LETTER FROM THE EDITOR IN CHIEF

Dear Readers,

As I was pondering on what topic to discuss in this month’s letter, I was drawn to the case report by Dr. Pothineni and colleagues from the University of Arkansas entitled “Disseminated Intravascular Coagulation after Radiofrequency Catheter Ablation of Idiopathic Ventricular Tachycardia.” I realize that this is certainly not my typical letter; however, I hope that my comments will be of help to you. What caught my attention is that this was initially an uncomplicated outflow tract premature ventricular complex (PVC) ablation case in a middle-aged woman with no structural heart disease.

This case, like most cases we perform everyday, should have gone well without any complications. However, the night after the procedure, the patient became critically ill with disseminated intravascular coagulation (DIC) following catheter ablation for no apparent reason. Within 24 hours of an uncomplicated routine ablation procedure, the patient went into acute renal and liver failure, had developed moderate pericardial effusion and multiple arterial and venous clots, and became thrombocytopenic and anemic.

Dr. Pothineni and colleagues should be commended for publishing this complication. For many physicians, it is very difficult to share cases that did not go as planned. Fortunately, this case had a happy ending 10 days later. I can only imagine the mental anguish and stress they must have endured over these 10 days, as this healthy patient came to the hospital for an elective procedure, only to later develop multi-system organ failure. Perhaps it is because I recently encountered a tragic complication following a routine ablation procedure that this case particularly resonated with me.

Whenever I experience a serious complication, especially following an elective procedure, it literally rips me apart. I play the case over and over in my mind wondering what could have been done differently. Invariably, the answer, as in this case report, is that nothing could have been done differently and that this was just an unfortunate complication. Certainly, there are always precautions that can be taken to minimize the risk of any complication, but in the final analysis, our complication rates will never be zero.

I know that for myself, I want so much to help my patients get better, and it causes deep soul searching when things do not go as planned. I start questioning myself as a physician. Sleep often becomes very difficult during these times, and it also puts a great deal of stress on my family, as I am often mentally ‘‘checked out’’ and not available for them.

I see this in myself, and I have observed it in many colleagues. Unfortunately, physician stress is a huge and underrecognized problem in our field. Indeed, according to a 2011 survey of more than 2,000 physicians by Physician Wellness Services and Cejka Search, 87% of physicians felt moderately to severely stressed and burned out on any given day. This same survey reported that physicians today generally feel more stressed and burned out than they did just 3 years ago.

What is going on, not just in medicine but in our field as well, that could account for the significant rise in physician stress and burn out? According to the Physician Wellness Services, some of the major workplace stressors for physicians are increasing levels of paperwork, excessive hours, internal conflicts, on-call issues, and medical liability concerns. These stressors are particularly magnified within our field because our level of paperwork has significantly increased to meet new government/insurer-related regulations and reimbursements from ablations have been cut approximately 30% since January 1, 2013. Ultimately, most of us will see a significant drop in our take-home pay as we increasingly put in more hours to complete paperwork only to be paid much less.

Fear of malpractice litigation also puts a tremendous amount of stress on emergency physicians (EPs), especially when complications occur. Indeed, I have been asked many times to review cases from defense attorneys representing EPs in cases resulting from procedural-related complications. In each of these cases, the EP did not stray from the standard of care but rather was sued due to an unfortunate complication arising from an indicated procedure following appropriate informed consent.
What can we do to improve our physical and mental health in this highly stressful EP job environment? As I have struggled with the impact of a very stressful occupation coupled with many other commitments, I have found that these four things have been particularly helpful in my life.

Stay Physically Active: As I have made outdoor exercise a priority in my life, I find that I am much less stressed; much more energized; and able to give more of myself to my family, patients, and friends. Whatever physical activity you enjoy doing, just do it regularly and enjoy the benefits.

Eat a Healthy Diet: I know this seems trite, but it is really important. We constantly counsel our patients to increase their intake of fruits and vegetables and avoid red/processed meats, processed foods, sweets, etc., but do we do the same? For most of my career, my daily breakfast, provided free by the hospitals I worked at, was a donut, bagel with cream cheese, and a diet coke. Is it any wonder why my health was deteriorating until a couple of years ago? If we eat right, we will have more energy, experience fewer sick days, and feel better about our lives and ourselves.

Invest in Relationships: Our relationships with our families, coworkers, and friends are the most important thing in this life. We need to invest in these relationships. Make people a priority and invest your time accordingly. Indeed, as we invest our time and effort in the people around us, all of our stresses and challenges will become much more manageable.

Rejuvenating Sleep: Sleep is absolutely critical to our health and our ability to function at a high level. Unfortunately, our field often makes sleep a luxury. Studies have shown that sleep-deprived motorists function at a level comparable to drunk drivers. The same is true for us in our fields. We need to create a system to minimize sleep deprivation while taking call.

I hope you will enjoy reading this case report, as well as the many other stellar articles in this issue of the Journal. As always, I look forward to your thoughts and comments with this Journal!

Warm regards,

John Day, MD, FHRS, FACC
Editor-in-Chief
The Journal of Innovations in Cardiac Rhythm Management
JDay@InnovationsInCRM.com
Director of Heart Rhythm Services
Intermountain Medical Center
Salt Lake City, UT