The second victim

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James' interest in medical education, especially that of early career doctors, grew during his role as the Director of Prevocational Education and Training at Royal Prince Alfred Hospital, Sydney, from 2008 to 2014. This led to his current role as the NSW Prevocational Training Council Chair at the Health and Education and Training Institute (HETI). James works clinically as an Emergency Physician at Royal Prince Alfred Hospital and is Director of the Department. The need to better prepare students for their first years of practice led James to take on the role of the Chair of the Sydney University Pre-internship (PRINT) block in 2012. James has a Masters in Medical Education from the University of Sydney. When not being a husband, father to two beautiful girls, juggling his multiple roles he loves to watch the Adelaide Crows (AFL) win and play tennis.

We go to work every day to help and heal our patients. We are socialised to expect perfection of each other and ourselves. But errors occur. You have probably made some, I certainly have.

Our attention is rightly focused on the nature of the error and its impact on the patient and their family, but it is important to remember that we can be also deeply impacted by errors. An excellent article by Dr Simon Judkins "Emergency Doctor- what did I miss" illustrated the challenges of working in Emergency Medicine but also the impact on a clinician when something goes wrong.

Doctors who have been affected personally or professionally experience have been described by Wu as the 'second victims' and may exhibit many of the same emotions and/or feelings of the 'first victims'- the patient and their family members (1). Second victims are defined as healthcare providers who are involved with a patient-related adverse event or medical error, and as a result, experience emotional and sometimes physical distress (1).

The second victim - the impact of errors on doctors' wellbeing

The significance of a second victim concept is illustrated by research demonstrating the impact that an error can have on a doctor's future wellbeing. In one study of residents, committing an error led to a three-fold increase in depression, accompanied by a clinically meaningful increase in burnout and decrease in overall quality of life (2). Similarly, high rates of anxiety, loss of confidence, sleeping difficulties, and reduced job satisfaction following errors has been reported (3). Feelings of distress, guilt, shame, and depression are common and may be long-lasting (2). In some cases, it has led to clinicians leaving medicine and changing careers or suicide.

The impact on clinicians appears to occur regardless of their stage of training. Junior doctors are “still learning” and are in some ways expected to make errors. But consultants also make errors and admitting or disclosing errors may be difficult because of concerns of subsequent damage to their professional reputation (4).

Errors not only affect the clinician but also future patients. A common reaction of clinicians to an error is to become unnecessarily cautious in subsequent encounters, resulting in the overuse of investigations and procedures that in turn can lead to increased healthcare costs and harm to patients. In keeping with this, those who experienced burnout reported increased rates of errors in the following months. This interesting finding suggests a vicious cycle in which errors and negative emotions beget each other (5).

Patient outcome and personal responsibility

Two factors related to the adverse event have been proposed as determining the potential impact on the doctor. The first is the patient outcome resulting from the error, and the other is the degree of personal responsibility felt for the error. As might be expected, errors for which the provider feels directly and fully responsible, and those that result in patient death or severe morbidity, have the greatest impact (6).

Given the significant impact that errors can have on clinicians, what can we do to help recovery? Certainly, prevention is one key: an error avoided is a recovery process that never needs to begin. However, once an error has occurred, the literature suggests several important steps.

Coping strategies for the second victim

Strategies supported by doctors following an error included – an opportunity to talk to someone, the reaffirmation of competence, validation of their decision-making process and reassurance of their self-worth (7). These strategies are predicated on the assumption of a competent doctor and in some circumstances, further education and supervision of the doctor are required.

The reassurance of self-worth is an important step. Doctors self-esteem is often closely linked to their performance at work and this can be a problem when a medical error occurs. In my experience, reassurance of your self-worth in a clinical sense is only part of the solution. It is also important to reflect that you are more than a doctor – you are a father, mother, partner, daughter, son or a best friend. It is important to remember that your qualities in these facets of your life more accurately reflect your self worth than your ability to diagnose or operate.

A requirement of many of these constructive coping strategies is seeking or receiving the support of others. Too often we feel that we must be able to cope alone. It is particularly important to understand that the need for support after an error is normal, not a sign of weakness. Typically, you will find your informal emotional support from colleagues or your social network. Doctors also emphasised how important it was that the people from whom they sought solace not dismiss the seriousness of the situation or the reality of the mistake (6).

Hospitals' responsibilities in relation to the second victim

Hospitals also have a responsibility to care for the second victims following an adverse event, in addition to preventing and investigating errors, in order to create a safer working environment. Consciously we accept that investigations such as Root Cause Analyses are not aimed at apportioning blame to individuals but rather to identify systems issues. But anyone who has received a letter requesting an interview as part of a formal incident investigation will attest that such inquiries inevitably lead you to question your own culpability.

Similarly, there is increasing emphasis in hospital on open disclosure and saying sorry when an error occurs. The benefit of this process is typically framed from the patient's perspective although it is an equally important component when it comes to the recovery of clinicians. Instead, the emotions triggered by the event remain overlooked leaving doctors to deal with these emotions in isolation.

Support mechanisms

So what formal support mechanisms are likely to be available within your hospital? Term supervisors or your Director of Prevocational Education and Training are excellent starting points. If you have a mentor, this is the time to arrange a meeting. You may be concerned that your disclosure of an error will be detrimental to your future term assessment or career prospects but it is more likely that you will be recognised for your honesty and reflective capabilities. Unfortunately, there remain some hospitals with a "blame and shame" culture or supervisors who lack understanding or the experience in dealing with someone in this situation.

For those that have been significantly impacted following an error, the Employee Assistance Program, your General Practitioner and the Doctors Health Advisory service are available and valuable resources.

Seeing errors as learning milestones

Accepting responsibility and pursuing additional training to better understand and prevent future mistakes is characteristic of a reflective practitioner. This is illustrated by the suggested mantra for self-care after an adverse event: *You need to recognise, forgive, repent, and finally, remember.* (Maybe the favoured approach for those of you that attended a Catholic school).

Errors play an important role of recalibrating our clinical practice and ensuring that we remain vigilant. They also represent significant learning milestones in our careers and are drivers of constructive change. Speak to your consultants and registrars, they will all have a story of an error that defined them as clinicians and changed the way they practiced. Involvement of doctors in quality and safety projects or the development of education resources frequently follows a critical error. Recent work has suggested a paradigm shift – from condemning doctors as 'second victims' to facilitating their learning, growth and wisdom in the wake of a mistake (6).

We all make mistakes

Errors will occur and no one is immune from committing them. They are rarely attributable to an individual and often associated with system failures. However, if you make a significant error and particularly if harm occurs, it will hurt. It should. What matters just as much as the errors themselves is how you respond to them. While there is no single best way, openly acknowledging the emotional impact of the error, turning to others for help and seeking experiences through quality and safety committees are some of the key strategies that will lead to a healthy and successful recovery for you and your future patients.

Personally, I am aware that when potentially damaging thoughts start to run through my head following an adverse event this is a signal that I need to speak to and seek support from my colleagues. Experience has shown me that the self-doubt and shame will pass but the memory of the patient affected by my error never will.

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Useful Resources

- **Employee Assistance Program**
- **Doctor's Health Advisory Service**
- **Beyond Blue Doctors Mental Health Program**
- **Lifeline**

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