DOCTOR'S CROSSING
CARPE DIEM PODCAST
TRANSCRIPT

EPISODE 61 Coping with anxiety as a new attending

With guest Dr. John Fondran

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JF: "I know that that's a really difficult call to make. And if you're calling somebody like that, that 911 call, then you're really hurting. You're really in trouble. And I don't want to just help my patients. I want to help other people. I've been through it so I know what they're going through. And if they're reaching out, then yeah, I'm glad they're reaching out."

HF: Welcome to The Doctor's Crossing Carpe Diem podcast. If you're questioning your career in medicine, you've come to the right place. I'm Heather Fork, a former dermatologist and founder of The Doctor's Crossing. As a master certified coach, I've helped hundreds of physicians find greater happiness in their career, whether in medicine, a nonclinical job, or something else. I started this podcast to help you discover the career path that's best for you and give you some resources and encouragement to make it happen. You don't need to get stuck at the white coat crossroads. So, pull up a chair, my friend, and let's carpe that diem.

Hello, hello and welcome back to the Doctor's Crossing Carpe Diem podcast. You are listening to episode number 61. This episode is in response to a number of calls I get from physicians who are new attendings and in that first year out of training.

They're struggling with significant anxiety and having a crisis in confidence. These feel a bit like 911 calls to me. For example, it might be an ophthalmologist or an orthopedic surgeon who's doing challenging cases for the first time on their own. Sometimes they tell me that they can hardly sleep at night before a case. Then in the morning, they're often too queasy to eat breakfast and may even throw up. Their mind starts racing with all of the things that could go wrong with a case and a patient. They start to question, "Am I even cut out to be a doctor? Maybe I should just give this up right now."

It's a big deal to go from being a resident or a fellow where the buck gets passed to the attending to now where the buck stops with you. You don't have to be a surgeon to have these kinds of doubts. It's common in emergency medicine, as well as for clinicians in general practice. This kind of anxiety can even plague seasoned physicians. Medicine is not playing Tiddlywinks after all. These are people's lives we're dealing with.

Today, I'm absolutely thrilled to have Dr. John Fondran, who has been practicing as a board-certified colorectal surgeon for 13 years, join us to offer his wisdom and words of advice. Not only has he had his own experience with his transition phase as a new surgical attending, but he's also mentored and taught residents and fellows and has been an assistant program director at his institution.

John is going to share with us the five-step process for coping with anxiety as a new attending. I'm very honored and grateful to be able to welcome Dr. John Fondran to the podcast. Hey John, how are you?

JF: Hi, Heather. How are you?

HF: I'm great. I love those cantaloupe walls behind you. It's a great color.

JF: Yeah, my wife's good at color. I just go along with it.

HF: My mother says “I'm much better at colors than I am at numbers.” For creative types colors are great, but all colors aside, I'm excited for you to help us out with this significant problem that really calls to my heart when I hear a physician suffering with this kind of anxiety.

JF: Oh, for sure, for sure. I certainly went through it myself and even now I kind of continue to cope with it. The cases don't get any easier, they just get harder, they should go along, but I've been through it myself. I've taken residents through new attendings, things like that. I know how hard it is. It's something that we don't talk about, but I think if we did, we’d make it easier for everybody.

HF: And that's exactly why we're doing it. Help normalize this experience. Would you like to start us off with telling us a little bit about what it was like for you when you became a new attending?

JF: Sure. Yeah. I'll break character as a surgeon, I'll admit to vulnerabilities. Yeah, it's an exciting time, but it's also scary. Every case that you do is the first case that you've done. My first case as an attending was an umbilical hernia and I remember shaking as I'm making the incision. You had asked about an example of the case and the one that was really vivid in my mind was a lap choley. Simple, straightforward, lap choley, no problems at all, I’m halfway home and it just popped in my head that I think I cut the common bile duct.

Spoiler alert, I didn’t. But I couldn't get that thought out of my head and I kept worrying about it and worrying about it. And I thought, “Well, okay, let me just go through the steps of what I did.” I visualized the whole procedure. I'd seen all the landmarks, all that sort of thing. And I said, okay, yep, everything's fine. And then I just kept doing that over and over and over again. And I really just couldn't stop. And then she came back into the hospital with elevated liver enzymes and the whole thing started all over again.

HF: Oh, no. You probably thought, yes, it's true. It's happened. I did it.

JF: Oh, yeah. It's started all over again. And then I'm thinking, "Oh yeah, I really did do something." And then everything turned out to be just fine. And there were no problems at all. I really lost several days of my life to be honest with it, because I just could not get this out of my head. That certainly isn't the only time that that's happened. And I know certainly a lot of people go through that.

HF: When you were going through that, did you tell anybody that was happening? Did you talk to anybody?

JF: No. Of course not.

HF: And you already identified one of the big problems. It's often our mind that starts driving us crazy, not reality so much, but those thoughts that start spinning.

JF: Yeah, exactly. The anxiety, it's an evolutionary thing. It's there for when you need to be running away from a bear or something like that, but it's there to protect you. It's there to warn you of danger and things like that. But when it gets out of control and it's inappropriate to the situation or it's detrimental to the situation, that's when it really becomes a problem.

It's a normal thing to have anxiety, but at a reasonable level. Especially as a new attending, if you don't have some anxiety over what you're doing operating on another human and if you don't have some anxiety, you're a sociopath. When you're working on a person, you're supposed to care about this and trying to do a good job and have some level of anxiety, but having it take over your life, and like you said, can't sleep, throwing up in the morning before cases, that's not healthy for you and that's not healthy for your patient either.

HF: I like that you brought out that some degree of anxiety is normal, so you're not trying to get rid of all of it or feeling like there's something wrong with you. If you have anxiety, it's a normal response to being responsible for somebody else's life.

JF: Yeah, exactly.

HF: As we go through these five steps, I'd love it if you'd share some more of your story as illustration, so feel free to bring that in as examples. This first step is something we've actually already been talking about, which is to recognize it's normal to have some degree of anxiety and doubt.

JF: Yeah, exactly. And like we said, you're not alone. Everybody goes through this. We as a profession, just don't talk about it. I think things have gotten a little better since when I trained, but there's still a lot of emphasis on not appearing weak and that really kind of hampers a dialogue on this sort of thing and prevents us from dealing with it in a healthy way.

HF: Recognizing that it's normal to have anxiety and doubt, to think about what's a healthy level for you. If there's going to be some of it, that's okay. But if you really start feeling like it's interfering with your sleep and being present with your family and just functioning, then that's really time to definitely get some help and speak with someone.

JF: I don't know. The line is going to be different for everybody, but for me, it's when I'm able to leave work at work. If I come home and I still have something on my mind that I can't get out of my mind at work, then that means I'm worrying about it too much. Ideally, I want to be able to leave work and be with my family. And then should something happen, I get the call and then I switch back into doctor mode and I can take care of it. But to be in doctor mode all the time, really just kind of takes away from the rest of your life and ends up making you a worse doctor.

HF: And you can't get that rest and recuperation that you need to show up and do your work. This brings us to the next step, number two, which is find those you can talk to.

JF: Yeah. And that's the key to any of this stuff is talking about it, which can be either easy or hard depending on your situation. I was blessed I had my senior partner, one of the best human beings I know. And he was somebody from the very beginning I could go talk to, run cases by, and all that stuff. And he was always very kind and understanding about it and everything like that.

Some people don't have that within their practice, but we all make relationships. We all have bonds from residency. I definitely reached out to some of the people I graduated with, some of the people I did residency with. Get that kind of bond of sharing a traumatic experience together going through residency. So, you know they're going through the same things.

And then don't hesitate to reach out professionally either. There are therapists, psychologists, employee assistance programs, all of that stuff. It's getting to be a little bit more common where things are certainly not ubiquitous, but there's help specifically for physicians. You kind of get embarrassed. I hear stories about people that travel an hour and a half away to see their therapist because they don't want anybody to know. We have to start breaking that down, but if you need that kind of help, then don't hesitate to get that kind of help. No shame in that.

HF: And interestingly, I'm going to be doing an episode with a psychologist, a therapist who works specifically with physicians and she helps out a lot of those who have anxiety. We're going to be getting her perspective too, which will be sort of a nice adjunct to this episode.

JF: Oh yeah. It's fantastic.

HF: Yeah. Yeah. And how do you feel when one of your former residents or fellows reaches out to you with one of those 911 calls?

JF: Oh, it's flattering for me. And like I said, I understand where they're at. I know that that's a really difficult call to make. And if you're calling somebody like that, that 911 call, then you're really hurting, you're really in trouble. And I don't want to just help my patients. I want to help other people. I've been through it. I know what they're going through. And if they're reaching out, then yeah, I'm glad they're reaching out.

HF: Yeah. And if anybody was multitasking, I just want you to go back and listen to this because he just said he's flattered to get these calls. We care about each other. We've been there. We want to help out and you're not bothering one of your mentors to call them up. And there's something huge about letting go of the secret that you've probably been holding onto of the anxiety and the self-doubt, because once you do start to share with someone else you can trust, it takes a big burden off your shoulder because you're not holding on to a secret any longer.

JF: Yeah. That first step of allowing yourself that vulnerability to talk to somebody, to let some of that stuff out. That's the hardest part. Once you get over that and realize how freeing it is to share some of that stuff and get rid of some of that burden, it gets a lot easier.

HF: Yeah. And you're right. You have to evaluate whether you can talk to someone within your program, whether you need to start outside of your program. I know some physicians have told me they've been in a practice where there's only one other person, and it's the person who hired them and they just don't feel supported. But even if you have that conversation with that person, you're going to find out, is this a tenable situation? Because their response will tell you, is this person going to help me grow and get through this transition period? Or are they not and am I going to have to even maybe consider leaving?

JF: Yeah. You don't start off by just dumping your entire soul into the first person you see. Trust is the most important thing in something like that. Trust builds up over time. We all deal with people and we're all savvy enough to know who to start testing that. You can test different people and see if there's somebody that you can trust and you can go to those steps further. But I guarantee that you can find somebody somewhere who's going to be able to help you.

HF: Right. And if you don't ask, you'll never know. We don't want it to compromise your career and even be a reason why you might decide to leave.

JF: No, no, of course not. Again, it's normal. Like I said, it doesn't go away, but if you approach it in the right way, it does get easier to cope with and easier to control and easier to live with and easier to not have it affect the rest of your life. But it takes work.

HF: Yeah. And I think it makes it worse when you keep it yourself, it tends to make anxiety worse.

JF: Yeah, absolutely.

HF: It definitely does.

JF: Absolutely. Because then it can just spin over and over and over in your head and if nothing stops that, it just picks up speed.

HF: Right, right. Snowball. Now this brings us to the third step, which is to develop coping strategies for anxiety.

JF: Yeah. There's just so many of them from simple breathing, taking a few deep, slow breaths can stop that spinning. Meditation, yoga, like I said, therapists and things like

that. Things like right in the moment, I know sometimes I'll be in the middle of a really hard case. And I can tell that I'm getting too wrapped up with anxiety once I start getting a headache during the middle of a case. And especially if things have really hit the fan and you get things under control. And there's certainly been times when I've stopped and told the resident, go get a Coke and come back in 10 minutes. And then I get a few minutes. And then we come back and regroup.

When there's difficult decisions to be made, I'll just step away from the table, walk around the room for a minute. Maybe people are thinking I'm weird for it, but I think more likely they understand that it's a hard decision to make. I'm just kind of thinking about it. As I've been doing this, nobody expects you to know everything right away. They expect you to think, they expect you to need to take some time and things like that. There are books and books and books written about coping with anxiety and different techniques and things like that.

HF: I like that you're bringing in a variety of coping strategies because it's never one thing. Not just one thing. And when I work with physicians with this challenge, they often end up seeing a therapist. They might work with me. They usually don't have to work with me very long, actually, because it doesn't take that long to turn this ship around. But they'll start implementing some thought work and that could be meditation, which I just like to think of as mind training, being able to control your thoughts better and choose the thoughts.

You also mentioned yoga. Exercise is huge. I think if you're not getting exercise, you're not able to off-gas this stressful energy. Then it just builds up. Sort of looking at things that you're doing in your personal life that can support you and then the practical things of being there in the operating room. And when you feel stuck or paralyzed, take a little break, walk around, get a Coke and chips and just regroup.

JF: Yeah. Call somebody else into the room for just another set of eyes. But yeah, those things where you can control and pick and choose which thoughts you're allowing to get through. And also, being able to parse out which thoughts reflect reality and which ones don't. Like my gallbladder story. It was very clear after the first 30 or 40 times I went through the case in my head that everything was okay. But still having that aberrant thought that everything wasn't. And the trick is to be able to identify and say, “Okay, that's a pathologic thought. It doesn't belong here.” And let it go.

HF: Yeah. Choose it. I think you had a story about a resident who had a great question for you. Do you want to tell that? That was really great.

JF: Yeah. He was a really good resident. Really, really, brilliant guy, also very low key. I don't remember what the case was, but I remember it was an emergency, it was really difficult. The patient went to the ICU and we're walking over there and I was enumerating all the things we have to watch out for. We have to check on this, we have to check on that. These bad things could happen. And I was going through all of them. He just stopped and looked at me and he said, “You think maybe just everything will be okay?” And the way he delivered it was priceless because it just hit me right full in the face. I was like, “No, actually it didn't cross my mind that everything might be okay.” And everything was okay.

I don't think, I know that we count our failures much more than we count our successes. There's definitely a negative thought bias on all of these things. Him bringing that back to that reality of, “Oh yeah. Most of the time when we do this, everything's actually okay.” It's really those smaller percentages of times when things go wrong. Putting it back into that perspective is important. I had a resident be able to do that for me. And now I try to do that more for myself.

HF: Yes. We can call that the Vince Reframe. This brings us to our next step number four, which is to get some objective feedback.

JF: Yeah. Yeah. And that can come from a lot of different places. The first place that can come from is yourself, just looking at things objectively. I have two daughters and sometimes they'll get in an argument, a fight and one of them will come to me and say, "We're always fighting. We never get along." And I have to say, they get along better than any sibling pair that I know. They have a fight. And when you're in the middle of that, they think, "Oh yeah, this is how it is all of the time."

And then I can step back and say, "Okay, well, what happened yesterday? What happened the day before that? What happened last week? What do you guys do together every weekend?" And it's all this positive stuff that you can't see at the moment. Taking a step back out from the situation that you happen to be in, getting a little bit broader perspective.

We track our complications. We track what's going on. And that gives you something that's a little bit more objective. We talked about the value of having good partners, good colleagues that can give you that feedback and things like that. I have some junior partners right now and sometimes they'll call me into a room and say, "Hey, what do you think of this?" And it's easy enough for me to just kind of take a look and say, "Yeah, that looks great." And then they've got that objective feedback.

Sometimes that's all it takes is to somebody else to look at something and say, "Yeah, that's right." Even my senior partner and I still do this to each other. We'll just walk into each other's office and talk about a real difficult case that we just had. And the other one of us says, "Yep, that's exactly what I would've done." That takes care of it. But again, it comes back to that talking. Talking to somebody.

HF: Yeah, this step number four - get objective feedback is so, so critical. They're all critical. But this one is especially because the imposter syndrome can come in here and we can really lose sight of the truth. But when I talk to physicians and I start asking them, "Well,

how are your patients doing? How are you doing in surgery? Well, well. Have you had any major issues? - Well, not really. - And how did you do in residency? - Really well." So, I start by saying, there really isn't any objective evidence for the imposter syndrome here. This would not hold up in court. It would be thrown out yesterday. But like you said, with your daughters, we can lose that perspective. And we start telling ourselves a totally different story that's not reality based.

JF: Yeah. And stepping outside yourself and trying to look at it from the outside, it's super easy when you're looking at somebody else. You're looking at somebody else, like I said, some of my junior partners will be saying, "Well I could have done this case of this better or that better" and I'm watching it going, "No, that's every bit as good as I would do it." And it's easy for me to see that from the outside, but then when it's me on the inside, it's much harder to kind of step out. Sometimes just taking that perspective of stepping outside yourself and thinking, "Okay, if I was one of my colleagues or somebody that you respect and they were saying all these things, how would you react to that?" And kind of turning it around can help.

HF: And the nice thing about medicine is there are objective criteria. This isn't like writing a poem and saying to somebody, "Well, what do you think of this poem?" That's pretty subjective. We can get very objective feedback. We can look at how we're doing compared to our peers. We can look at complications rate, we can look at how the patient does. And part of that objectivity leads us to this next step, because it also has to do what our expectations are for ourselves. We might be expecting perfectionism, which we often do. I know it's a double edge sword. This brings us to step five, which is managing expectations.

JF: Yeah, exactly. You said perfection, that's what we expect. That's what's pounded into us during residency. If we're not holding our suture at just the right angle or not in exactly the right plane, you get pounded on by your attending. And then a lot of it we internalize. And also, we talked about it, anxiety is normal. When you're taking care of

another person you want to do the best that you can do. And we start falling into a few different traps. One is that you can be perfect. Nobody's perfect. Certainly, nobody's perfect all the time. A lot of times you can't be perfect. I don't know if I'm allowed to curse here, but we have a saying sometimes that "You can't make chicken salad out of chicken shit."

All you can do is the best that you can with it. If you're given bad tissues in a bad protoplasm, and you do the best you can with it, and it doesn't come out anything like you would want it to, but you've done the best that you can. And that's a better goal, not perfection. Did everything come out exactly the way that you wanted it to, or expected it to? It's "Did you do the best that you could with what you had?" And that's a really difficult perspective to get, because we all want to be perfect. We all want to be perfect. We all want to have good outcomes. I'm a colorectal surgeon, we all want to have zero leaks, zero wound infections, and that's just not possible.

The other trap that you fall into too, is thinking that you're the only thing influencing this patient. I've seen some absolutely horrible complications come from absolutely perfect surgeries. Everything looked perfect when we were done. And something goes awry and then we're into some complications.

There's been those patients, like I said, where it's not the tissue that I want, it's not the patient that I want, it's not the situation. And you just kind of do the best that you can and you walk out of there really hard on yourself because it just didn't look like the textbook. And a lot of those people just happen to do really well.

It's not solely on you. There are other people on the care team. And we don't like to talk about this, but a lot of this ends up being random chance, strange things happen. People heal at different rates. People have different problems and things like that. And like I said, you can do the absolute perfect surgery, but if the patient has something causing a wound healing problem, no matter how perfect you make it, they're going to have a

problem. Perfection is not a good goal. Doing the best that you can, I think is a better goal.

HF: All right. That's golden. This is a really powerful reframe.

JF: Yeah. And you can't do better than your best. I've heard it said too and read it in a bunch of different places that perfectionism isn't about doing something perfect. It's about never being good enough. You could say, okay, I want to close this wound perfectly and you do it perfectly, but then maybe you see some little thing that's not perfect and you can really kind of continue to do that.

But when you really get into that trap of pathologic perfectionism, there never is a good enough. There never is a perfect. There's always something wrong when it gets out of control. And if you're setting a goal that's never achievable, you're in a really bad place. Perfectionism, when it gets this bad that you're throwing up before and after a case, it's not that you're trying to do things perfectly, it's that it's never good enough. And if you set that kind of expectation, you're going to fail. Don't be so hard on yourself.

And one of the things my partner said to me early on, I had a complication and it beat me up really badly. I talked to him about it and he said, “Look, X, Y, and Z, this wasn't your fault.” And then he followed it up and I didn't like it at the time, but he said “This wasn't your fault, but you know what? One of these times it is going to be your fault and you have to figure out how to deal with that because we all make mistakes.” We all do things that we look back on and say, “Well, I should have done it differently.”
And you have to learn how to cope with that. And I certainly didn't want to hear that at the time. I don't even like saying it right now.

But we get compared to the airline industry a lot of times with all of their checklists and zero tolerance for errors and things like that. But they're dealing with mechanical things.

There are set known parameters there. We're dealing with a person. And there are so many variables that are way out of our control. We can't expect a zero-error rate.

HF: And planes crash. Planes crash. We have to be able to have our crashes too.

JF: Yeah. And it's not something any of us want. We don't want it. We don't want to think about it, but it's a reality. And you have to accept the reality that you're doing a really hard job that most other people don't want to do. You have to kind of keep that in perspective too, that this isn't easy. The people that have been doing it,your attendings, during training, they make it look easy, but it's not. And I think we have to acknowledge that too.

HF: Absolutely. Give yourself grace.

JF: Another adage is I kind of reverse the golden rule. "Not treat others how you would like to be treated, treat yourself how you would treat somebody else." And it's certainly true. We're a lot easier and a lot more understanding with other people than we are with ourselves.

And it's really hard to give yourself a break, but you really need to do it because if you're getting into this place where you're so anxious that you can't function, that's going to hurt you and that's going to hurt everybody that you're trying to help. You really do have to give yourself a break and pretend that you are not you. Pretend that you are one of your friends from residency and what would you be saying to them after that postoperative bleed or leak or whatever. What would you be saying to somebody else that you respect? I guarantee it's a lot more kind than the things that you're saying to yourself.

HF: Exactly. Oh, that's such a great point. I love that, John. I just want to quickly review the five steps that we went through. Number one, which is to recognize that it's normal to

have anxiety and doubts. Two, find those you can talk to. Three, develop coping strategies for anxiety. Four, get objective feedback. And five, manage your expectations.

John, this has been really great. I know this is going to be really valuable for anyone really who's struggling at some point in their career. It could be a new attending, or it could be someone just having a tough time.

Thank you so much for coming on the podcast and all that you do. Good luck to you and your patients and the residents and the fellows that you help.

JF: Well, thank you for having me. I appreciate being able to talk about this.

HF: All right, guys, thanks so much for listening. I hope you found some value in this podcast. Feel free to share it if you know of anybody it could be valuable for. And don't forget to carpe that diem, and I'll see you in the next episode. Thanks, and bye for now.

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Podcast details

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