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CORE TRAINING FOR DOCTORS

Edited by Dr Daniel JB Marks, Academic Clinical Fellow in Translational Medicine, and **Dr Philip J Smith,** Academic Clinical Fellow and Specialist Registrar in Gastroenterology, University College London

Medical error: the second victim

Case study

David, a CT2 doctor in accident and emergency, forgot to check for allergies before prescribing Mr Smith penicillin for his tonsillitis. Mr Smith had an anaphylactic reaction. Later that day, he died. David was distraught. With a consultant, he explained what happened to Mr Smith's family, and apologised. Afterwards, the consultant stopped letting David assist on complicated procedures. David lost his confidence and kept ruminating on his role in Mr Smith's death. He tried to tell the other trainees how the incident had affected him, but they kept minimizing the importance of the incident, so he felt obliged to pretend he was fine.

David was required to testify at a fatal accident inquiry, which terrified him and made him feel like a criminal. He stopped being able to sleep, felt constantly anxious, and found himself becoming distracted, absent-minded and scared when treating other patients. He ended up making another error and that night he took an overdose of sleeping pills.

Introduction

It is a fact that of the millions of medical errors that occur in health care each year, many result in major harm or even death to patients (Institute of Medicine, 1999; Department of Health, 2000). However, in focusing on these patients and their families, it is easy to brush over the major harm these errors simultaneously cause to the doctors, nurses and others who are involved in the incidents, and who might have reason to consider themselves in some way responsible.

That is why it is important to be aware that for every serious patient safety incident, there are at least two victims (Wu, 2000). Through their involvement or even simply their proximity, doctors often go through very similar series of reactions to the patients, or their families, as the second victims of the incident (Scott et al, 2009).

While there are often standard protocols in place regarding how to manage patients and families following a patient safety incident, it is usually far less clear how to help these second victims, who might need just as much support (Wu and Steckleberg, 2012). This is particularly true in the context of a medical culture that demands a stiff upper lip. And while any health worker can easily become the second victim of a patient safety incident, core trainees are particularly vulnerable because they are still developing not just their clinical skills but also their confidence and professional identity (Kronman et al, 2011).

The Hippocratic Oath compels doctors to 'do no harm', and the belief that you have done harm to the very person who needed your help can naturally have short- and long-term emotional and behavioural effects for any doctor who cares about his or her patients.

The effects of becoming a second victim

In the short term, after an incident that harms a patient, many doctors experience an acute stress reaction. This can manifest with anxiety and depression, feeling numb, having insomnia, restlessness, poor concentration, memory disturbances, and harbouring a fear of disclosing the error to the patient or family, or a dread of medicolegal repercussions. They may also experience associated physical symptoms such as sweating, palpitations,and tremor. They may feel shame, guilt, self-doubt, anger, and fear that they have lost the trust and respect of their colleagues (Wu and Steckleberg, 2012).

In other situations, people usually use coping strategies to get through this, such as avoiding talking or thinking about the incident, or avoiding reminders of the incident, enabling denial (Gelder et al, 2006). However, in a clinical context, this option is often rendered impossible as doctors may

Dr Layla McCay *is Visiting Scholar, Johns Hopkins Bloomberg School of Public Health and* **Professor Albert W Wu** *is Professor of Health Policy and Management and Director, Center for Health Services and Outcomes Research, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD 21205*

Correspondence to: Professor AW Wu (awu@jhsph.edu)

need to return to the scene of the incident every day, or repeatedly treat similar patients. There may not even be time to discuss the incident or to make sense of it (Kenney and van Pelt, 2005), and when an incident becomes secret or stigmatized, it becomes harder for doctors to achieve closure.

A doctor who has become a second victim may find that his or her professional performance is impacted. The doctor may struggle to focus on duties, fight self-doubt, and worry about colleagues talking behind his or her back, all the while trying to maintain professional confidence (Wu et al, 2008). Performance and professional competence may actually be impaired, as a result of problems with concentration and memory, internalizing perceived judgments by colleagues, and trying to suppress and avoid memories of the incident. Ironically, this may increase the risk of additional errors (Gawande, 2007).

These effects can last for days to weeks, and often resolve, particularly if the second victim is able to confide in a trusted colleague or friend. However, in a busy clinical environment, there is often little time for coming to terms with the situation. There is the risk that the experience can become a chronic stressor, and progress to symptoms typical of post-traumatic stress disorder, such as flashbacks, nightmares, memory problems and irritability (Waterman et al, 2007). In extreme cases, this can affect personal and professional relationships and lead to good doctors leaving medicine, or even committing suicide.

What's the problem: how second victims can fall into a downward spiral

A lack of institutional awareness of the issue of second victims, and insufficient structures and support networks in place, can make the difference between a doctor processing the incident and returning healthily to work, and the same doctor being unable to do so.

Second victims need both informational and emotional support after these incidents. They need to understand what happened and how they were involved. They also need to be comforted and reassured and for their suffering to be acknowledged. However, very few health-care facilities have formal mechanisms to help doctors manage their reactions after a patient is harmed.

Staff assistance programmes often focus primarily on issues such as substance abuse, and there is often stigma around accessing mental health services, and a taboo around discussing mental health problems. Anecdotally, health-care staff are either not aware of services that exist or are disinclined to use them. This leads to second victims often relying on informal support networks.

This can sometimes work well. However, not everyone has a readily available network of supportive individuals. In addition, untrained members of informal support networks may be unable to deliver what the distressed doctor needs. Doctors attempting to provide support to colleagues may find it awkward or difficult to address the issue, and might knowingly or subconsciously try to discourage second victims from talking about it: discussing what went wrong exposes the human fallibility that health-care culture often colludes to deny.

The tendency to label errors as the fault of one person may help provide reassurance to the others, but it only leads to the second victim feeling stigmatized and punished. Similarly, unsympathetic responses from colleagues may exacerbate shame, guilt, self-doubt and stigma, as can the subsequent investigation that can make the second victim feel as though he/she is on trial for a crime rather than being supported as someone who has undergone a traumatic experience (Wu and Steckleberg, 2012). Neither the system nor the culture in health care is typically set up to support second victims, despite the high numbers of doctors, nurses and other health-care workers that have been affected.

What you can do: as a colleague of a second victim

It is virtually inevitable that you will observe a colleague who, after a traumatic patient incident, is suffering as a second victim. There are positive steps that you or any hospital worker can take as the colleague of a second victim. You may be one of the first responders to your colleague's distress, and you can ensure you are prepared to deliver the psychological first aid he/she needs after a patient safety incident where he/she was involved in a patient being harmed (Wu et al, 2008):

- Actively seek out your colleague to ask how he or she is feeling and provide comfort, counsel and reassurance
- Encourage your colleague to talk about what happened openly and honestly, in as much detail as he/she wants
- Acknowledge the importance of the incident and do not try to minimize it
- Be empathic, and perhaps share stories of similar situations you have experienced
- Acknowledge how difficult it can be to live with mistakes
- Provide professional reaffirmation and reassurance
- Help to deter any stigma or condemnation by colleagues
- Help your colleague find the information he/she needs about the details of the incident, related medicolegal processes and professional sources of support
- Continue asking your colleague how he/she is doing after the incident.

What you can do: as a second victim

All practicing physicians make mistakes, and adverse patient outcomes are common in hospitals and other health-care settings. Thus, it is probable that sometime in your career you may find yourself emotionally traumatized by a patient-related event. After an incident, you will likely have a wave of emotions. Remember that it is normal to react emotionally to a traumatic incident, and that it has happened to many of your friends and colleagues. It is a sign that you care about your patients. But you can take some steps to ensure that you are able to deal with your response and be effective in your work and relationships.

After a patient safety incident where a patient is harmed, you should organize your actions into three categories (Wu et al, 2008):

Practical actions required

- Think about how to honestly and openly disclose the incident to the patient or his/her family in a timely manner, and apologise to them as appropriate for any errors (NHS National Patient Safety Agency, 2009); seek support as required to do this
- Ensure you have fully documented the incident, as your defence mechanisms will kick in and you may find it difficult to remember in detail later
- Contact your hospital risk manager (or ensure a colleague has done so) to ensure the necessary processes are in place

- Contact your defence union and ensure you have medicolegal advice and support as required.

Peer support

- Find trusted peers or colleagues as soon as you can and talk through what happened and your emotional responses to it
- Remember that things do not always hit you immediately – keep up the dialogue with your trusted peers or colleagues in the coming days or weeks
- Do not try to minimize the incident and its impact on you when you are talking about it
- Try to accept your peers' support and reassurance
- Seek professional reassurance from senior colleagues you respect.

Formal support

- Find out as soon as possible whether your health-care facility has any support services to help staff cope with the emotional repercussions of injuries caused by medical care
- Look into expressive writing programmes – these have been shown by numerous randomized controlled trials to improve doctors' physical and mental functioning after patients have been harmed by medical care (Frisinia et al, 2004; Frattori, 2006; Sexton et al, 2009). Expressive writing programmes involve 20–30-minute sessions repeated three or four times, where you write about your deepest thoughts and feelings about an event to bring cognitive structure and organization to your thoughts, reduce rumination, and improve your memory and emotional regulation
- If your symptoms persist, you should consider seeking help from a trained counsellor or psychotherapist.

Case study

Oliver, a surgical CT1, obtained informed consent to perform a partial liver resection on James, a 30-year-old with a benign hepatic tumour. He assured James that the consultant surgeon has a great deal of experience with this kind of problem, and said to him 'see you in a couple of hours'. In the operating theatre, during the surgery, the patient began to bleed profusely from multiple sites. He received dozens of units of blood, but ultimately exsanguinated, suffered a cardiac arrest and died. Oliver felt numb. After he left the operating theatre he was barely able to speak to the scrub nurse who attempted to comfort him. He walked straight upstairs to the office of his surgical mentor, Peter, who welcomed him in. Peter listened empathetically to Oliver describe his disbelief at what had just transpired, saying 'you must feel like someone unexpected punched you in the stomach'. They discussed different elements of the case to try to figure out what went wrong.

Later Peter described a case from early in his career in which a young patient died unexpectedly on the operating table. Oliver was given the rest of the day off, and went to speak to a staff psychologist, who told him his reactions were normal and expected. Oliver was able to go back to work the next day, although he thought about the case every day for weeks to come.

Conclusions

Anyone working in health care can become the second victim of a patient safety incident, and at some time or another, most probably have. Acknowledging that traumatic incidents are very likely to have an emotional effect on you and your colleagues, and ensuring good support to help each other through it, are key to ensuring you cope and are able to learn and move on. BJHM

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KEY POINTS

- When medical errors harm patients, they also harm the health workers involved, making them the 'second victims' of the error.
- Any health worker can become the second victim of a patient safety incident, but core trainees are particularly vulnerable.
- Becoming a second victim can impact on you psychologically, physically and professionally, and can harm subsequent patients.
- You can support colleagues who are second victims by being empathetic, acknowledging the importance and personal impact of the incident, encouraging them to talk about it, sharing your own experiences and providing reassurance.
- If you become a second victim, you can help yourself by talking honestly about the incident and its impact on you with trusted peers or colleagues.