WR P | EM
Wellness Resilience and Performance

Medical Error and 2nd Victim

Case Studies – Facilitator Version

The following case studies discuss clinical errors involving junior doctors. These cases may be used as an activity to supplement learning around medical error, second victim or critical incident debriefing.

The suggestion is that participants will divide into groups of 3.

- 1 person to role play the junior doctor
- 1 person to role play the debriefer (a more senior doctor)
- 1 person to observe and give feedback on the debriefing

Case Study 1 (15 minutes)

James/Jenny is a junior doctor who was involved in a clinical error on a recent night shift. They looked after a 42-year-old male patient with abdominal pain who presented in the middle of the night.

The patient was diagnosed with gastroenteritis and sent home with antiemetics. 14 hrs later the patient represented looking unwell with fevers and worsening abdominal pain. The patient underwent a CT scan and was diagnosed with a perforated appendix. An urgent appendicectomy was then performed. The patient is now recovering on the surgical ward with a prolonged course of antibiotics for sepsis.

James/Jenny has returned to work this evening for their night shift and was informed of the outcome by another junior doctor. They have become upset.

Your task is to meet with James/Jenny and debrief them regarding the case.

Additional Information for Role Player: (James/Jenny)

You are playing the role of James/Jenny, a PGY2 doctor who is on rotation to the Emergency Department. You have not had much experience assessing patients with abdominal pain as you did your surgical rotation on the Orthopaedic ward.

You saw the 42-year-old male patient 2 nights ago. He complained of cramping central abdominal pain for the previous 8 hours. He was still able to work in his job as a teacher but did not eat dinner as he felt nauseated. He had opened his bowels during his ED visit and they were described as loose. He did not have a documented fever. On examination he just had generalised abdominal tenderness in the lower part of his abdomen but not localized to the right. You diagnosed him with gastroenteritis and sent him home with a script for

Metoclopramide. You did not discuss the case with the Senior doctor on overnight as they were very busy with a sick patient in the Resus area and told you to come back later. It was getting late so you sent the patient home.

You are very upset to have discovered that he actually had appendicitis. You will ask what you should have done differently. You are concerned that you are going to fail your term as a result of this error. You have a supportive family but live alone. You do not have many friends in ED as you are only on rotation for 8 weeks. You will be receptive to an offer of some time off work and support from a mentor or supervisor.

Debriefing Points for Facilitator:
This is a case of misdiagnosis or delay to diagnosis by a junior doctor with minimal experience. It may raise the issue of errors of clinical reasoning such as early closure, anchoring bias and confirmation bias.
It also raises the issue of lack of supervision on night shifts.
There may also be systems issues involved such as lack of availability of imaging overnight.
The junior doctor is likely to feel vulnerable as this may be their first clinical error. They should be offered to discuss their version of the events that occurred and be supported in raising any departmental or systems issues that they feel may have contributed to the events.
The debriefing interaction should have a strongly supportive tone, and avoid one of blame towards the junior doctor. Follow up support should be offered including time off work (if required), further debriefing with a supervisor or mentor, education sessions about assessment of abdominal pain, advice about how to access better supervision.

Case Study 2 (15 minutes)

Sam/Sarah is a Registrar in your department who has just performed a central venous line insertion on a patient with sepsis. This was required for commencement of inotropes. The patient was too unwell to consent for the procedure and verbal consent was obtained from the next of kin for the procedure.

During insertion of the line in the Subclavian vein, the patient sustained a pneumothorax. This subsequently caused the patient to deteriorate due to a tension pneumothorax. The patient is now stable after insertion of an intercostal catheter and has been transferred safely to the ICU.

The Registrar has become upset after returning from ICU as they felt the ICU staff were critical of their choice of the Subclavian vein as the site of insertion. They have asked you to debrief them regarding the events.

Your task is to meet with Sam/Sarah and debrief them regarding the case.

Additional Information for Role Player: (James/Jenny)
You are Sam/Sarah, an experienced ED trainee in your last year of training. You are preparing for your Fellowship exams at present and are feeling the pressure to perform. You are not tired or having any personal issues at present.
You inserted the CVL as described above. You have performed lots of these procedures during your critical care term and feel comfortable that this one was performed using the correct technique. You have never caused a pneumothorax before although you are aware that this is a known complication of this route of insertion. You routinely discuss this with patients during the consent process but in this case did not as it was over the phone and the patient's relative did not seem to be listening to what you were discussing as they were keen to go up to ED as soon as possible.

You feel bad that you caused a complication and are dreading telling the family when they arrive. You are also upset that you didn't recognize the tension pneumothorax right away and that your supervising consultant was the one to recognize this when the patient deteriorated. You became upset after the staff in ICU criticized your decision to use the Subclavian route for insertion of the CVL, and that you heard them comment that "ED doctors are so bad at this stuff".

You will be reassured if the debriefer reinforces that this is an expected complication and not your fault. You will not want any time of work, you would prefer to just get on with it. You have a mentor and are happy to meet with them to discuss this further after your shift.

Debriefing Points for Facilitator:
This is a case of a predictable complication of a high risk procedure without obvious error. The Registrar has some experience in this procedure & is not a novice but handled poorly this event may cause them to lose confidence in themselves and their procedural skills. The debrief should be handled in a way that normalizes, but does not minimize the significance of the adverse event. The Registrar should be given a chance to vent about their concerns about the case & the interaction with ICU staff. They should be shown support in the form of time off work if required, follow-up meetings, support from a supervisor or mentor and the chance to regain their confidence with the procedure by assisted practice if required. The tone of the debrief should avoid blame and be supportive towards the distressed Registrar.