The College of Emergency Medicine

Supporting the Second Victim

Safer Care

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Summary

Second victims are health care providers who are involved in an unanticipated adverse patient event, in a medical error and /or become victims in the sense that they are traumatised by the event[1]. Key actions to support a second victim include:

- The physician involved should be encouraged to talk, discuss and reflect on events
- Assign an experienced colleague who is a good listener to support involved staff to discuss, reflect and learn
- Ensure your department's culture is one where incident reporting is encouraged and learning gained
- Train all senior staff to support others

Background

Second victims are health care providers who are involved in an unanticipated adverse patient event, in a medical error and /or become victims in the sense that they are traumatised by the event[1]. Despite this term being first coined in 2000 by Professor Wu of John Hopkins[2] it is only in recent years that those responsible for training and managing doctors are actively establishing processes to support staff involved in critical incidents that cause harm to their patient.

The emotional distress caused as a result of involvement in a medical error is obvious and support for these individuals is clearly required but there is anecdotal evidence that currently this need is largely unmet. This document aims to set out the College's recommendations for supporting emergency physicians who find themselves involved in an error as part of their work.

Why it is important?

Whilst the data about the frequency of medical errors amongst consultants is limited, 92% of surveyed doctors in one study reported that they had been involved with a near miss or error[3]. In contrast the reported frequency of self-defined errors by doctors in training varies between 18-47%, with many reporting more than one error[4-7].

Physicians reported that their anxiety about potential for error increased after being involved. Such involvement also negatively affected their confidence in their abilities as a physician, ability to sleep, job satisfaction, and professional reputation. Eighty-one percent of physicians reported experiencing at least one of these symptoms after an incident[3].

Evidence suggests that trainees are even more profoundly affected and elicit intense emotional responses and much personal distress. Poor patient outcomes and greater perceived responsibility are associated with a more severe reaction[8]. Remorse, anger, frustration, fear, guilt, embarrassment are commonly reported[5, 9-11]. These effects can be long lasting with some doctors feeling permanently affected as a result[1,5,12,14,15,16]. Doctors reporting involvement in errors had significant adverse association with overall quality of life, all three domains of burnout (emotional exhaustion, depersonalisation and personal accomplishment) and an increased likelihood of screening positive for depression[7]. Furthermore, an increase in depersonalisation and emotional exhaustion score was associated with an increase in the odds of reporting an error in the subsequent 3 months.

Doctors in training are an important and vulnerable group whose first experiences with medical error may shape their future practice and skill in coping with stressful situations. It is known that a doctor's future behaviour and response to critical incidents and error is based on behaviours learnt early in their professional practice[9, 10]. As such, any planned intervention and training that enables doctors in training to cope effectively with incidents associated with medical error will have significant implications for these individuals and positively impact on the NHS.

Recommendations

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].

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.

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.

Conclusion

Any framework developed to support staff must include strategies that ensure the provision of emotional support whilst also promoting the health of the doctor and allowing them to learn from the error. It is likely solutions at a number of different levels within the health system are necessary to create the appropriate culture that cares for the second victim. These levels will include the clinical area, the wider organisation within which the doctor works, specialty national training programmes for trainees, regulatory bodies and the NHS as a whole.

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