When Bad Things Happen to Good Anesthesiologists

From Surviving to Thriving – A Burnout Story

Jeffrey W. Hartwig, DO

Jeffrey W. Hartwig, DO
Assistant Professor, Department of Anesthesiology and Perioperative Medicine, Loyola University Medical Center, Maywood, Illinois.

Burnout! The new buzzword and phenomenon (that meant something completely different in high school) hit my life hard in spring 2019. The concept of physician wellness has gained traction in recent years, but it certainly was not a focus when I started medical school in 2002. I'm not going to provide a lot of definitions, give lists of risk factors, or outline prevention or treatment strategies; that paper has already been written by experts. My goal is to tell the story of what happened to me. I realize that everyone has adversity in their lives through difficulties with family/friends, stress at work, war wounds from training, health issues, or the death of loved ones. These are the very things that led to my burnout. This is simply a personal account of my journey inside and outside of medicine that contributed to burning out, stepping away, growing, rebalancing, reconnecting, and then returning to the career and field that I love.

Let's pick up the adventure with some venting from my training after graduating from medical school in 2006. The 80-hour work week rule had just been implemented – something that existed but was only loosely adhered to or enforced. While completing an internal medicine internship, I was subject to Q 4-5 call (no night float) for much of the year, admitting patients and cross-covering for sometimes 50 patients. This was accompanied by post-call rounding with private practice internists at a 12-story community hospital in the Chicago suburbs. In the beginning, leaving between 13:00-14:00 p.m. was brutal; at the end, finishing by 10:00 a.m. seemed like a victory. I rarely saw the call room, and 100-hour work weeks were not uncommon. Starting CA-1 year with 24-hour calls seemed like a luxury. This quickly faded. Working 24 straight "anesthesia hours" introduced me to a whole new definition of hard work. We took 7-9 calls per month our first year with things like "Frunday Call" (Friday and Sunday weekend calls). I turned 30 on a solo Saturday CV ICU call in April 2008 as the CA-1 "senior." I'll stop the BbBbBb… bleeding here. Residency was difficult, to say the least.

To provide some context from my personal life, I have long suffered chronic back pain. During my senior year in college, I herniated my L5-S1 disk. Unfortunately, I waited over a year, favoring noninvasive physical therapy to get the failed epidural steroid injections that might have been curative. Around this same timeframe, I was struggling emotionally with coming out of the closet. I venture to say that my physical and emotional pain kind of fused together along with depression and anxiety. The discomfort transitioned into chronic myofascial pain. Living with chronic pain takes its toll. So, keep this in mind, especially when considering the physically demanding practice of anesthesia. Stress plays an ever-present role. I manage with the multimodal strategies I've learned over the years, but it has had a profound effect on my life and still persists.

I often wonder how I made it through those years. At that time, to say you were struggling was to admit defeat or weakness, and so I stayed silent. Thankfully, the culture in medicine has been changing for the better. Everyone has their own training wounds, no matter when they occurred. This adversity enhanced my education, making me a strong clinician upon residency graduation in 2010.

My early years as a faculty member at the academic medical center where I stayed to practice after residency were filled with the typical growing pains that accompany new attending physicians. With these new responsibilities, difficult cases and less-than-optimal outcomes increased my stress. A notably stressful chapter from my practice came during my time spent on our liver transplantation team. The head of surgical abdominal transplantation was a notoriously and horrifically difficult person, which added additional stress to an already stressful procedure. I departed the team in 2016 as a result, but I learned valuable lessons throughout the process. I then took on the role of clinical director and started running the board. The stress of this already thankless job became exacerbated by extreme staffing shortages in 2018-19 that would prove to be one of the final straws. As clinical director almost a third of the time, I found myself regularly carrying two rooms plus the board, with its 40 sites and countless demands.

Turning 40 in April 2018 marked the beginning of a profoundly challenging period in my life. What initially felt like a simple milestone soon spiraled into a series of devastating events that fueled my growing sense of burnout. My close-knit circle of friends, whom I considered my second family, was shattered by a divorce, leading to emotional turmoil that rippled through our group. Shortly afterward, I lost a dear friend to suicide, just weeks before my first grandmother passed away. The grief compounded when my second grandmother died later that winter, and the following spring, another friend tragically died from a likely brain aneurysm. As if that weren't enough, my professional life was also in turmoil. Our department faced significant upheaval, culminating in the sudden death of our chairman from pancreatic cancer in spring 2019. Any one of these events could have sent someone into a tailspin, and I found myself numb, grappling with an overwhelming sense of loss and uncertainty. I knew I couldn't stay silent any longer.

After almost 10 years as an attending anesthesiologist, I was exhausted and stressed, with increasing back pain from constant flare-ups. I could no longer manage the stress. My life had become a daily battle to survive. The sum of all the forces at work in my life left my head just barely above water. Many metaphors could be used to describe the incongruent state of my physical, emotional, mental, and spiritual well-being. My burnout was now official. Like a switch being flipped, it was obvious that something had to change. I had neglected and now needed to address each aspect of my health – physical, mental, emotional, and spiritual. I needed to change from simply surviving to fully thriving. And so, I walked out of the hospital on June 30, 2019, not sure if I would return to medicine, with the weight of all these difficult years needing to be unpacked. I realized it was time to focus on myself. Fortunately, being single and without children, I had the freedom to do so.

To address my physical pain, I turned to a new treatment from an osteopath in Indiana as well as an alternative medicine healer. I started walking regularly and reintroduced physical therapy with new techniques. Living in Chicago's River North neighborhood gave me easy access to the River Walk, my "concrete jungle," and a connection to nature. I also discovered the joy of audiobooks and podcasts, which enriched my walks with history and philosophy courses, offering a refreshing break from years of focusing on science. I started down my new spiritual path after reading one of the most influential books in my life – "A New Earth: Awakening to Your Life's Purpose." I started practicing meditation and attempting to live in the present. Through these teachings, I found new ways to cope with adversity, anxiety, and difficult relationships. With some help from gratitude, I'm learning to find balance. To further assist my mental and emotional states, I returned to talk therapy, something I had let expire over the years. We addressed the emotional pain that had built up throughout the recent avalanche of life events. We also redressed lifelong scars.

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My mind craved unstructured time – also called "self-care" these days. I have always been an artistic person, so I revisited creative outlets from the past I had let go. I began sketching, journaling, and playing piano again. However, a newfound hobby unexpectedly changed my life – learning to knit and crochet. Here was something creative, technical, hands-on, yet quite meditative in nature. It struck a chord with me by providing a way to tune out the bad and turn up the good. Completely self-YouTube-taught, wonky-shaped scarves soon turned into blankets, hats, and mittens.

Before I knew it, I found myself in a whole new space. I was now happy to take on each new day. My anxiety, stress, and pain levels had decreased considerably to a manageable level with the new tools I was acquiring. I had found new joy in my life with a whole lot of self-care. I had restored some balance to my life and began to thrive.

About six months after leaving my institution, I realized I missed more than just the people – I missed being an anesthesiologist. I missed teaching residents, helping anxious patients through surgery, and even performing procedures like I.V.s and epidurals. At the department's holiday party, our chairman suggested I work part-time. As a 0.5 FTE, I could keep most benefits with adjusted pay. It turned out to be one of the best decisions I've ever made! Now, I enjoy a more balanced life, continuing in a profession I love while maintaining self-care, guided by equanimity and gratitude. ■

Navigating the Aftermath

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significantly more emotional support than attending physicians after the death of their patients (*BMJ* 2003;327:185). Debriefing and creating spaces for trainees to reflect on their emotional experiences have proven to be beneficial in helping them recover (*Cureus* 2023;15:e39715).

The growing role of simulation of patient death among trainees offers a potential for enhancing existing curricula that prepare trainees to navigate these outcomes. While few studies point to greater levels of stress and anxiety in medical students in simulated patient death, this research is primarily focused on small cohort studies that do not follow long-term educational outcomes (*Cureus* 2023;15:e39715). We argue for further research in this growing field as high-fidelity simulation becomes a more standard practice in anesthesiology training.

What happens next?

The assumption that most anesthesiologists may remain insulated from intraoperative death is a fallacy and may further lead to poor support systems for navigating the aftermath. We strongly advocate for the incorporation of routine discussions of intraoperative death at the anesthesiology trainee level through lectures and simulations. Additionally, we call for systemic changes to ensure that all anesthesiology trainees have immediate access to robust emotional and psychological support resources in the event of an intraoperative patient death. Our training should prepare us to handle every outcome, especially the most unimaginable.

At a minimum, these unexpected outcomes force us to shine a light inward to answer the questions: What makes a good anesthesiologist? What makes a good career? It is hard to say. But perhaps "being good" comes from knowing that taking care of a patient can mean both comforting a patient as they fall asleep, and rapidly resuscitating them in the face of a crisis. It comes from also knowing that our patients can be both extremely resilient and exquisitely tenuous at the same time – that our cases can be simple and complex, routine and emergent. And finally, it comes from knowing that we, as anesthesiologists, can be both strong and vulnerable, sensitive and brave, as we handle the good outcomes and the bad. ■