Supporting the Second Victim

Given the significant impact involvement in an error can have on an individual emergency physician, interventions aimed at minimising the distress and harm are vital. Prevention of the error in the first place is the preferred option but once an error has occurred there are a number of steps that are known to limit the impact on the doctor[17].

	Recommendations – For Individuals
1	Clinicians should understand that the need for support after an error is normal. It is a common coping strategy to talk to colleagues, family or close friends[8, 18].
2	It is important to avoid counterproductive or maladaptive behaviours following an error such as emotional repression, avoidance of patients and defensive medical practice, which are unlikely to benefit patients or the doctor[8, 15].
3	Additional qualitative data suggest that talking to the patient about the error (disclosure), and apology when appropriate, to patients represents an important and positive step toward resolution for both patients and staff after a medical error [19-21].
4	The use of reflective notes should be encouraged. It offers an opportunity for the individual doctor to review what has happened, how it happened and how future practise or behaviour needs to change in order to avoid or reduce the risk of error in future.
	Recommendations for Senior Teams within the ED
5	Identify an experienced, respected colleague who has the appropriate listening and supportive skills, to support the doctors through the process of disclosure, investigation and implementation of any recommendations. The length of time support is required will vary.
6	An appropriate and just culture needs to be developed within the department. One where all staff appreciate that risk and error can occur within the practise of emergency medicine and will result in distress for all involved. Individuals involved in an error need to be willing to report and discuss any error and feel confident and safe in doing so whilst their colleagues should understand the need to share in any learning and avoid malicious gossip.
7	Formal arenas for discussion, such as mortality and morbidity meetings, need to be framed so that they facilitate the detailed analysis and honest evaluation of error rather than be a source of humiliation and blame. They should offer an opportunity for senior staff to act as role models in discussing their own errors or poor outcomes.
8	Senior teams should ensure staff are aware of what happens following an error or incident; the institutional processes used for investigation, such as root cause analysis or face to face interviews, should be widely understood.
9	Local faculty should implement training as outlined in the curriculum in patient safety and the management of risk and error at all levels of medical training. Each incident should be used as an opportunity for learning.