Emergency Room Medical Providers: Mental Health Needs

Brenda F. Seals, PhD, MPH
Executive Director and Research Associate
Native American Cancer Research

Acknowledgements

Temple University:

Emergency Medicine:

Linda Kruus, PhD

Amy Goldberg, MD

Nursing

Pamela Bender, RN

Funded in part by Tobacco Initiative
Pilot Projects, Sponsored Programs

Background

PTSD well documented in:

- veterans of war
- refugees
- assault victims
- EMT and other responders

Yet little data on ER staff

ER staff experiences

- Frequent exposure to human suffering (daily at large centers)
- Considerable rate of patient fatality
- Long hours
- Irregular sleep, often due to rotating shifts
- Intermediate “surges” in cases (20 car pile ups)
- On-call

Consequences

- Difficulty sleeping
- Tightness in the throat or chest
- disorientation
- Periodic or chronic anxiety
- Periodic or chronic depression

Difficult to separate out “normal” reaction to job stress from PTSD

Goal

This study was a first step toward understanding and addressing the mental health needs of emergency room service providers.

Rationale

- Under the auspices of a study to develop a mental health intervention for accident victims coming into the emergency room, focus groups were scheduled with service providers.
- At the request of the staff, the investigator was asked to expand the study to address the needs of service providers.

Methodology

- IRB approval was obtained from Temple University for all parts of the study.
- Consent documents included the right to present summary information and use altered quotes
- Focus groups were scheduled to be at the time of regular staff meetings
- Focus groups were audio taped.

Theme Identification

- The staff and PI debriefed immediately after focus groups to identify important themes.
- Tapes were reviewed to verify initial themes and to identify quotes.
- Themes were shared with select ER staff and refined

Results

- Focus groups were conducted in the summer and fall of 2006.
- Focus groups were composed of primarily physicians and nurses working in the ER. A few staff members also participated.
- Because of the small number of participants, specific demographics are not available.

  Only summary results are presented.

Demographics

- The focus groups were fairly equally divided by gender. However, physicians were disproportionately male and nurses female.
- All participants were adults with most being middle age. Older participants were more often physicians and younger participants were female. Staff were more likely to be female.

Overall themes

- "Normal" stress
- Unusual stress
- Difficulties seeking services
- Lack of social support
- Coping strategies
- Possible remedies
- Policy implications

"Normal" stress

- Participants listed facets of their work that increased their stress. Beyond those listed in the literature review (on call, schedules, high death rate, lack of sleep), were:
  - Giving patients difficult information (". . . you're not going to walk again")
  - Telling patients and family/friends about the death of others involved in the accident.
  - Working with patients who are disoriented due to injury or medication.
  - Dealing with patients/family/friends who are upset and blaming.

Unusual Stress

- Occasions involving:
  - large numbers of injured requiring long hours and pressure to finish each patient quickly as others were waiting (eg. Multiple car accidents)
  - significant injury requiring a multitude of specialists.
  - Difficult cases where opinions different on the course of treatment.
  - Youth or children patients.

Difficulties seeking Services

- Although participants were aware of employee services and insurance options for mental health services, no participant reported making use of these services due to:
  - Lack of time to seek services
  - Perceived lack of skill among available providers (general training didn't include PTSD, significant problems)
  - Perceived lack of faith in the efficacy of mental health services

Lack of Social Support

- Inability to confide in family/friends
  - Participants held that their experiences in treating emergency cases were so unique that family/friends did not have a base to understand.
    - "Their" interests were in the most exotic or sensational elements.
    - Seemingly insignificant components that were reportedly more bothersome to staff were not of interest to family/friends.
    - Desire to protect family/friends from stress.

Social Support continued

- Inability to confide in co-workers
- Perceived pressure to "hide" any problems and/or to maintain the façade of well-being
  - Fear that others morale would suffer
  - Worry how others would react (not understand)
  - Concern that others would not believe them or would "minimize" their problems
  - Thought that they would be "relieved" of their duties, letting the team down when they were needed

Coping Strategies

- Humor (outsiders may consider “gallows”)
- Being “family” to each other
  - Attending parties, sports games, etc. together
  - Paying attention to each other
  - Willing to give each other “pats on the back”
  - Sharing stories of “worse” events
- Support and understand from senior staff
- Taking time off
- Developing outside interests
- Seeing a future in the job

Possible Remedies

- Adding a mental health professional to their team
  - Help deal with giving “news” to patients/family
  - Help early identify stressful situations and provide support during unusually stressful situations
- Having a periodic mental health consultant with special training in PTSD and trauma be available to come at least quarterly to staff meetings and/or after unusual events to debrief and early identify potential problems

Remedies Continued

- Staff development/workshops providing training in relaxation techniques
- Coaching in how to talk to family and friends about stressful working conditions
- Education in anxiety, stress and depression including symptoms, “self-help” ways to cope better with symptoms, and advice on when to seek further care
- Advocacy with administration around on-call schedules and time-off

Discussion

- High stress occupations with high turn over create a downward spiral that could cripple emergency response infrastructures.
- Insufficient recruitment efforts further exacerbate existing staff shortages.
- Medical schools provide little training in interpersonal skills that may help providers:
  - Discuss difficult information with patients
  - Provide support to colleagues

Discussion continued

- Mental health providers need to be better integrated into emergency room services to:
  - Assist patients dealing with life changing injuries.
  - Assist family/friends with patient death and injury.
  - Assist staff to recognize, resolve and adjust to stressful work conditions.
- Mental Health providers need to be on-site available to emergency staff
  - Periodic and as needed debriefings.
  - In-service trainings (coping, social support)
  - Early identification and referral to services

Conclusion

- Public Health advocates need to prioritize emergency medicine as a way of improving quality of life and mental functioning of emergency room personnel.
- Expanding mental health provider roles in emergency medical response could ameliorate worker turnover and improve recovery and/or coping among patients and families.

Policy Implications

- Closing emergency rooms forces remaining facilities to serve larger numbers, increasing staff exposure to stressful events. Without proactive efforts to better prepare and assist existing staff, turnover and lack of recruitment may leave facilities with insufficient coverage.
- All emergency response efforts depend on preparedness of sufficient, well-trained corps of emergency health professionals.