Supporting the ‘second victim’ after a medical error

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The consequences of a medical error are likely to provoke feelings of guilt and intense emotional distress in the ‘second victim’ – the clinician. Roger Kirby outlines some strategies to help the doctor cope and explains how colleagues can provide support by sharing the experience in a constructive and analytical way.

Talking to colleagues about the experience of medical error can play a critical role in dealing with the issues ("Mark Thomas/Science Photo Library")

In other walks of life, if an individual is injured as the result of an error or accident, for example in a road traffic or industrial accident, financial compensation follows, which serves to assuage the culprit’s guilt. By contrast, when a doctor makes a serious mistake that results in harm to a patient, a complex series of events ensues: complaints are received, experts opine, coroners enquire, judges adjudicate and regulators investigate any indications of impaired fitness to practise. All of this may occur over a very protracted period of time.

Unfortunately, there is very often a culture of blame that focuses all the attention on the individual clinician and ignores the ‘error chain’ and corporate failings that often pave the way to the eventual fatal mistake. Doctors often find it difficult to be open and reflective in this situation, with the consequence that the opportunity to evaluate and analyse the error constructively is lost, and the likelihood of a repetition thereby increased.

IMPACT OF MEDICAL ERROR ON THE CLINICIAN

There is now an increasing appreciation of the impact of error on the so-called ‘second victim’ – the clinician himself (or herself) – and calls for those involved in training to recognise this in their curricula. However senior the doctor, a medical error is likely to provoke feelings of guilt and intense emotional distress. Commonly this manifests itself as self-doubt, confusion, fear, remorse and feelings of failure. These naturally significantly increase the risk of burn-out and depression. Worryingly, evidence suggests that a continuous cycle of these symptoms is followed by an increased risk of suboptimal patient care and error. The emotional response to medical error has been described as coming in four distinct phases. The initial ‘kick’ on realisation involves feelings of failure, with associated physiological effects such as nausea and tachycardia. This is followed by the ‘fall’ of spiralling feelings of self-doubt. The next phase is the ‘recovery’: this is where the individual most needs the

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support of family and friends, but often there is a reluctance to share the distress for fear of losing face and reputation. The final ‘long-term impact phase’ can be prolonged and significantly affect a doctor’s personal and professional identity. Some clinicians have described ‘a piece of one’s self being taken away with every complication’.

Individually, many doctors have coped with these issues by means of three classic strategies: first, denial (‘that wasn’t an error’); second, discounting (‘it was somebody else’s fault’); and third, distancing (‘we all make mistakes’). More constructively, sharing the experience by talking and listening to colleagues talk about the issues seems to play a critical role in dealing with the experience of error and drawing constructive lessons from it.

RESPONSE TO MEDICAL ERROR

So what should be the correct response to a medical mistake leading to serious harm or even death of a patient? First and foremost, absolute honesty about the circumstances surrounding the case is paramount. There is of course a natural temptation to mitigate the situation by adding to or adjusting the notes or to conceal some incriminatory fact or detail. This must be resisted because doctors are expected by the GMC and law courts to exhibit absolute probity. In the tragic case of David Sellu, discussed in the ‘First Word’ section of this issue of Trends, a perceived lack of candour about the instruction to prescribe antibiotics must have counted heavily against him, and may crucially have made the difference between a suspended and a custodial sentence.

Second, a full and complete investigation of the circumstances surrounding the case should be instituted, usually by an impartial third party. A fulsome apology and explanation to the patient, as well as to his or her relatives, can often go a long way in avoiding lengthy, tedious and expensive litigation.

Third, lessons need to be learned, not only by the individual doctor, but also by the entire medical and paramedical team. Sharing difficult experiences in a constructive and analytical way can go a long way to assuage feelings of guilt and inadequacy, and the ensuing discussion can be highly educational. Morbidity and mortality meetings are an excellent venue in which this can be achieved, providing that they are not too negative or judgmental. Very often, patients and relatives will say that their main concern is to ensure that lessons are learned so that others will not have to go through what they did.

REDUCING THE RISK OF ERROR

No doctor comes in to work in the morning intending to do harm to a patient, but sadly mistakes do, and always will, happen. Reducing the risk of error by developing a careful, cross-checking mentality, and preparing yourself mentally for disaster when it does occur, is one positive way ahead. Discussing the possibility of things going wrong and simulating a response when they do with the team you work with is often valuable. Most importantly, actively supporting any colleague emotionally when they are involved in a medical error scenario is now part and parcel of being a successful clinician.

REFERENCES