Second victims of clinical incidents and errors

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Please respect the confidentiality of the patients, families and staff discussed in this presentation
Winchester, Christmas 2007......
....by 4pm, Christmas Eve
Two previously healthy new mothers who had delivered in our Maternity Unit in the last 48 hours had died;

- One (apparently) from Group A Streptococcus (GAS) infection
- The second not obviously related at this stage but……???
Context

• 2,500 deliveries annually
  – Above average ratings, well-regarded locally
  – The last maternal death had been in 1996
• There was a recent increase in GAS infection locally
• (In the UK, from 2006 to 2008 there were 13 maternal deaths linked to GAS)
Context 2

• An organization in transition
  – New CEO, first post
  – New Chairman
  – Several Board and executive team vacancies
  – As MD I was one of the few executives who had been there more than a year

• Christmas Holidays
As MD, my immediate concerns...

• Could this really be as bad as it seems?
  – How could the cases be linked?
  – Could there be ongoing risk to other patients?
  – Are staff implicated?
  – What do we do now?
Subsequently:

- Both deaths due to GAS
- No further deaths
- Independent inquiry
- Coroner’s investigation
- The story became public on 4\textsuperscript{th} January
  - BBC Radio 4, TV
  - Daily Mail, Sun, Mirror etc
  - Abusive blogs, e mails etc
18 months later...
Inquests May 2009

- No route of transmission was established
- We were found to have deficiencies, but to have done everything which could reasonably be expected to investigate
- We were commended for our approach by the Coroner and the families’ legal teams
- The media gave us reasonable reports
- We put the report on the internet
(http://www.wehct.nhs.uk/index/ournews.htm?newsid=9231)
What went well*

• Assuming the worst
• Taking control early and being decisive
• Being seen at the front line
• Managing other senior leaders
• Developing and following a crisis management plan

*...considering the tragic circumstances for 2 families
What went well

• Being open
• Patient and family support
• A proactive media strategy
• Media training
What could have been better

• Having a plan in advance
• Our capacity to respond was stretched;
  – An inexperienced leadership team in transition
  – Christmas
• Staff support
Staff

• I didn’t adequately recognise the trauma for staff at all levels;
  – Frontline
  – Senior clinical leaders
  – Organisational leaders

• This was aggravated by the prolonged investigation and external publicity
Staff support

• Like most clinicians, I had experienced the “second victim” role before..
• …but was not really aware of systematic work in this area
• For me, it felt very personal (which probably impaired my ability to recognise and respond to others)
IHI experience

• IHI regularly get asked to help organisations across the US facing similar crises
• A framework for response has been developed drawn from this experience and from the business literature
• 75% of required actions are predictable and can be planned for
IHI experience

Most organisations;

– Don’t plan
– Regard each crisis as unique
– Make matters worse by their response
– Don’t learn
Respectful Management of Serious Clinical Adverse Events

What’s Your Crisis Management Plan?

www.ihi.org
Priorities in this order

1. Patients and families
2. Staff
3. The organisation
Medical error: the second victim

The doctor who makes the mistake needs help too

When I was a house officer another resident failed to identify the electrocardiographic signs of the pericardial tamponade that would rush the patient to the operating room late that night. The news spread rapidly, the case tried repeatedly before an incredulous jury of peers, who returned a summary judgment of incompetence. I was dismayed by the lack of sympathy and wondered secretly if I could have made the same mistake—and, like the hapless resident, become the second victim of the error.

Strangely, there is no place for mistakes in modern medicine. Society has entrusted physicians with the burden of understanding and dealing with illness. Although it is often said that “doctors are only human,” technological wonders, the apparent precision of laboratory tests, and innovations that present tangible images of illness have in fact created an expectation of perfection. Patients, who have an understandable need to consider their doctors infallible, have colluded with doctors to deny the existence of error. Hospitals react to every error as an anomaly, for which the solution is to ferret out and blame an individual, with a promise that “it will never happen again.” Paradoxically, this approach has diverted attention from the kind of systematic improvements that could decrease errors. Many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster. And, although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims.

Virtually every practitioner knows the sickening realisation of making a bad mistake. You feel singled out and exposed—seized by the instinct to see if anyone has noticed. You agonise about what to do, whether to tell anyone, what to say. Later, the event replays itself over and over in your mind. You question your competence but fear being discovered. You know you should confess, but dread the prospect of potential punishment and of the patient’s anger. You may become overly attentive to the patient or family, lamenting the failure to do so earlier and, if you haven’t told them, wondering if they know.1-3

Sadly, the kind of unconditional sympathy and support that are really needed are rarely forthcoming. While there is a norm of not criticising,4 reassurance from colleagues is often grudging or qualified. One reason may be that learning of the failings of others allows physicians to divest their own past errors among

Wu, Albert. BMJ 18/03/2000
Second victim

• Healthcare providers involved in unanticipated medical errors or adverse events who feel traumatised by their experiences
• They frequently feel personal responsibility for the patient outcome
• May feel as though they have failed the patient

Scott 2009; Qual & Saf in Healthcare; 18; 325-30
Second victim effects

Acute stress reactions (days to weeks)

– Numbness, anxiety, sleep disturbance, grief, detachment, loss of trust, lack of concentration, poor memory

Longer term effects

– Shame, guilt, anger, self-doubt, flashbacks, irritability (similar to PTSD?), depression, behavioural change, drug and alcohol abuse etc
Severity of effects related to...

- The severity of the incident
- The characteristics of the patient
- The attitude of clinical colleagues
- The conduct of the enquiry
- Legal proceedings
- The relationship with the patient
Prevalence

Estimates between 7 and 40% of medical incidents, depending on:

– Severity of incident
– Organisational responses
– Support mechanisms
– Professional and organisational culture
– Willingness of individuals to report
Consequences

- Patient safety risks
  - Immediate aftermath
  - Longer term consequences for safety culture, openness, team-working, defensive practice, disruptive behaviour, working relationships etc

- Staff health, welfare, recruitment & retention
Trajectory of recovery (Scott 2009)

Chaos & accident response → Intrusive reflections → Restoring personal integrity

Obtaining emotional first aid → Enduring the inquisition

6. Moving on

Dropping out → Surviving → Thriving
Survey of RCP Fellows & Members 2013*

- 1755 responses
- 37% female
- Mean age 47 years
- All parts of UK
- All medical specialties
- Broadly fits the profile of NHS consultant physicians

*unpublished data
# Psychological effects of involvement in a safety incident

<table>
<thead>
<tr>
<th>Outcome</th>
<th>%</th>
<th>N</th>
</tr>
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<tbody>
<tr>
<td>Lower confidence in ability as a doctor</td>
<td>63.2</td>
<td>886</td>
</tr>
<tr>
<td>Difficulty sleeping</td>
<td>59.9</td>
<td>840</td>
</tr>
<tr>
<td>Reduced job satisfaction</td>
<td>48.5</td>
<td>681</td>
</tr>
<tr>
<td>Affected relationships with colleagues</td>
<td>25.5</td>
<td>358</td>
</tr>
<tr>
<td>Damaged professional reputation</td>
<td>20.1</td>
<td>282</td>
</tr>
<tr>
<td>Other personal or professional outcomes</td>
<td>15.8</td>
<td>221</td>
</tr>
<tr>
<td>Anxious about potential for future errors</td>
<td>81.5</td>
<td>1192</td>
</tr>
<tr>
<td>Generally distressed (e.g. depressed, upset, angry)</td>
<td>73.6</td>
<td>1077</td>
</tr>
<tr>
<td>Generally anxious (e.g. nervous, panicky, tense)</td>
<td>68.5</td>
<td>995</td>
</tr>
<tr>
<td>Negative towards yourself (e.g. shame, guilt, feeling incompetent)</td>
<td>27.3</td>
<td>399</td>
</tr>
<tr>
<td>More confident in your abilities (e.g. effective, efficient, competent)</td>
<td>7.5</td>
<td>110</td>
</tr>
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| Determined to improve (e.g. determined, resourceful, strong)            | 80.6  | 1179  

8% reported severe feelings of distress
4% reported severe anxiety
Sources of support

• Formal mentor 5.5%
• Family and friends 66%
• Peers 85%

84% had supported a colleague and 87% said they would use a formal mentor if they had one
Incident reporting

- 80% had used NHS incident reporting systems
- 28% were satisfied with the way it had been dealt with
- 25% admitted being involved in an incident which they knew they should have reported, but didn’t
What can we do?

As leaders and professional bodies
As organisations
As individuals
  – The second victim
  – Colleagues
“Abandon blame as a tool and trust the goodwill and good intentions of the staff”
As leaders and professional bodies

• Recognise and publicise the concept, and that….
  – it’s primarily a patient safety issue
  – something can be done
• Promote mentorship for clinicians
• Promote work to understand the best approaches to support within a wider learning culture
• Model expected behaviours
As organisations

• Build structures into incident responses to;
  – Recognise and mitigate the potential risks to patients after an incident
  – Recognise and support second victims
• Promote and model a (genuinely) open, transparent, non-judgemental reporting culture
Tier 3: Expedited Referral Network
- Established Referral Network with Employee Assistance Program
- Chaplain
- Social Work
- Clinical Psychologist

Ensure availability and expedite access to prompt professional support/guidance.

Tier 2: -Trained Peer Supporters
- Patient Safety & Risk Management Resources

Tier 1: ‘Local’ (Unit/Department) Support

- Department/Unit support from manager, chair, supervisor, fellow team member who provide one-on-one reassurance and/or professional collegial critique of cases.

Trained peer supporters and support individuals such as patient safety officers or risk managers who provide one on one crisis intervention, peer supporter mentoring, team debriefings, & support through investigation and potential litigation.
As individuals

Colleagues

– Offer informal support to colleagues who may be potential second victims
– Recognise effects in yourself and seek help early
RCP work

- Second Victim work as part of our wider Patient Safety agenda
- An in-depth interview study with clinicians in collaboration with the Bradford Institute for Health Research and Leeds University
- Collaboration with other professional bodies and deaneries to develop support mechanisms
- Collaboration with European partners to coordinate work across EU
Summary

• Second victim effects are common
• They affect clinicians across the spectrum
• This is;
  – Dangerous for patients
  – Harmful for clinicians
  – Bad for the service
• Something can be done to reduce the risks
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Useful references

1. Wu, A. Medical Error; the second victim. BMJ; 2002;320:726-7