Collaborative FOR ACCOUNTABILITY AND IMPROVEMENT
Reaching resolution after patient harm

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Mitigating the Toll of Medical Errors on Clinicians

Jo Shapiro, MD, FACS

Introduction

The practice of medicine is filled with immense rewards and challenges. Our training and culture have explicitly stated and implicitly implied that the challenges are just part of our job and that we should be strong and not let the challenges affect us emotionally. Somehow, we are meant to not feel, acknowledge that we are feeling, or process whatever feelings we have after sometimes devastating clinical traumatic events. While this denial is reasonable in the moment – where we must focus on our patients and their families – it is not a sustainable long-term practice. It is not sustainable for our own wellbeing or careers, and it is not sustainable for our capacity to give compassionate and wise care to our patients.

Making the Case for Peer Support

At no time are the emotions so intense as after we have made a medical error. The literature is replete with the negative emotional impact on clinicians who are involved in inadvertently causing harm to their patients. These effects can lead to burnout, depression and even suicide. We have not yet moved entirely from a culture of shame and blame to a culture of psychological safety. This failure to fully change the culture ultimately limits the learning in the organization and therefore also limits the improvement in safety and quality of our patient care. In addition, the involved clinician's emotions can have an unintended negative impact on the communications with their patients and patients' families: it is nearly impossible to be transparent and compassionate when feeling ashamed and fearful. A truly accountable organization will need to support the clinicians after involvement in patient harm.

Common emotions after medical errors include:

- Shame
- Sense of incompetence
- Fear – including patient and family's reactions; reputation; punitive responses from medical organizations such as the Board of Registration; lawsuits
- Isolation

It is after such events, therefore, that the need for support is most crucial. Studies show that particularly after errors, physicians most want support from physician colleagues rather than mental health providers, and speaking with colleagues has been shown to

correlate with physicians' recovery and resilience after such events. We also know that physicians are unlikely to seek support because of barriers including concerns about stigma, confidentiality and time pressures. Building and sustaining a peer support program needs to account for the realities of the culture and workflow of physicians and other healthcare team members. Leaders need to understand that not supporting clinicians after emotionally stressful events is costly in the many ways outlined above.

Building Blocks for Peer Support Program

Due to the barriers for clinicians seeking out support for themselves, it is important to have peer support be a reach-out program rather than requiring that the clinician self-identify as needing support. In addition, peer support should be a preventative intervention, rather than waiting for a colleague to experience prolonged suffering. As such, the peer support intervention needs to be proactively offered after an event. Events such as errors, being reported to the Board of Registration, being sued, etc. should all be automatic triggers for offering peer support. The program therefore should be woven into the fabric of the organization.

Leadership support – making the case for why this program is crucial and why it needs resources

Choosing a clinician or group of clinicians to lead the program – frequently these are the wellbeing committee or champions, supported by clinical leadership.

Collaborating, engaging and informing various groups about the program (e.g., risk management, patient safety, legal and other clinical leaders) – these groups will need to both approve of the program as well as often being the sources of referrals for peer support.

Deciding to which groups you will offer peer support (e.g., everyone on the clinical team; physicians and APPs or only physicians): this depends upon resources and structure of the organization.

Selecting peer supporters based on nomination by peers and/or chosen by clinical leaders – this is preferable to self-nomination as not everyone who thinks they would be an effective peer supporter would in fact be.

Training peer supporters – because formal peer support differs from informal peer support and mental health support, being a peer supporter requires different skills that should be taught rather than assumed. They need specific training in how to reach out to peers; how to be present for their peers; how to balance listening with eliciting coping strategies and sharing when appropriate.

Deciding how to assign peer supporters – this will depend upon who is trained and available at the time of the event. Considerations include, for example, the seniority of the colleague to whom the peer support will be offered and the colleague's discipline and specialty.

Supporting the supporters – quarterly meetings for the peer supporters to reconnect as a community, debrief, and practice peer support interventions.

Keeping a de-identified database for program utilization

Assessing the impact on the peer who were supported – this can be done with an anonymous on-line survey, for example

Summary

Events such as medical errors, traumatic clinical events, and lawsuits are likely to have some negative emotional impact on the involved clinicians. Peer support programs are a way to both help individuals navigate these difficult events and for our organizations to move from a culture of shame and blame to a culture of psychological safety.

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