I didn't think it could (would) happen to me — Revisited

Martin A. Koyle, MD, MSc

Hospital for Sick Children, University of Toronto Department of Surgery and Institute of Health Policy, Management, and Evaluation, Toronto, ON, Canada

Cite as: Koyle MA. I didn't think it could (would) happen to me — Revisited. *Can Urol Assoc J* 2021;15(6Suppl1):S44-5. http://dx.doi.org/10.5489/cuaj.7231

More than two years have passed since I first wrote about my own experience with burnout and second victim syndrome in a *CUAJ* editorial.[1] It's amazing how burnout has become almost a word in daily conversation since the COVID-19 pandemic began impacting the planet, no matter who is in the discussion — healthcare worker or not. However, second victim syndrome is still seemingly hidden. Earlier in this edition, I wrote a piece on second victim syndrome, and realize that I am one of those, who in my current environment, will never be who or what (I thought) I was before. I have survived, not thrived. I have now reached a liminal phase of my life, a somewhat ambiguous period where I am at a transition point between my past life and identity, and the next chapter.

I write this as I wait for my elective case on a 21-month-old to begin. It is 8 pm on a Friday night, and although all other cases on my list were completed within their planned "procedural" times, the anesthetic and room turnover times delayed this case so that it was bumped into the after-hours schedule. Since the child had to have a COVID-19 test preoperatively, if the case was cancelled, a repeat swab would be necessary. Understandably, the parent(s) chose to wait with their "fasting" child, while the anesthetist and regular hours nursing staff get to go home. I find it almost amusing how despite the concept of the "surgeon as captain of the ship" paradigm of yesteryear having gone by the wayside in favor of the team approach, the surgeon is the one who still gets blamed for "going over." The surgeon and housestaff and, of course, the poor patient are the ones that suffer.

When I first returned to Canada in 2011, I received a call from a very senior anesthetist, who called and told me to order a complete blood count preoperatively on a patient. I asked him why and he replied that it was his routine. I suggested that if it was his routine and it was necessary for him to safely perform anesthesia, that he might order the test. I was informed that he was a "consultant," and I was the "most responsible physician," the MRP, and hence it was *my* duty. I refused to order the test with the counterargument being that if I ordered the test, I was responsible for following up on the results and dealing with any consequences if there was an abnormality, i.e., it was not *my* routine and had no necessity related to my portion of the procedure. As this went up the chain of command, and similar episodes occurred, I realized that MRP meant I was always the one with ultimate responsibility and liability. The concept of MRP has remained a thorn in my side, as the blame for any outcome rests on our shoulders, with rare or inadequate root cause analysis and consideration of system or organizational flaws. As I wrote in my earlier piece, the concept of team, collegiality, and communication were absent in my new institution, and silos and finger-pointing were the norm. There was no system. When you are almost 69 years old, these stories get old.

Organizational and inherent cultural change are major challenges. In healthcare, with common and ongoing disruptions leading to potential turmoil, strong adaptive leadership becomes increasingly incumbent not only in the C-suite, but by physician and other healthcare leaders as well. Since the pandemic arose, I receive texts and emails frequently — from the College of Physicians and Surgeons of Ontario, the Ontario Medical Association, the Canadian Medical Association, the American College of Surgeons, and the Canadian Medical Protective Association — regarding wellness and burnout. This is a step in the right direction, but still the message is aimed at individuals, not the overall structure of the systems and organizations in which we work. Nevertheless, the second victim syndrome is never addressed in these communications. I must commend my institution, SickKids, for establishing a peer support team over the past few years to train multidisciplinary personnel in crisis intervention and to rapidly engage with individuals and, more commonly, teams, where an unexpected outcome or adverse event has occurred. Scott et al have identified rapid response with appropriately trained individuals after such traumatic events as being pivotal in individuals' recovery from such event.[2,3]

We all have innate resilience, but I would hazard a guess that most of us, despite our best efforts at optimizing our wellness, have great difficulties in achieving healthy, balanced lives. As I search for my next life chapter, whether it be semi or total retirement from clinical medicine, I will

leave with no regrets regarding my chosen career and accomplishments, but with sadness that I only survived, rather than learned and thrived, during my ongoing recovery from second victim syndrome and burnout.

By opening up in my editorial of 2019, I received many supportive emails and other communications from colleagues and others who I had never met, and I have been asked to lecture on the subject(s) related to physician and healthcare worker wellness, as well as been interviewed on radio and social media sites. Nobody wants to celebrate the fact that they have suffered burnout or second victim syndrome. Still, our calling in healthcare is to help others, and that also means one another, not just patients! If we see someone clutching their chest and collapsing, none of us would turn the other way. We would respond without question. My parting words are, don't let your colleagues suffer in silence and alone. They may seem to be Superman or Superwoman, but they all have their own responses to kryptonite.

References

1. Koyle MA, Siemens DR. I didn't think it would (could) happen to me. *Can Urol Assoc J* 2019;13:79-80. https://doi.org/10.5489/cuaj.5950
2. Scott SD, Hirschinger LE, Cox KR, et al. Caring for our own: Deploying a systemwide second victim rapid response team. *Jt Comm J Qual Patient Saf* 2010;36:233-40. https://doi.org/10.1016/S1553-7250(10)36038-7
3. Scott SD, Hirschinger LE, Cox KR, et al. The natural history of recovery for the healthcare provider "second victim" after adverse patient events. *Qual Saf Health Care* 2009;19:325-30. https://doi.org/10.1136/qshc.2009.032870

Correspondence: Dr. Martin A. Koyle, SickKids, Toronto, ON, Canada; Martin.koyle@sickkids.ca