

Opinion Article

Balancing Burnout with Hope: The Importance of Resident Participation in Follow-up Care

Carmine Suppa, Zaid Bilgrami and Ruth Milanaik*

Developmental and Behavioral Pediatrics, Cohen Children's Medical Center of New York, New Hyde Park, NY, United States

***Corresponding Author:** Dr. Ruth Milanaik, Developmental and Behavioral Pediatrics, Cohen Children's Medical Center of New York, New Hyde Park, NY, United States, Tel: 516-802-6100; E-mail: rmilanai@northwell.edu

Received: 28 October 2017; **Accepted:** 13 November 2017; **Published:** 16 November 2017

Keywords: Burnout; Residents; Follow-up care

Abbreviations: NICU-Neonatal Intensive Care Unit; PICU-Pediatric Intensive Care Unit

1. Balancing Burnout with Hope

Before Baby G even saw the world or took his first breath, he was destined for open heart surgery and a long neonatal intensive care unit (NICU) stay. Soon after birth, an echocardiogram and cardiac MRI confirmed a hypoplastic transverse arch, multiple ventricular septal defects, and a severe coarctation of the aorta. Furthermore, he exhibited dysmorphic facial features, micropenis, a weak cry, poor feeding, and moderate hypotonia. After two months in the NICU full of multiple IVs, countless imaging studies, breathing and chest tubes, numerous invasive procedures including cardiothoracic surgery requiring bypass, and a myriad of specialty consults, his problem list at discharge included: supraventricular tachycardia, vocal cord paralysis, laryngotracheomalacia, axial and appendicular hypotonia, and inconclusive genetic testing.

Seven months later, Baby G was scheduled for his visit in the Neonatal Follow-up Care Clinic. During my core Developmental & Behavioral Pediatrics rotation, I sat in the office reviewing his NICU course in preparation for his visit. I mentally prepared myself for the worst. Thoughts swirled through my mind after reviewing Baby G's history. I imagined not only the patient and family's struggle, but also that of my fellow residents who at times must have felt completely helpless. The medically complicated cases of the NICU often become regulars of the PICU. I began picturing my last stint in the pediatric intensive care unit (PICU), full of children with similar stories, now with

feeding tubes, tracheostomies, and severe contractures. I thought of the patients I cared for who died before leaving the NICU and the chronic patients who coded and died in the PICU over my three years of residency. Consequently, upon reading Baby G's history, I braced myself for an infant failing to thrive, meeting no milestones, and on his way to becoming a frequent flyer of the intensive care unit.

With these thoughts in mind, I entered the exam room. I immediately thought I was in the wrong room, as seated in front of me were a plump, smiling infant and his equally beaming mother. Upon seeing my shocked face, the mother was quick to inform me that Baby G excelled after leaving the NICU. His appetite increased, and he began to grow along a normal growth curve. He no longer needed any medications, and besides his cardiologist for surveillance, had no follow up appointments, as no other specialists deemed it necessary. Baby G giggled and babbled his way through the visit, sitting on his mother's lap, reaching out for toys and transferring them from hand to hand, easily meeting all the 6-month milestones. The only remarkable finding from his physical exam was a well-healed sternal scar. I found myself grinning, too. Baby G's laughter seemed to pry out a feeling I had buried after three full years of seeing numerous sick children throughout my residency: hope.

Baby G's first two months of life were difficult, but not uncommon in a large, tertiary care children's hospital. Pediatric residents spend several months caring for neonates suffering from congenital abnormalities, as well as extreme prematurity, cardiac defects, hypoxic ischemic encephalopathy, and many more conditions with high morbidity and/or mortality. When these children are born, residents and fellows work tirelessly to maintain appropriate oxygen levels, blood pressures, and nutrition, sometimes to no avail. As in the case of Baby G, residents attempt many difficult and invasive procedures in the face of poor prognoses. Such seemingly hopeless cases can torment young physicians. Despite fatigue and internal turmoil, a resident must empathize with and comfort overwhelmed families. These patients progress slowly, if at all, which fuels frustrations among parents and providers. Parental frustration can often be directed towards the medical team, with the residents being first in line. When this occurs, thoughts of underappreciation and resignation begin to seep into residents' minds. Furthermore, the severely sick neonates may spend months in the hospital, while resident spend only four weeks during their rotations. A resident who is responsible for the majority of a baby's care will rarely have the chance to discharge the baby home. After discharge, there is minimal attempt to include residents in their patients' follow-up care.

In the past few years, the issue of resident burnout has garnered widespread attention among health professionals, with most of the discussion focusing on regulation of residents' work hours. However, the lack of opportunities for residents to see successful follow-ups with patients may also contribute to feelings of burnout.

Every year, approximately 2,700 medical graduates enter pediatric residencies with the noble goal of improving the lives of children. However, the majority of time pediatric residents spend with patients is in acute care settings where patients are seriously ill. These patients are then discharged to the care of their private pediatricians. As a result, pediatric residents are rarely able to witness positive post-discharge developments in their inpatients. Given that residents have limited opportunities to see the fruits of their labor, it is easy to see why they may feel an

emotional detachment from their work and a low sense of accomplishment, two central components of burnout [1]. Indeed, 39 to 76% of pediatric residents report burnout [2, 3] and first-year residents reportedly suffer from burnout at the highest rates [4]. In the NICU, burnout affects 7.5% to 54.4% of all staff and creates an unsafe environment for both patients and residents [3, 5, 6].

As pediatric residents manage complicated patients such as Baby G, they witness suffering among one of the most vulnerable patient populations, which inevitably takes a toll on residents' mental, emotional, and physical well-being. Structural modifications of residency programs that allow residents to participate in more follow-up care for critically sick patients may provide a sense of hope to combat burnout.

For me, seeing Baby G reignited my passion and revived my sense of hope for the critically sick patients of the NICU. I am sure that if the residents who cared for Baby G in the NICU saw what I saw, they would see how their work truly improves lives of patients and their families. They would be reassured that they are indeed achieving the noble goals that initially sparked their pursuit of a medical career. They, too, would share Baby G's adorable grin.

2. Financial Disclosure

The authors have no financial relationships relevant to this article to disclose.

3. Conflict of Interest

The authors have no conflicts of interest to disclose.

References

1. Maslach C, Schaufeli WB, Leiter MP. Job burnout. *Annu Rev Psychol* 52 (2001): 397-422.
2. McCray LW, Cronholm PF, Bogner HR, et al. Resident physician burnout: is there hope? *Fam Med* 40 (2008): 626-632.
3. Baer TE, Feraco AM, Tuysuzoglu Sagalowsky S, et al. Pediatric Resident Burnout and Attitudes Toward Patients. *Pediatrics* 139 (2017).
4. Pantaleoni JL, Augustine EM, Sourkes BM, et al. Burnout in pediatric residents over a 2-year period: a longitudinal study. *Acad Pediatr* 14(2014): 167-172.
5. Profit J, Sharek PJ, Amspoker AB, et al. Burnout in the NICU setting and its relation to safety culture. *BMJ Qual Saf* 23 (2014): 806-813.
6. Tawfik DS, Sexton JB, Kan P, et al. Burnout in the neonatal intensive care unit and its relation to healthcare-associated infections. *J Perinatol* 37 (2017): 315-320.



This article is an open access article distributed under the terms and conditions of the

[Creative Commons Attribution \(CC-BY\) license 4.0](https://creativecommons.org/licenses/by/4.0/)