Published in: Tingle, J and Bark, P (2011). Patient Safety, Law Policy and Practice. Routledge, London, p64-84.

5 Psychological Aspects of Patient Safety

Pippa Bark

When care goes wrong, patients and carers may suffer extreme distress both from the care they receive and the way it is handled. Staff are also highly affected by the unintentional harm to, or even the death of, a patient. Distress may then be compounded by the patient safety, complaints or litigation processes that follow. Those individuals involved in medical accidents may face clinical, emotional and practical consequences. In recognition of this, over the past 10 years, policy documents[1] [2] [3] [4] [5] have acknowledged the human suffering experienced by patients, carers and healthcare staff when something goes wrong. There has been a national drive to improve patient safety with improved incident reporting, openness and fair blame policies and improved processes for handling complaints and litigation. It is notable however, that whilst patient distress is readily acknowledged, policies focus on informing the patient after an adverse event and the need to communicate with the patient and carers and have little on the emotional aspects or how to deal with them psychologically. Similarly whilst the healthcare professional involved, sometimes referred to as the second victim, is now routinely mentioned, policy has focussed on openness, fair blame and encouraging reporting. However there has been little written on emotional impact and this may be the key to understanding why some staff are reluctant to fully engage with the patient safety initiatives.

Published in: Tingle, J and Bark, P (2011). Patient Safety, Law Policy and Practice. Routledge, London, p64-84.

Unless we are aware of the experiences of all involved, it will not be possible to comprehend why policies are not fully implemented or what policies may be needed in the future. This chapter is written in three sections: the first will examine the issues and reactions of patients and carers who have experienced poor healthcare and who may then be caught up in complaints or litigation processes. There are still many who have not experienced the benefits of the policies and we need to be mindful of any gaps between policy and practice. The second section considers what happens to the staff involved in these circumstances. In particular the psychological processes that affect how people cope by distancing or blaming will be highlighted. Finally the third section will look at what support is in place to help those involved.

This chapter therefore, discusses a neglected area in patient safety of patient, carer and staff reactions in the aftermath of medical mistakes. Research is surprisingly limited in this area, with very little on litigants' experiences or patients involved in root cause analysis or other patient safety initiatives. However there has been an increased recognition in certain areas, namely the effect on staff and the importance of openness.

The Experience of Patients and Carers

The effects of being harmed by treatment

Patients harmed, albeit unintentionally, by their medical care differ from those who suffer from other accidents; they are likely to have been unwell to start with and therefore physically and emotionally vulnerable. In addition, the trust they put in the professionals helping them has been unintentionally damaged. Although 56% of those who have experienced an adverse event have no effects or a minor disability, 19% suffer a temporary disability, 7% permanent disability and tragically 7% die[6]. After an incident the patient and their carers may be facing the ramifications of unexpected time in hospital, increased pain, worsening of their condition, additional operations and potentially a worsening prognosis. It should be remembered that this is in addition to the illness that the person was initially dealing with. This clearly has the potential to impact on quality of life with effects on work, finance and relationships. Traumatic and life threatening events produce reactions in any case, so since routine procedures[7] or normal childbirth[8] can result in potentially serious emotional reactions, it is not surprising that those who experience the results of a medical error suffer.

Descriptions of patient and carer reactions typically come from research on complainants[9] or litigants[10]. In an early study of 491 complainants[11] the physical effects of treatment were clear; 49% reported a need for additional medical treatment, 42% reported that the patient's condition had worsened as a result of treatment, and 36% said that unexpected side effects had been experienced. In 5% of cases the patient had died. Complaints arose from serious incidents, generally a clinical problem combined with staff insensitivity and poor communication. Clinical complaints were seldom about a clinical incident alone (11%); most (72%) included a clinical component and dissatisfaction with personal treatment of the patient or care. All described some level of suffering as a result of the incident, with strong feelings of anger, distress, worry, and depression. Over a third (36%)

reported feeling humiliated. Complainants frequently described the frustration with the process itself and some felt further mistrust of the health service they were reliant on.

Since this study, government policy has striven to create a single approach to dealing with complaints. New regulations for handling NHS and adult social care complaints came into effect on 1 April 2009 giving organisations the flexibility to deal with complaints effectively under The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009[12]. This aims to encourage a culture that seeks and uses people's experiences to make services more effective, personal and safe. Over 90 health and social care organisations have tested the approach and there is a guide to help complaints professionals work with colleagues to improve listening, responding and learning from people's experiences. It is designed to be accessible to anyone working in health and social care organisations that is involved in receiving feedback and resolving concerns and complaints from patients, service users and their representatives. Additional advice sheets for complaints professionals have also been produced covering a range of issues.

This more patient-centred approach is mirrored in the advice from the key regulating bodies including the Medical Defence Union, the Medical Protection Society and the General Medical Council signifying a change in attitude. One such example is the Medical Protection Society's website[13] in advising practitioners on how to approach complaints: 'Sometimes, acknowledging that the person's feelings of frustration or anger at what happened are real and understandable, regardless of whether the complaint is justified or not, is enough to defuse the situation.'

There have been few studies on medical litigants despite the impetus to find ways to reduce medical negligence claims. In one of the few in-depth studies[14] of 277 litigants, over 70% were seriously affected by incidents that gave rise to litigation with long-term effects on work, social life, and family relationships. Intense emotions were aroused and continued to be felt for a long time. The decision to take legal action was determined not only by the original injury, but also by insensitive handling and poor communication after the original incident. In addition, a protracted battle with the health service or through the courts is emotionally draining, and due to the length of time it takes, support from family and friends may dwindle[15]. One of the improvements patients and carers felt could be made was an appreciation of the severity of the trauma they had suffered[16].

Depression

The full impact of some incidents, and the attendant reactions, may only become apparent over time. For example, a surgical mishap may result in the need for further operations and time in hospital. In one case, a mismanaged pressure ulcer of a paralysed patient resulted in an additional three operations, a 14 inch scar and a further 5 months of bed rest in hospital. She reports that missing her son's tenth birthday because of this was one her lowest points and was one of the only times she cried in hospital.

Depression is a common response to medical injury and more typical than post-traumatic stress disorder[17]. Whether people become depressed depends, amongst other things, on the degree of injury and the level of support from family, friends and health professionals[18]. Sudden, intense and uncontrollable events are particularly likely to lead to psychological problems[19] with awareness under anaesthesia being one example. Anxiety, intrusive and disturbing memories, emotional numbing and flashbacks may be experienced. As with any stressful event these will fade with time, however they can be deeply unpleasant and prolonged.

Bereavement

In a study of significant mistakes made by 254 junior doctors[20], patients had serious adverse outcomes in 90% of cases and death had occurred in 31%. In these cases, the trauma for those left behind and the staff involved is obviously severe.

Where the patient dies, those suddenly bereaved may struggle to come to terms with the loss and make sense of what may have been avoidable. Bereavement reactions, as described in the Kübler-Ross[21] stage theory of grief, are familiar to those in the health service: Denial-dissociation-isolation, anger, bargaining, depression, and acceptance. Whilst each person will experience things differently, these are seen as typical reactions for many groups relevant to patient safety: terminally ill patients' awareness of their impending death[22], children's reactions to parental separation[23], and clinical staffs' reactions to the death of an inpatient[24]. It is likely that there will be similar patterns for family and carers dealing with a death after an adverse event. Many people who have lost a loved one in an accident ruminate about the accident for years after seeking what could have been done to prevent it or in a struggle to find meaning. Some may blame themselves, others may apportion blame.

'I know there wasn't a dry eye in the whole entire room when I was telling them about the guilt that I had felt and then [the doctor] said that it had nothing to do with me and it wasn't my fault.'[25]

Often it may be difficult to ever ascertain whether death or disability could be avoided and the litigation that sometimes accompanies such cases as a way of finding resolution and financial support may prolong grief and guilt for the family and staff[26].

Death in childbirth or death of a child may be particularly hard to bear as joy and the promise of a new life ends in tragedy[27]. Vincent[28] presents the heartbreaking description of Jamie's father, who lost his son at 2 months having sustained spinal cord injury at birth due to inadequate obstetric care.

> Mr Carter's reaction to Jamie's death was intense, violent and prolonged. For a year he suffered from disturbing memories and horrific dreams. He became quiet and withdrawn and remote from his wife, feeling 'empty and hopeless'. He was tormented by disturbing images and memories of Jamie, of the birth, of his slow death and particularly of his small, shrunken skull toward the end. He suffered from stress related stomach disorder. His sleep was

> interrupted by violent nightmares of a kind never experienced before. During the day violent images came into his head that horrified him. 'I was really angry all the time, so aggressive – I wanted to hurt people, and I'm not like that at all. I felt I had to blame someone all the time for everything.' Two years late, he is a sadder and quieter person. The anger he feels at the grave subsides. (Adapted from Vincent 2006)[29].

Patients' Confidence and Trust

One of the keystones in maintaining a relationship with the patient or carer, especially after an adverse event, is that of trust. The impact of an adverse event is strong since in many cases the patient is reliant on further care from, if not the same people, the same profession. They may have conflicting feelings about those involved which can be very hard to resolve, even if the staff are sympathetic and supportive. The basic essentials of confidence and trust are currently being tackled by the DH (2008) in their Confidence in Caring Project Overview[30]. They stress the importance of building and maintaining the relationship through:

- A calm, clean, safe environment;
- a positive, friendly culture;
- good team-working and good relationships;
- well-managed care with efficient delivery; and
- personalised care for and about every patient.

There is, in many places, still a disparity between the ideals and the reality.

The reliance on care particularly at a time of vulnerability is likely to be part of the reason why the majority of people who have received substandard care do not complain. Whilst in hospital they are fearful of ramifications were they to voice concerns. Once home, many want to get on with their lives or cannot see what they would get out of complaining. One such example took place in a London trust:

A woman who received no post operative checks and minimal nursing care in a teaching hospital following major abdominal surgery, felt intimidated by nursing staff after being snapped at and then witnessing a fellow ward member being shouted at for asking for analgesia.. As a result, until the next shift came on, she emptied her own urine bags and changed her own soiled sheets. Despite her resolution that she would never return to that hospital again, when asked to complete a patient survey form, she answered in a surprisingly positive light. When asked why, she reported that she wanted the nurses to be kind to her, and since the survey was not asking about her issues the target questions about welcome, cleanliness and so on could all be rated well. She had no confidence that her fundamental concerns would be heard in a constructive way. Once home, she stated that she wanted to get on with her life. These patient experiences are particularly sobering for those staff involved in collecting patient data who genuinely believe that patients will be able to express their concerns. The Confidence in Caring document specifically mentions handling concerns before they become complaints, and yet the department were, I suspect, unaware of many failings.

Openness

Open disclosure has been one of the major shifts over the last decade with the principals ingrained in policy in Australia[31], the USA[32], Canada[33] and Britain[34] [35]. Within the policy is an explicit statement that patients will be told as soon as possible after an event. In England and Wales, the NPSA's Being open framework (2009) has provided a set of principles describing how NHS staff need to communicate with patients, their families and carers when something goes wrong. This framework is supported by policy makers, professional bodies and litigation and indemnity bodies. The NPSA's Chief Executive Martin Fletcher said:

> 'Discussing patient safety incidents promptly, fully and compassionately is the best way to support patients and staff when something does go wrong. Evidence from other countries shows that by following the principles of Being open, formal complaints and litigation claims can also be reduced.'[36]

However, the extent to which individuals follow these follow the policies may vary greatly. In a study considering cataract surgery[37], 92% of patients believed that a patient should always be told if a complication has occurred compared to only 60% of ophthalmologists, The ophthalmologists who did not believe that patients should always be told replied that either the patient should never be told or that it depended on the circumstances. 81%

of patients, but only 33% of ophthalmologists, believed that a patient should not only be informed of a complication but also be given detailed information on possible adverse outcomes. In a more recent Australian interview study[38], 22/23 participants appreciated the opportunity to meet with staff and have the adverse event explained to them. However they had some concerns about how Open Disclosure was being enacted: disclosure was not occurring promptly or was seen as too informal; disclosure was not being adequately followed up with tangible support or a change in practice; staff were not offering an apology, and there were not opportunities for consumers to meet with the staff originally involved in the adverse event. They found that a combination of formal Open Disclosure, a full apology, and an offer of tangible support had a higher chance of a success than if one of these components was absent. Iedema and colleagues[39] concluded that staff need to 'become more attuned in their disclosure communication to the victims' perceptions and experience of adverse events, to offer an appropriate apology, to support victims long-term as well as short-term, and to consider using consumers' insights into adverse events for the purpose of service improvement.'[40]

When staff are proactive in coming forward, acknowledging the damage and taking action, the support offered can ameliorate the harm[41] for both patients and also for the staff themselves. Staff report a sense of relief in being true to themselves and to be free to offer the level of care and caring that they would normally provide. Although fears of restrictions from the trust or legal, insurance or financial bodies are seen as hampering what would be seen by some staff as a mere extension of routine good care, there has been considerable progress in encouraging openness.

It is too early to judge the extent to which policy meets reality. On recent training courses, British risk managers freely discussed reservations about full openness. They describe the norm as being that patients are told when there is a bad outcome, however in cases of a minor outcome or a near miss many would regard it as inappropriate to tell the patient. They indicated that the culture of their organisations would support this selective approach. Action against Medical Accidents (AvMA), a charitable organisation set up to assist patients, still receives 5000 cases a year[42]. The experiences of their clients appear to indicate that there is still some way to go, with carers and patients commenting that it was only with the support of the organisation that they reached a satisfactory conclusion:

> 'Mr B, an otherwise fit and strong gentleman of 71 years of age, underwent surgery for cancer of the oesophagus in 2002. The procedure involved the use of a nasogastric tube. It was apparent to the family after the operation that something had gone very wrong. Mr B became very seriously ill and, after suffering terribly, died five months later. The family asked the hospital for an investigation. When the hospital replied it explained that a hole had been made in Mr B's stomach when the nasogastric tube was replaced (against all guidelines) when it had come out. Although the Chief Executive expressed his and the staff's sincere condolences, there was no apology for the error itself which had brought about Mr B's death.

> There was no assurance given that steps would be taken to prevent similar errors in the future. There was no suggestion that Mr B's family should be entitled to compensation or should seek independent legal advice.'[43] (AvMA)

The majority of investigative effect goes on cases where the outcome has been severe, however despite recommendations about the benefit of involving patients and carers in patient safety initiatives[44] some staff are fearful of involving people who may be upset by an investigation and who may additionally complain or sue. As such, even in severe cases, patients and carers may not be involved and their anger and mistrust may grow over time if they are unaware of what is going onto resolve the situation.

In a tragic case where a mother and baby had died from a rare undiagnosed condition, described by Vincent and Page[45], the first responses by staff to the deaths were seen as timely and appropriate. The widower and father of the baby were seen by senior clinicians who expressed their sorrow and a commitment to a thorough investigation with open feedback. Although the clinicians concluded their investigation within appropriate time scales, the hospital faced potential litigation and there were considerable delays in the process of approval from a higher organisational level. There was also anxiety about sharing the report with the widower that led to severe delay. These delays added to his grief and eventually he became extremely angry. By the time the report was released, relationships with him were strained and trust had been eroded. Soon after, he started legal proceedings. His grief was intensified and rather than being supported by the organisation, he found himself in conflict with it.

Whilst seeking an apology is common, whether the apology is successful depends on the timing, the sincerity and who the apology is received from. In an investigation on forgiveness, John McCarthy, the journalist who was kidnapped, talked about how it was possible to forgive actions that had been done to oneself, but much harder, and sometimes impossible, to forgive those that affected our near ones. Whilst the circumstances are hugely different, as many complaints or lawsuits are delivered by carers or parents, one facet to take into account is the anger and helplessness felt by those attempting to help their charges. It may be that complaints delivered by the patient themselves are easier to resolve than those delivered by a representative.

The Experience of healthcare staff

There is no doubt that patients and carers experience distress, sometimes extreme, both from a problem in the care they receive and in the way it is handled. At the same time healthcare staff, who are by the nature of the service already in a stressful environment, also experience distress at having made an error and the attendant after-effects. Unless we are aware of what happens to all involved, it will not be possible to comprehend why policies are not fully implemented or what policies may be needed in the future. This second section then will consider what happens to the staff involved in these circumstances. In particular the psychological processes that affect how people cope by distancing or blaming will be highlighted.

Staff Distress about Errors

A survey of 3171 physicians[46] in 2007 working in internal medicine, paediatrics, family medicine, and surgery examined how errors affected five work and life domains. Physicians reported increased anxiety about future errors (61%), a loss of confidence (44%), sleeping difficulties (42%), reduced job satisfaction (42%), and harm to their reputation (13%) following errors. Their job-related stress increased when they had been involved with a serious error. In addition, a third of physicians only involved with near misses also reported increased stress.

> '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.'[47]

The very nature of medicine means that errors will happen some of the time and yet there is an expectation that medical staff should be so skilled and technology so advanced that bad outcomes should not happen. Training focuses on error free practice where individuals strive for perfection, and where mistakes are seen as unacceptable and considered a failure of character. This is compounded in that role models reinforce these notions and whilst the patient safety policy and research literature accepts that good people will make mistakes, in reality this is only partially realised. One consultant commented that 'In the past we were treated as gods but forgiven our mistakes: today we are treated as technicians and expected to be perfect'.

Stress is high in healthcare professionals and it is known that making mistakes is a major stressor[48]. At the same time, the personal distress caused by being highly stressed makes an individual more likely to make errors thus creating a vicious circle[49]. Where an individual perceived themselves to have made an error there were measures of a decreased quality of life, increased burnout, symptoms of depression and a decline in empathy.

The extent to which a mistake impacts on staff depends on the circumstances: it will be found to be more traumatic if:

- there is a severe outcome
- there has been close involvement with the patient,
- there is anger or distress from the patient or family,
- colleagues are critical,

- the action was a departure from clinician's usual practice,
- the practitioner has a self critical personality,
- there is a lack of support from family/friends/colleagues,
- the practitioner does not discuss concerns with others,
- there is a complaint or litigation.

In terms of the stress caused by making mistakes, a bad outcome resulting from making a mistake will intensify the health professional's reaction as well as the judgments of their peers. Psychiatrists dealing with patient suicide[50] will see themselves as personally responsible with attendant feelings of blame and anxiety. They may experience irritability at home, be less able to deal with their own family, have poor sleep patterns and low moods. They themselves may become preoccupied with suicidal thoughts and have decreased self confidence that extends beyond work.

It is not unusual for clinicians to respond to their own mistakes with anger and sometimes projecting the blame onto someone else[51]. This could be another health professional, and at times it can be the patient. Some may blame or scold the patient or other members of the healthcare team. Some may act defensively or callously. In the long run some physicians are deeply wounded by their experience, lose their nerve, burn out, or seek solace in alcohol or drugs. As Wu points out, this is likely to include some of the most reflective and sensitive colleagues. When junior doctors discussed their emotions after significant errors, they were most likely to report feelings of remorse, anger, guilt and inadequacy[52]. A few house officers reported persistent negative psychological impact of mistakes, some after the death of a patient, leading to avoidance or unease about their specialty.

There is mixed evidence on whether openness helps physicians. Whilst some proponents have advocated that it provides relief to the staff member to be true to themselves[53], Waterman et al[54] found that physicians who were satisfied with their disclosure of a serious error to a patient were no less distressed than physicians who did not disclose. Even errors with minimal or no impact on patients had lasting impacts on physicians: physicians felt more distressed when they had disclosed a minor error or near miss to their patient than physicians who did not disclose. 'Patients who respond angrily to disclosure add coal to the fire of the physician's distress'. Clearly disclosing errors will be highly emotive for both patients and staff in some cases. Whether the openness policy is beneficial to individual staff members may be reflecting the quality of the disclosure[55], the level of training in handling this situation and the level of support.

Wu[56] discusses the affect of peer responses in the aftermath. He points out that unconditional sympathy and support are rare. Reassurance from colleagues is often grudging or qualified. One way to face guilt after a serious error is through confession, restitution, and absolution, however this is discouraged by the lack of appropriate forums for discussion and risk managers and hospital lawyers. There are no institutional mechanisms to aid the grieving process. Morbidity and mortality meetings examine medical facts rather than feelings of the patient/physician. As a result of this, it is not surprising that physicians find ways to protect themselves, some of them dysfunctional.

Despite the evolution of a systems approach and the encouragement of a fairer culture, peer disapproval and personal shame still exists. Peters et al[57] suggests that identifying scapegoats serves a defensive function. A belief that risk lies in the individual nurse or doctor means that once the operator is removed, for retraining, transfer or dismissal, the risk is eradicated. The alternative of attributing the cause to organisational deficiencies such as poor communication, inadequate equipment or training offers little comfort until the weaknesses are addressed and fixed.

Staff distress about litigation and media coverage

s with the patients, litigation compounds distress. Reports of prevalence are higher than might perhaps be expected. An English study[58] found that 49% of senior surgeons and 23% of senior doctors in the medical specialties reported having been involved in litigation. More recently in Australia[59], 60% of GPs reported being sued.

Despite the increase in patient safety activity, the last three decades have seen few changes in reactions to being involved in litigation. In the 1980s Charles and colleagues[60] revealed that more than 95% of American physicians experienced periods of distress during the lengthy process of litigation. 'This may begin.. by a sense of outrage, shock, or dread about the personal and financial effects of the eventual outcome. Feelings of intense anger, frustration, inner tension, and insomnia are frequent throughout this period'. Depressive disorder, adjustment disorder and the onset or exacerbation of a physical illness occurred. In an English study[61] in the late

1990s, 79% of senior doctors reported experiencing distress from being involved in litigation. The lawsuit itself affected work, but also life more generally and home relationships. Doctors reported feeling angry, guilty and ashamed. Some lost confidence. With financial implications for the health service, almost a fifth of consultants wanted to give up medicine. This does not of course take into account those who had already done so.

It would appear that the patient safety initiatives have more to do to alleviate the distress. An Australian survey of 566 GPs in Sydney[62] showed that doctors currently involved in malpractice litigation had high rates of psychiatric problems, such as depression, and alcoholism. They also had significant impairment in work, social and family life compared to doctors who were not subject to litigation. Male doctors who had been involved in medico-legal actions in the past had significantly higher rates of alcohol use than doctors with no history of litigation. Even when the action was over, doctors had higher rates of depression and disability than doctors who had no history of litigation. One of the limitations of these findings is that we cannot infer about causality. We do not know whether the litigation caused the distress, or whether attendant problems put the practitioner at higher risk of error and/or litigation.

In addition to the litigation, there may be negative media coverage – not all understand that one incident may be against a backdrop of an unblemished career or that a tragedy may have been unavoidable. 37% of claims are made when an error has not occurred.[63] The shame compounds whatever emotions the practitioner had over the original care:

> 'We live at a time when blame and retribution are prominent in media coverage of what has gone wrong. It is important that there should be proper accountability, but we also have to ask whether the climate of blame and retribution can go too far.' Chief Medical Officer, Sir Liam Donaldson[64].

Human biases versus fair blame

Unsafe care can arise from human error in a weak system) and from poorly performing doctors. The risks posed by the former are many times greater than those posed by the latter[65]. For a systems approach to work, there has to be a distinction between failures that arise because of weaknesses in a complex system, and those that are the result of individual deficiencies[66]. Whilst there are a few poor doctors and nurses who are involved in a disproportionate number of cases, it is unlikely to account for the high number of adverse events. In addition, in cases where an inexperienced individual has been found wanting, it is not unusual to find that others have made the same mistake previously. Making this distinction is made more difficult by the natural tendency to make mental shortcuts to understand one's own or other's behaviour. Parker et al[67] summarise the principal biases that contribute to the natural tendency to judge or blame, inherent biases that need to be understood in any investigation if a fair blame culture is to work:

Fundamental attribution error is the tendency to explain the behaviour of others by focussing on characteristics such as personality, intelligence or status, but to use situational factors to explain our own behaviour. For example, I may consider you made an error because you were a nurse (status), but I made the error because of long hours (situation). A second bias is the belief that we 'get what we deserve'. This enables us to feel protected from chance outcomes. The more serious the outcome, the more likely we are to judge the individual as inappropriate, regardless of the professional's actions or decisions. In one experiment, anaesthiologists changed their judgement on the appropriateness of care if they were told that outcome was permanent rather than temporary[68]. Nurses attached more importance to the error if the outcome was severe[69] (Murier et al).

If there is a severe outcome, the behaviour of healthcare professionals is rated as more risky and inappropriate (Lawton and Parker 2002). Judgements of responsibility (blame) are greater and judgements of appropriateness are less favourable (Caplan et al). Deviations from normal practice are deemed to be more blameworthy than either error or compliance with the protocol or guideline irrespective of outcome.[70] This is particularly relevant for those interested in root cause analysis who are trained to look at the secondary gain (the motivation) for deviating from practice.

Cognitive biases also lead to blame[71]. People defend themselves when a colleague is involved in an adverse outcome by distancing themselves. One strategy is to maintain an unrealistic level of optimism by thinking it could not happen to you, so that when a peer makes a mistake, others may deny personal vulnerability to the same sort of negative outcome. This is apparent when smokers, heart patients, motorcyclists, and so on consider themselves at less risk than others. In terms of adverse events, this means that health professionals convince themselves the same outcome would not have occurred had they been the attendant clinician. Another strategy is the illusion of control – this is a tendency to believe that we have more control than similar others (through experience, skill or efficiency for example), and hence could have avoided a poor outcome. These biases minimise our sense of vulnerability to negative events, but foster unsympathetic responses.

We can therefore predict that when the outcome is serious or when there has been a deviation from standard practice, colleagues are likely to reassure themselves that it could not happen to themselves and to blame. This will have ramifications for the individual:

> 'When I was a house officer another resident failed to identify electrocardiac signs of the pericardial tamponade that would rush the patient to the operating theatre later. The news spread rapidly, the case was tried repeatedly before an incredulous jury of peers who returned a summary judgement of incompetence'[72].

Supporting Patients, Carers and Healthcare Staff

Organisational trust

The key to avoiding awakening shame is in fostering trust at a deep organisational level[73]. Psychologists have demonstrated the benefits of trust on group cohesion and organisational effectiveness, factors core to patient safety, and teams that have a high level of trust report errors more frequently. Staff can tell the truth, and can enhance their reputation by having the confidence to admit to errors rather that by providing a front of error free practice (Firth-Cozens 2004). When examining what makes doctors more likely to make constructive changes in practice after a significant mistake, extensive discussions were likely to lead to a positive change, whereas perceptions that the institution responded judgmentally led to defensive changes[74]. One resident expressed the desire for more discussion so that 'some of the unsaid horrors of our experiences can be discussed and dealt with'.

The NHS remains largely unsupportive of whistle-blowing, with many staff fearing the consequences of going outside official channels to highlight unsafe care (Houses of parliament). Hence staff need to be able to have confidence in management that they seen not as telling tales on colleagues but are protecting patients, that patient safety action will be seen as a result of their reporting, and that their reputation will be enhanced by honest reporting.

Management must be trusted to be open and fair about the handling of error throughout the organisation, investigate with care, integrity and sensitivity, not harm the one who reports, treat the error fairly, use the information to improve patient safety, and trust staff to provide accurate data.[75] In some trusts, boards are experienced as having a policing role rather than being part of the patient safety process. In the endorsement of the safer patient initiatives, the House of Parliament pointed out that 'Boards too often believe that they are discharging their responsibilities in respect of patient safety by addressing governance and regulatory processes, when they should actually be promoting tangible improvements in services'. They recommended, amongst other things, that boards banish the blame culture and provide leadership to harness the enthusiasm of staff to improve safety. To borrow the words of Firth-Cozens, 'trust is fragile but essential'[76].

If trust is present at an organisational level and staff feel confident and supported, there is a far higher chance that patients' needs will be met. Recent policy developments have aimed at increasing public trust in the drive to be more open with patients, both in terms of their own treatment, and in terms of the service in general (eg. High quality care for all 2008, NPSA's *Being open* framework 2009). If in parallel to this, staff are trained and supported, the policies are more likely to be fully implemented. This is a significant shift over the past decade.

Removing barriers to talking to the patients

Appreciating the depth of the distress is a key factor in restoring patient confidence and many have derived comfort from the empathy or staff sadness at the experience. The NHSLA circular, released in May 2009 has provided confirmation that clinicians do not need to fear the ramifications of doing so:

> 'It is both natural and desirable for clinicians who have provided treatment which produces an adverse result, for whatever reason, to

> sympathise with the patient or the patient's relatives; to express sorrow or regret at the outcome; and to apologise for shortcomings in treatment. It is most important to patients that they or their relatives receive a meaningful apology. We encourage this, and stress that apologies do not constitute an admission of liability. In addition, it is not our policy to dispute any payment, under any scheme, solely on the grounds of such an apology'.[77]

One common theme from interviews with patients injured by their care is that the professionals made great efforts to deal with their medical symptoms but omitted to ask about their mental state (Vincent 2006). Although Being Open talks about 'practical and emotional support', the advice focuses on practical issues or on providing support contacts. Vincent's recommendation to ask about crucial areas such as depression, anger or loss of trust without the fear of 'making things worse' is a useful reminder on how to resolve conflict and demonstrate caring.

Training

The communication skills for successfully disclosure are specific since this is about an issue a) which is likely to be emotive for the healthcare professional and the patient or carers, and b) where the professional may be the target of the expressed distress. Only 18 percent of physicians in Waterman's survey had received education or training on disclosing errors to patients, while 86 percent were somewhat or very interested in receiving it. To lessen the chance of disclosure going poorly, Waterman suggests that patient safety specialists and risk managers be present when disclosure occurs to respond to patient questions, debrief with the physician afterwards, and provide professional reaffirmation and support for the physicians.

By routinely offered training in dealing with the process, from the point of disclosing the error, through to the root cause analysis and potential litigation, some of the unknown can be dealt with. The NPSA's being Open Policy is one such example of providing guidance on communicating with patients, their families and carers following a patient-safety incident. They offer

- training workshops on *Being open* for healthcare professionals that incorporates video and actor role-playing methods
- an e-learning tool: *Being open*
- Training for Root Cause Analysis
- An e-learning tool: A guide to root cause analysis from the NPSA
- The Incident Decision Tree

Studies to evaluate the effects of interventions to support physicians are rare though measures such as including patient safety into medical curricula and training, mentoring and above all, a change in culture, have been suggested for alleviating the emotional distress of physicians.

Patient and carer support

Injured patients can receive support from family, friends, colleagues, doctors or organisations. As Vincent highlights[78], an especially important source will be from those who are involved in the treatment where possible. It is vital that staff do not withdraw from the patient due to guilt, anger or embarrassment. If care was substandard, the patient must be offered a referral elsewhere, however if the incident is dealt with effectively then the relationship can be maintained and trust restored.

With the relatively new literature on supporting healthcare staff, there is a risk that there is a belief that we already have robust systems for patient and carer support. However despite some significant progression in dealing with incidents, there appears to be an assumption that adequate support is in place. Without current research on this, there is the likelihood that interventions will not be as adequate as hoped.

Healthcare staff support

The marked increase in papers describing the effect on healthcare staff suggests that culturally we are already becoming more accepting of the fact that healthcare staff suffer and, by implication, will need support.

On the whole, team members, other clinicians and family and friends tend to be the most common and effective source of help. Colleagues are invaluable because they know what it is like to take such responsibility and their support mitigates the sense of professional isolation that can be felt. Friends and family offer an equally vital role in bringing comfort[79]. We do know, however, that colleagues are not always nonjudgmental and that it is unwise to assume that this ad hoc approach is sufficient. In a study of staff reactions to suicides (Alexander et al 2000), psychiatrists felt that it was important there was additional access to more formal counselling or debriefing on offer.

As with talking to patients, sensitivity to language will play a large part in how supportive an encounter is found to be. Some trusts avoid referring to 'errors': others focus on what was done and not who did it.

Many doctors have been through litigation whether as an expert witness or a defendant and could be tapped as a source of support. One Being Open policy initiative has been in encouraging the role of senior clinical counsellors. Senior clinical counsellors are to provide mentoring and support to their colleagues by:

- mentoring colleagues during their first discussion
- advising on the process
- being accessible to colleagues prior to initial and subsequent discussions
- facilitating the initial team and debriefing meetings
- signposting the support services for colleagues
- mentoring colleagues to become senior clinical counsellors

Counselling

Since it is unusual for staff to be routinely offered personal support[80], a starting point would be to consider what talking therapy would be acceptable for healthcare staff involved in an incident. In an American and Canadian study[81], the majority of doctors involved in serious events (80%)

expressed interest in counselling and few physicians (10%) believed that health care organisations adequately supported them in coping with error-related stress. However there were some reservations when support services were available: physicians felt that taking time off for counselling was difficult (43%), expressed concerns that counselling would not be helpful (35%), that confidentiality would be breached if they were sued (35%), and their counselling history would be placed in their permanent record (34%). 18% feared being judged negatively by their colleagues for receiving counselling.

Whilst there is no doubt that most hospitals will already have professionals the expertise to provide support such as counsellors, psychologists and psychiatrists, the majority are reluctant to use the services because of doubts about their value and confidentiality, and because of personal barriers such as shame, denial and reluctance to appear weak. A link with an outside contact might be useful for when staff feel responsible for a serious injury or death[82] (Hirst 1996, cited in Vincent 2006).

Peer counselling groups run by respected healthcare professionals might be one model of emotional support for physicians, however although there is some support for them, they are not commonly used in Britain. In America[83], peer counsellor training was set up to handle emotional stress brought on by adverse medical events, and they launched a peer support team project for Brigham and Women's Hospital which then became a hospital-wide initiative.

Self-care for healthcare staff

Whilst many of the strategies mentioned focussed on dealing with process afterwards, West et al[84] also mention the importance on preventative or preparatory action. First, they recommend specific curricula on personal awareness and self-care to promote strategies for coping with the emotional impact of errors. They comment that these are needed but have been slow to develop. Second, programs are needed to prevent, identify, and treat burnout and to promote empathy and well-being for the welfare of staff and patients.

Conclusions

There have been huge strides in the last two decades in acknowledging the emotional impact of an adverse event on patients, carers and staff. Policies routinely mention the importance of supporting patients and staff and have focussed on providing frameworks (eg Complaints, litigation, Seven Steps to Patient Safety, Root Cause Analysis, Manchester Patient Safety Framework, being open) and training (eg Foresight Training, Patient Safety First 'How-to' guides) for bringing about a consistent patient safety approach. There is much to be proud of, however there is still a gap between policy and practice in some areas. Open disclosure may not be as common or of the quality aimed at. The emotional support of individuals can be a hit or miss approach. Fair blame in policy documents is not always experienced as such by the recipients, and blame can inappropriately overshadow systems analysis at times. Some patients feel let down. Many staff may naturally feel defensive. Studies on staff involved in litigation suggest that distress remains high, and studies on patients and carers involved in litigation are rare.

The initiatives have begun a promising journey towards patient safety and many of the frameworks have potential. In terms of the emotional reactions, there needs to be organisational trust – without this, staff will not have the confidence to be open, and patients will not receive appropriate openness and support. In-depth training for staff needs to be set up, and these training programmes need to be piloted for efficacy. There is more opportunity to explore how best to support patients and staff. Most of all, we would benefit from implementation studies to see if these initiatives are helping the individuals involved to be supported.

References

---

[1] NPSA (2009). Being open framework

[2] Department of Health (2006). Good doctors, safer patients. Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients. A report by the Chief Medical Officer.

[3] Department of Health (2008). High Quality Care for All.

[4] Department of Health (2008). Confidence in Caring Project Overview.

[5] Department of Health (2009).The NHS Constitution for England.

[6] De Vries EN, Ramrattan MA, Smorenburg SM, Gouma DJ, Boermeester MA (2008). The incidence and nature of in-hospital adverse events: a systematic review. Qual Saf Health Care 17, 216-223.

---

[7] DM Clarke, PA. Russell, AL. Polglase, DP McKenzie (1997). Psychiatric disturbance and acute stress responses in surgical patients. Aust. N.Z. J. Surg. (1997) 67, 1 15-1 I8.

[8] Czarnocka J.; Slade P. (2000) Prevalence and predictors of post-traumatic stress symptoms following childbirth British Journal of Clinical Psychology, Volume 39, Number 1, March 2000 , pp. 35-51(17).

[9] P Bark, C Vincent, A Jones, J Savory. Clinical complaints: a means of improving quality of care. Qual Health Care 1994;3:123-132.

[10] Vincent, C, Young, M, Phillips, A (1994).Why do people sue doctors? A study of patients and relatives taking action. Lancet 343, 1609-13.

[11] Bark et al (1994)

[12] The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009).

[13] Medical Protection Society http://www.medicalprotection.org/

[14] Vincent, C, Young, M, Phillips, A (1994).Why do people sue doctors? A study of patients and relatives taking action. Lancet 343, 1609-13.

[15] Vincent, C, Page, L (2009). Aftermath of error for patients and health care staff. In: Hurwitz, B and Sheikh A. Health Care Errors and Patient Safety. Wiley-Blackwell. Chichester.

[16] As above

[17] Vincent, C, Coulter, A (2002). Patient safety: what about the patient?

Qual Saf Health Care 2002;11:76-80.

[18] Vincent, C, Page, L (2009). Aftermath of error for patients and health care staff. In: Hurwitz, B and Sheikh A. Health Care Errors and Patient Safety. Wiley-Blackwell. Chichester.

[19] As above

[20] Wu, AW, Folkman, S, McPhee, SJ, Lo, B (2003). Do House officers learn from their mistakes? QSHC, 12, 22-228.

[21] Kübler-Ross E. (1969). On Death and Dying. New York, NY: Macmillan.

[22] As above

[23] Bowlby J. (1980). Attachment and Loss. New York, NY: Basic Books.

---

[24] Leibenluft E, Green SA, Giese AA (1988). Mourning and milieu: staff reaction to the death of an inpatient. Psychiatr Hosp. 19, 169-173.

[25] Iedema R, Sorensen R, Manias E, Tuckett A, Piper D, Mallock N, Williams A, Jorm C (2008). Patients' and family members' experiences of open disclosure following adverse events. International Journal for Quality in Health Care 20(6): 421-432.

[26] Vincent, C, Page, L (2009). Aftermath of error for patients and health care staff. In: Hurwitz, B and Sheikh A. Health Care Errors and Patient Safety. Wiley-Blackwell. Chichester.

[27] As above

[28] Vincent, C (2006). Patient Safety. Churchill Livingstone, London.

[29] As above

[30] Department of Health (2008). Confidence in Caring Project Overview.

[31] Australian Council for Safety and Quality in Health Care (2003). Open disclosure standard: a national standard for open communication in public and private hospitals, following an adverse event in health care. Canberra: Commonwealth of Australia. http://www.safetyandquality.org.

[32] Joint Commission on Accreditation of Healthcare Organizations: 2006 Comprehensive Accreditation Manual for Hospitals: The Official Handbook. Oakbrook Terrace, IL: Joint Commission Resources, 2005.

[33] Canadian Patient Safety Institute. Canadian Disclosure Guidelines (2008) Canadian Patient Safety Institute.

[34] National Patient Safety Agency. In: Being Open: Communicating Patient Safety Incidents with Patients and Carers (2005)

[35] NPSA (2009). Being open framework. http://www.npsa.nhs.uk

[36] NPSA (2009). NHS urged to say sorry when things go wrong. http://www.npsa.nhs.uk/corporate/news/nhs-urged-to-say-sorry-when-things-go-wrong/. Accessed 25/06/2010.

[37] Hingorani, M, Vafidis, G (1999). Patients’ and doctors’ attitudes to amount of information given after unintended injury during treatment: cross sectional, questionnaire survey. BMJ. 318(7184), 640–641.

---

[38] Iedema R, Sorensen R, Manias E, Tuckett A, Piper D, Mallock N, Williams A, Jorm C (2008). Patients' and family members' experiences of open disclosure following adverse events. International Journal for Quality in Health Care 20(6): 421-432 .

[39] As above

[40] As above

[41] Vincent, C, Page, L (2009). Aftermath of error for patients and health care staff. In: Hurwitz, B and Sheikh A. Health Care Errors and Patient Safety. Wiley-Blackwell. Chichester.

[42] Action against Medical Accidents (AvMA) (2010). http://www.avma.org.uk/pages/about_us.html. Accessed 10/4/10.

[43] As above.

[44] NPSA 2004

[45] Vincent, C, Page, L (2009). Aftermath of error for patients and health care staff. In: Hurwitz, B and Sheikh A. Health Care Errors and Patient Safety. Wiley-Blackwell. Chichester.

[46] Waterman AD, Garbutt J, Hazel E, et al. (2007). The emotional impact of medical errors on practicing physicians in the United States and Canada. Joint Commission Journal on Quality and Patient Safety 33(8), 467-476.

[47] Wu, Aw (2000). Medical error: the second victim. The doctor who makes mistake needs help too. BMJ, 320 31, 726-7.

[48] Firth-Cozens, J, Payne, R. (1999). Stress in health professionals. Wiley.

[49] West CP, Huschka MM, Novotny PJ, Sloan JA, Kolars JA, Habermann TR, et al (2006). Association of perceived medical Errors with Resident Distress and Empathy. JAMA, 296, 1071-8.

[50] DA Alexander, S Klein, NM Gray, IG Dewar, JM Eagles Suicide by patients: questionnaire study of its effect on consultant psychiatrists BMJ 2000; 320: 1571-1574.

[51] Wu, A (2000). Medical error: the second victim. The doctor who makes mistake needs help too. BMJ, 320 31, 726-7.

[52] Wu, AW, Folkman, S, McPhee, SJ, Lo, B (2003). Do House officers learn from their mistakes? QSHC, 12, 22-228.

---

[53] Vincent, C, Page, L (2009). Aftermath of error for patients and health care staff. In: Hurwitz, B and Sheikh A. Health Care Errors and Patient Safety. Wiley-Blackwell. Chichester.

[54] Waterman AD, Garbutt J, Hazel E, et al. (2007). The emotional impact of medical errors on practicing physicians in the United States and Canada. Joint Commission Journal on Quality and Patient Safety 33(8), 467-476.

[55] Iedema R, Sorensen R, Manias E, Tuckett A, Piper D, Mallock N, Williams A, Jorm C (2008). Patients' and family members' experiences of open disclosure following adverse events. International Journal for Quality in Health Care 20(6): 421-432.

[56] Wu, A (2000). Medical error: the second victim. The doctor who makes mistake needs help too. BMJ, 320 31, 726-7.

[57] Peters JD, Nord SK, Woodson RD (1985). Empirical analysis of the medical and legal professions' experiences and perceptions of medical and legal practice. JL Reform, 1985 – HeinOnline.

[58] Bark P, Vincent C, Olivieri L, Jones A (1997). Impact of litigation on senior clinicians: implications for risk management. Quality in Health Care, 6, 7-13.

[59] Nash L; Daly M; Johnson M; Walter G; Walton M; Willcock S; Coulston C; van Ekert E; Tennant C (2007). Psychological morbidity in Australian doctors who have and have not experienced a medico-legal matter: cross-sectional survey. Australia and New Zealand Journal of Psychiatry 41 (11), 917 – 925.

[60] Charles, SC (2001). Coping with a Medical Malpractice Suit. West J Med 174, 55-58.

[61] Bark P, Vincent C, Olivieri L, Jones A (1997). Impact of litigation on senior clinicians: implications for risk management. Quality in Health Care, 6, 7-13.

[62] Nash L; Daly M; Johnson M; Walter G; Walton M; Willcock S; Coulston C; van Ekert E; Tennant C (2007). Psychological morbidity in Australian doctors who have and have not experienced a medico-legal matter: cross-sectional survey. Australia and New Zealand Journal of Psychiatry 41 (11), 917 – 925.

[63] Studdert, DM, Mello,MM, Gawande, AA, Gandhi, TK, Kachalia, A, Yoon, C, Puopolo, AL, and Brennan TA (2006). Claims, Errors, and Compensation Payments in Medical Malpractice Litigation 354, 2024-2033.

[64] Donaldson LJ (2001). Lessons for the health field. The Journal of the Foundation for Science and Technology 17, 5-7.

[65] As above

---

[66] Parker, D, Lawton R (2003). Psychological contribution to the understanding of adverse events in health care. QSHC, 12, 453-457.

[67] As above

[68] Caplan RA, Posner KL, Cheney FW, et al. Effect of outcome of physician judgments of appropriateness of care. JAMA 1991;265:1957–60.

[69] Murier, C. E. (2000). Understanding the nature of errors in nursing: Using a model to analyze critical incident reports of errors, which had resulted in an adverse or potentially adverse event. Journal of Advanced Nursing, 32(1), 202.

[70] Parker, D Lawton R (2003). Psychological contribution to the understanding of adverse events in health care. QSHC, 12, 453-457.

[71] As above

[72] Wu, A (2000). Medical error: the second victim. The doctor who makes mistake needs help too. BMJ, 320 31, 726-7.

[73] Firth-Cozens, J (2004). Organisational trust: the keystone to patient safety. QSHC 13: 56-61.

[74] Wu, AW, Folkman, S, McPhee, SJ, Lo, B (2003). Do House officers learn from their mistakes? QSHC, 12, 22-228.

[75] Firth-Cozens, J (2004). Organisational trust: the keystone to patient safety. QSHC 13: 56-61.

[76] As above.

[77] NHSLA circular, released in May 2009

[78] Vincent, C (2006). Patient Safety. Churchill Livingstone, London.

[79] As above

[80] Waterman AD, Garbutt J, Hazel E, et al. (2007). The emotional impact of medical errors on practicing physicians in the United States and Canada. Joint Commission Journal on Quality and Patient Safety 33(8), 467-476.

[81] As above

[82] Vincent, C (2006). Patient Safety. Churchill Livingstone, London.

[83] van Pelt, F (2008). Peer support: healthcare professionals supporting each other after adverse medical events Qual Saf Health Care 2008; 17: 249-252.

---

[84] West CP, Huschka MM, Novotny PJ, Sloan JA, Kolars JA, Habermann TR, et al (2006). Association of perceived medical Errors with Resident Distress and Empathy. JAMA, 296, 1071-8.