or unnecessary surgical interventions, as this is mostly when complications occur. Even in the 1950s, Dr Paul Hawley, the Director of the American College of Surgeons, stated that ‘the public would be shocked if it knew the amount of unnecessary surgery performed.’

CONCLUSION

Although the incidence of postoperative surgical complications continues to decrease with every passing year, when one does
There is a 4-stage process that every surgeon goes through when hospital management instead of just being named and shamed.

Surgeons themselves should understand the importance of sound knowledge/training, good interpersonal rapport with patients, the team and their colleagues, good habits and a healthy lifestyle, so that they can do complete justice to the art that they have trained for.

REFERENCES


