



Critical Events in the Emergency Department: How Best to Manage the Aftermath

Shooting of colleagues in the emergency department, large earthquakes, and the death of a pediatric patient have two things in common: 1) they have already occurred and will occur again, and 2) they have a profound impact on the ability of health care providers to function over the long term. If handled properly, most individuals experiencing these events can resume quickly normal activity. If handled poorly, health care providers may require a protracted period of time to return to full function, and some may never heal. Using individual cases and speaker-audience interaction, the lecturer will review the psychologic consequences for emergency department personnel who experience such troubling events and make recommendations for intervention. (Participants can submit cases in advance for consideration.)

- Identify the types of events likely to exceed the coping capacity of emergency department personnel.
- Describe the psychologic impact of these critical events and the maladaptive psychodynamics emergency department personnel can exhibit.
- Discuss the intervention options likely to be successful in aiding the psychologic recovery of emergency department personnel.

WE-182
Wednesday, October 13, 1999
5:00 PM - 5:55 PM
Room # N208
Las Vegas Convention Center

FACULTY

William R Ahrens, MD

Assistant Clinical Professor,
Emergency Medicine/Pediatrics,
University of Illinois, Chicago,
Illinois

Critical Events in the Emergency Department: Managing the Aftermath

1. Examples of Critical (Traumatic) Events:

Assaults on Department Staff
Pediatric Deaths
Mass Casualty Incidents
Violent Deaths
Managing Deaths of Friends or Colleagues
Mistakes and Bad Outcomes

2. How is Emergency Medicine Different?

- a. Patients are usually strangers
- b. "Regular" work does not stop for critical events
- c. Shift Work-- the fatigue factor; lack of down time to discuss events with co-workers.
- d. Dependence on Consultants
- e. Perception of many physician colleagues that EM physicians are "second class citizens?"
- f. Many "critical events" are socially isolating
- g. The "Fishbowl Factor"
- h. Critical events are unpredictable, except that there will be more critical events
- i. The one and only chance phenomenon

3. How do Critical Events Affect E.M. Physicians?

+There is little if any study of either short or long-term effect of "critical events" on EM physicians.

+A study evaluating the effect of a failed pediatric resuscitation found that most EM physicians found it to be extremely stressful, that a significant number felt guilty regarding the child's death, and that most felt impaired for the remainder of their shift.

+A few studies have evaluated the effect of mass casualty incidents on emergency services personnel.

*A significant number develop some characteristics of Post-Traumatic Stress Syndrome.

*Risk factors for increased stress response are complex and not easily evaluated: a "dissociative reaction" to the event may be important.

+Several studies evaluate the "burnout" factor in EM physicians. Estimates of attrition vary widely; it does not seem true that original grim predictions of a mass exodus have been fulfilled. However, a high percentage of EM physicians admit to "emotional

fatigue" and "depersonalization" but whether that translates into attrition is unclear.

+No survey of EM physicians regarding attrition, job satisfaction, or "burnout" has evaluated the effect of isolated or accumulated critical events.

4. The Relationship Between "Burnout" and Post-Traumatic Stress Disorder

PTSD was recognized as a formal diagnosis in the psychiatric nomenclature in 1980. Its acceptance as a diagnosis derived from the study of the effects of trauma on Vietnam Veterans.

After exposure to a trauma, most people become preoccupied with the event. Involuntary intrusive memories are almost universal.

The most fundamental aspect of normal adaptation involves integrating the traumatic event into the totality of one's life experience.

* Thus at the core of PTSD is the inability to integrate the reality of particular experiences; this can result in a repetitive replaying of the trauma in images, behaviours, physiologic states, and interpersonal relationships.

* The traumatic event(s) becomes dissociated; the result can be emotional numbness or exhaustion. Feelings can include anger, loss, betrayal, and helplessness.

* Physiologically, a state of hyper-arousal can result.

* In the extreme, life becomes organized around effort to avoid repeated trauma.

5. Goals of Treatment of PTSD

- The primary goal of treatment is to re-establish a sense of personal equilibrium.

People must come to terms with horrifying experience and re-establish personal and interpersonal efficacy.

- The traumatic experience must be seen in a larger context. Traumatic memories must be re-processed so that they make sense. The alien, incomprehensible, and terrifying must be integrated into one's self-concept and vision of the world.

6. Can Crisis Intervention Prevent PTSD?

- The realization that exposure to a traumatic event can in some people lead to PTSD has led to the development of crisis intervention programs to prevent the disorder.

- A popular method is Critical Incident Stress Debriefing.

There are various techniques, which basically involve the "victim" relating their experience, sharing their response with other victims or the therapist, attempting to contextualize the event, and obtaining "closure."

- There is growing concern within the psychiatric community that not only is there little if any data to support the utility of CISD, it may in some cases be harmful. Traumatized individuals are vulnerable to being re-traumatized, even by well-meaning care-givers.

- There are no clear guidelines to direct the care of the individual. In addition, therapy that is helpful for EMTs or nurses may not work for EM physicians.

7. What Can Be Done Now?

- Recognition of some of the accepted principles involving how people experience traumatic events may make it possible for the EM community to prevent some of the long-term damage.

1) Violence: Create a Culture of Work-Place Safety:

The first principle in treating victims of violence is to provide them with a safe environment. It is absurd that in many hospitals violence is an accepted part of the ED culture. This includes verbal as well as physical violence. Hospital administrations must be held accountable for providing adequate security. The EM community must demand that the legal system hold individuals who commit violent acts in the ED accountable.

2) Deaths (Pediatric and Adult)

Lack of a sense of preparation has been identified as a possible risk factor in patients who develop symptoms of PTSD after a traumatic event. Training in managing sudden death will almost certainly improve survivor's perception of the EM experience and perhaps aid their own recovery. Awareness of the "normal" EM physician reaction to a pediatric death may lessen the sense of isolation from this particular trauma. Knowledge that one has handled a bad situation as well as possible lessens the feeling of guilt and powerlessness.

3) Mass Casualty Incidents

This entity deserves further study. Whether EM physicians share the experience of Emergency Service personnel and nurses is unclear. Good disaster preparation is the key to avoiding compounding stressors like disorganization, which may contribute to PTSD.

4) Mistakes and Bad Outcomes

Everybody has them. A sense of isolation is an almost universal response to a traumatic event; what experience in emergency medicine is more lonely than making a costly error, or being involved with the "special" patient who dies despite the best care. Little can matter more at such a time than the support of one's colleagues.

5. Focus on the Positives

One factor identified in "burnout" in multiple fields is a poor self-evaluation of job performance that is not substantiated by measured performance. Working in a culture that focuses on the positive aspects of emergency medicine may protect EM physicians' self-esteem and help individual's to perceive traumatic events in the context of a supportive, collegial atmosphere. Nobody does emergency medicine better than emergency medicine physicians.

6. Shift Work and the Fatigue Factor

There is agreement that everybody must somehow process traumatic events. This may mean taking a few hours or a few days off. This allows time to re-experience (a

normal response to trauma) and to critically analyze the traumatic event in a non-stressful environment. This means that the E.D. staff must create an environment where trauma related "down time" is acceptable, and not perceived as a sign of weakness.

6. " Alternative Therapy"

Most physicians do not need formal therapy after a traumatic event. Many find relief discussing the situation with friends, family, or fellow physicians. Others by contextualize the event in terms of their religion.

Some physicians find reading and writing about traumatic events or other issues in medicine to be cathartic. "Literature in Medicine" is becoming a growing field in many medical schools. It is a way to explore issues of human suffering from both the patient and physician perspective.

7. What in the future?

Evaluate the effect of traumatic events on EM physicians. Identify those that are the most prevalent and destructive. Which physicians are at risk for "burnout" or PTSD?

Research is needed on the best method to manage both acute traumatic events and the long-term effect of trauma on EM physicians.

The psychiatry community may be useful in conducting multidisciplinary research on EM physician "burnout" and the effect of critical events in producing PTSD.

Prepare residents for what they will face. Share your experiences with the younger generation.

Old landmines blast to the surface
leaving traces of blood
on dried grass and twigs.
Empty farm fields,
pastures lush and green
turn battlefield once more.
Exploding shells rise to tell
the war never stops.
Bonnie Salomon, M.D.

References

- Ahrens WR, Hart RG. Emergency physicians' experience with pediatric death. *Amer J Emer Med* 1997;15:642-643
- Cudmore J. Preventing post traumatic stress disorder in accident and emergency nursing: A review of the literature. *Nursing in Critical Care* 1996;1:120-125
- Curtis JM. Elements of Critical incident stress debriefing. *Psychological Reports* 1995;77:91-96
- Goldberg R, Boss RW, Chan L, et al. Burnout and its correlates in emergency physicians: four years experience with a wellness booth. *Acad Emer Med* 1996;3:1156-1164
- Lavoie FW, Carter GL, Danzl DF, et al. Emergency department violence in United States teaching hospitals. *Ann Emer Med* 1988;17:143-149
- Hall KN, Wakeman MA, Levy RC, et al. Factors associated with career longevity in residency-trained emergency physicians. *Ann Emer Med* 1992;21:291-291
- Hart RG. Lost sleep. *Ann Emer Med* 1995;25:849-850
- Levin PF, Hewitt BJ, Misner TS. Insights of nurses about assault in hospital based emergency departments. *Image J Nurs Sch* 1998;30:249-254
- Marmar CR, Weiss DS, Metzler TJ, et al. Stress responses of emergency services personnel to the Loma Prieta earthquake interstate 880 freeway collapse and control traumatic incidents. *Journal of Traumatic Stress* 1996;9:63-84
- Van der Kolk BA, McFarlane AC, Lars Weisaeth, eds. *Traumatic Stress: The effects of overwhelming experience on mind, body, and society*. 1996 The Guildord Press
- Weiss DS, Marmar CR, Metzler TJ, et al. Predicting symptomatic distress in emergency personnel. *Journal of Consulting and Clinical Psychology* 1995;63:361-368
- Whitley TW, Gallery ME, Cockington RA, et al. Work-related stress and depression among practicing emergency physicians: an international study. *Ann Emer Med* 1994;23: