

Medical Error and 2nd Victim – The Synopsis

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Introduction

This module centres around the impact that medical errors have on the individual doctor and the healthcare team. The term “Clinical Errors” may be preferred if the discussions will include members of a multidisciplinary team, as this module applies to all members of the healthcare team.

In recent years, there has been a huge Patient Safety movement in hospitals, which whilst beneficial for patients, has had an unquantifiable impact on the wellbeing of the staff involved in these errors.

Errors are inevitable in medicine. Diseases are complex, patients do not always present in textbook fashion. Errors will always occur as all the individuals in the system are human, and humans make mistakes. Significant errors are thought to occur in up to 3% of hospital presentations in the USA. (1) No one comes to work wanting to cause harm to patients, however the reality is at some point in our career we will be involved in a medical error.

The Second Victim

The effect of medical errors on the health professionals involved ranges from feelings such as sadness, guilt, shame and fear of criticism, to helplessness, loss of self-confidence, anxiety and depression. They have shown to impact how individual clinicians practice even years later in their career. (2) The way we deal with these inevitable mistakes when they occur is important to the long-term wellbeing of our staff.

The impact of finding out that you have been involved in an adverse event can be devastating. Albert Wu coined the term “second victim” in an article in the BMJ in 2000. (3) It describes how, without the right support, it is possible for the healthcare worker to become the second victim of an error. This can have long term effects on their wellbeing and their work with future patients. If their ability to confidently diagnose and treat patients becomes affected, the next patient that they see may become the third victim. They may develop a tendency to avoid patients with similar pathology, or over-investigate to prevent missing another diagnosis. This may continue for many years into the future. They may also carry this impact home with them so that their spouse or family members become the fourth victims. To avoid this, it is important that we provide appropriate support to the staff involved in clinical errors so that they don’t go on to become victims themselves.

Support for Individuals

To mitigate the risk of an individual becoming a second victim after an adverse event, the organisation need to have an inbuilt support structure in place to support their staff during these events. Debriefing with colleagues is an effective way of dealing with the stress of a critical event or error. (4) Most Emergency departments however, do not have formal debrief structures in place to accommodate this for their staff, nor access to trained debriefers.

Debriefing after an adverse event can occur in a number of ways. (5) The team debrief or “hot debrief” which occurs immediately after the event. This proximate version of a debrief is designed to check in on all the team members and check how they have reacted to the situation. It also allows team members to vent their feelings to the group. It is a good way for the team leader to gauge whether an event has been significant enough to require a delayed and more formal debrief to occur.

The second type of debrief is the more formal delayed debrief. This may involve staff coming in at a later time and be facilitated by a trained outside provider such as a psychologist or trauma counselor. One of the goals of this module is to get you thinking about how your department manages the staff involved in critical incidents and whether you could incorporate better support for your staff in this situation.

Support for junior staff may also be necessary after relatively clinically minor adverse events. For a junior doctor, it may be devastating to find out that they have missed a fracture or made an error whilst prescribing. It is important to recognize this and provide appropriate support in the form of follow up discussions and provide the individual with an opportunity to reflect on and discuss the case with a more senior member of staff if needed.

Blame cultures vs Just Cultures

Making mistakes is essential to allow us to learn and prevent the same mistakes happening again in the future. It is how we evolve as human beings, through a repeated process of trial and error. Individuals and organisations that cover up their mistakes, lose the valuable opportunity to learn and improve. (6)

There are a number of ways that organisations respond to errors. Literature around patient safety discusses the role of blame versus no blame cultures.

An organization with a blame culture will focus on the individuals involved in an error. These organisations may attempt to analyse errors as part of the systems process but individuals will still feel singled out or blamed for their role in the events. A culture like this can be very damaging as it will discourage individuals from speaking up about potential errors in the future, thus losing the opportunity to learn, improve and prevent future mistakes.

This is the opposite to a no-blame culture, where errors are investigated are part of a complex system but there is no accountability for the individuals involved. Whilst this is psychologically safer than a blame culture, it means that there may be no accountability when an individual is acting outside the expected standards. This has been proposed by some as the preferred style for healthcare organisations to adopt, however removing professional responsibility for errors has been criticised by some as counterproductive.

An organization with a just culture, by comparison, develops a culture of trust in the process of safety investigations. Individuals are assured that any actions or omissions will not be subject to punitive or disciplinary actions, as long as they are within acceptable standards of practice. All errors will be investigated as part of the complex system and the organization will seek to identify areas for improvement in the system. The whole team will be encouraged to disclose, discuss and learn from the error that occurred. Individuals will not be singled out and will feel empowered to focus on the learning points for the error and not feel victimized.

In the area of just cultures we take our lead from the aviation industry, where errors are openly disclosed and investigated so that everyone can learn from the mistakes that occur. As a result, the airline industry has an impeccable safety record and a well-established culture of open reporting of errors. Errors are reflected upon, investigated as part of a whole system approach and the outcomes are used to learn and make improvements to avoid the same event occurring again in the future. (6)

Moving an organization from a blame culture to a just culture can be challenging. Leaders in an organization hold a key role in determining how the organization responds to errors. Some ideas for changing the culture of an organization from one of blame to one of a just culture include considering the language you use when you discuss errors, the methods employed to investigate errors and the support provided to individuals involved in an error. Creating a culture of psychological safety around error will go a long way towards changing from a blame culture to a just culture.

Personal Response to Failure

Your personal response to failure is also a factor in how you will react when involved in a medical error. For many high-achieving clinicians, failure is not something that they have had any experience dealing with, even by the time they are quite well advanced in their career. It may be possible that they have gone through their whole life, schooling and university being a high achiever and never had to encounter and deal with failure. A clinical error or adverse event may be the first time that feelings of failure have occurred for them and as such the skills required to cope with this may be lacking.

Different people see the same events in different ways. Do you know how you respond to negative feedback or failure? Exploring your personality type (eg Myers-Briggs) or response to blame (7) may assist you in understanding why

you react the way you do to failure. Self-awareness is one of the keys to managing our response to failure.

The medical profession is over-represented with individuals with Type A personality traits and a tendency towards perfectionism. This may be seen as a positive personality trait by those who exhibit these qualities, however perfectionism is not always positive. Perfectionists set impossibly high, and often unattainable standards for themselves. In many ways, this makes them even more vulnerable to failure as they can never reach their own self-imposed high standards. Perfectionists tend to be fearful of failure and worry more than most about the possibility of making mistakes. They are also motivated by a strong sense of duty and obligation making them more vulnerable when they do make a mistake. Perfectionists with self-critical tendencies are more likely to suffer from depression, anxiety and guilt regarding their failures.

Personal Strategies for Dealing with Failure

A number of cognitive strategies may be helpful for learning to deal with failure.

Positive psychology is a method where refocusing thoughts on positive aspects rather than dwelling on negative aspects is thought to be beneficial to wellbeing. It is explored in more detail in WRaP Module 3 – Positive Psychology.

Optimism is a protective trait when it comes to dealing with adverse events. Those individuals with optimistic tendencies tend to see things as the glass being half full rather than half empty. Those with optimistic tendencies are less likely to blame themselves for adverse events and more likely to be able to see events from a different perspective. Changing your preferred style to be more optimistic is possible and some cognitive strategies such as cognitive restructuring & thought reframing may be helpful.

Thought reframing is the idea that whenever a negative thought enters your head regarding a situation, that you are able to “reframe” it into a more positive thought. For example let’s use the case of a patient that has died in the ED from a traumatic cardiac arrest. Negative thoughts may occur such as “I failed as a doctor as I did not have the skills to successfully resuscitate the patient.” Reframing this thought may look more like, “The patient came in with a non-survivable injury and the team did everything we could to try and save them.” There is a Cognitive Restructuring worksheet in the resources section for this module which is from the website Mind Tools that may be useful to help individuals work through this process regarding an event.

Acceptance - We need to accept that failure is a constant. No matter how hard we study, how skilled we are at our jobs, how diligently we work, we will all experience adverse events with our patients. Failure should be seen as an opportunity to learn and improve rather than a reflection of how we are as a person/doctor. Failure is not a bad thing if it drives growth and improvement both personally and for the health system. Accepting failure is important in being able to move on from failure when it occurs.

Self-compassion – Being kind to yourself and forgiving yourself when you make a mistake is important in the ability to move on from an adverse event.

Identity - Many doctors derive a strong sense of identity from their role. When failure occurs in this role, the individual may feel like a failure as a person, if they do not have a strong identity as a person outside of medicine. It is important to take the time to develop this self-worth outside of medicine by being involved in other projects and hobbies that are not work-related. “If Medicine is your major, you need to have something else as your minor”. This is important so that your entire identity is not wrapped up in your role as a doctor. It allows you, when failure occurs, to still see yourself as successful as a person as you have interests outside of your role as a doctor. It is immensely important to separate failure from your identity and not let it define you.

Growth Mindset

A growth mindset is described as when one can openly admit to one’s mistakes and see them not as failure but as a way to learn and improve. Mistakes that are covered up or not analysed in detail do not allow us the opportunity to grow from them. This is discussed very nicely in the book “Blackbox Thinking” by Matthew Syed. (6) He gives multiple examples from industries such as aviation and manufacturing (Dyson vacuum cleaners) to highlight the need for a growth mindset. Encouraging your junior staff to develop a growth mindset can be protective for the individual when they are faced with dealing with a medical error.

Carol Dweck covers the difference between a fixed mindset and a growth mindset in the book “Mindset” (8) and in her TED talk “The Power of Believing that you can improve”. (9) The link to this talk is provided in the resources folder.

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