The Center's mission is to encourage a culture that values and promotes mutual respect, trust and teamwork.
Peer Support: Mitigating the Emotional Toll of Medical Errors

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Disclosures

No disclosures/conflicts
Deep Bow

Sydney Ey
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OHSU Resident and Faculty Wellness Program
Team Sport

Allison Lilly and Henri Menco: EAP

BWH Risk Management

Patient Safety

CRICO: Beth Cushing, Bob Hanscom

CPPS Staff

Rick van Pelt, Linda Kenney

Tom Gallagher, Albert Wu
Institutions are...

“where the human heart either gets welcomed or thwarted or broken.”

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Reflection

Think of a time when you were involved in a medical error that caused patient harm.
What were some of your feelings?
Emotional impact of errors on clinicians

- Sadness
- Shame
  - Self-doubt
- Fear
- Anger
- Isolation
Helmreich’s observations:
Similarity between medicine and aviation

“...[both stress] the need for perfection and a deep perception of personal invulnerability...”

Emotional impact of errors on clinicians

• Sadness
• Shame
• *Fear*
• *Anger*
• Isolation
The Fantasy

“That’s OK Doc. I know you always try your hardest and that you were only trying to help me.”
More fantasy

No shame and blame

Shared responsibility
Vs. the Reality

Patient anger
Family anger
Litigation
Lack of support
Emotional impact of errors on clinicians

- Sadness
- Shame
- Fear
- Anger
- Isolation
Many people may be significantly impacted

- Patient
- Family
- Physician
- Team
- Institution

*Everyone should have access to support*
Normal reactions to abnormal events
Reactions may include

- **Behavioral**: insomnia, decreased productivity
- **Emotional**: anxiety, fear, anger, depression, loss of confidence
- **Cognitive**: impaired concentration, obsessive re-play of event
- **Physical symptoms**: fatigue, backaches, nausea
Many times reactions are transient

But sometimes recovery is thwarted...

... causing harm to clinicians and their patients
Error impact

• 265 MDs and nurses in two large teaching hospitals in the UK and US
• Following medical error ~30%:
  – At least moderate negative impact on work performance or personal life
  – Strained colleague relationships

Factors associated with perceived medical errors

**TABLE 5. Factors Independently Associated With Perceived Medical Errors on Multivariate Analysis**

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Shanafelt et al, Annals of Surgery, 2010
Burnout is a syndrome of depersonalization, emotional exhaustion and a sense of low personal accomplishment that leads to decreased effectiveness at work.

Physician suicide

- **40% HIGHER**: The suicide rate among male doctors than among men in general

- **130% HIGHER**: The suicide rate in female doctors than among women in general

Schernhammer E. NEJM 2005
So, how do we facilitate coping and resilience after adverse events?

Talking about it with colleagues

Disclosure and apology

Forgiveness

Dealing with imperfection

Learning from the error/understanding how to prevent recurrences

Sharing that learning with colleagues and trainees

Sometimes an entire team is affected
But physicians and clinicians at the sharp end of the error may have different needs...
Attitudes and needs of physicians for emotional support: The case for peer support

Barriers to seeking support

- Lack of time (89%)
- Stigma (77%)
- Lack of confidentiality (79%)
- Access (67%)
Sources of support

- Physician Colleagues: 88%
- Mental Health Professionals: 48%
- EAP: 29%
BWH Peer Support Program

Group peer support

Sometimes an entire team is affected

We also offer 1:1 peer support
1:1 peer support fundamentals

- Listening: empathic, non-judgmental
- Sharing experiences
- Reinforce coping skills
- Encourage teaching and involvement in systems safety
- Resource information and referral
Peer support at BWH
2012 – 2015
N = 224

Individuals
# of Groups

2012: 50
2013: 48
2014: 36
2015: 81

0 10 20 30 40 50 60 70 80 90 100

2012 2013 2014 2015

Individuals
# of Groups
Disclosure Impact

Do we think that any of these emotions might have an effect on our discussions with patients and families?
Do we think that any of these emotions might have an effect on our discussions with patients and families?

How could they *not*?
Disclosure Coaching

Disclosure is a process, not an event
Safety culture impact
Naming adverse events leads to outcome bias and reinforces unhelpful cultural biases.
What we know but don’t act on

Human error is inevitable

We work within systems that have fallibilities

The systems were designed by humans and with limited resources

Sometimes there are competing values
Every safety and quality committee reinforces the culture regarding how we respond to adverse events
Outcome Bias

• We tend to focus on the **outcome** instead of the **choice** made by the individual
• We cannot judge the **quality** of a person’s choice by the outcome, good or bad
• We punish for mistakes where there is harm
  – Drives error reporting down
  – Focuses on the wrong part of the event
If we want to learn, we need to examine the choice and the system.
Just Culture

Human Error

Product of Our Current System Design and Behavioral Choices

Manage by changing:
- Choices
- Processes
- Procedures
- Training
- Design
- Environment

At-Risk Behavior

A Choice: Risk Believed Insignificant or Justified

Manage through:
- Removing incentives for at-risk behaviors
- Creating incentives for healthy behaviors
- Increasing situational awareness

Reckless Behavior

Conscious Disregard of Substantial and Unjustifiable Risk

Manage through:
- Remedial action
- Disciplinary action

Console

Coach

Discipline

Balanced Accountability

Consistency in Rules and Response
Defendant Support
Board of Registration complaints
Many Brigham workers sought help from peer counseling.

People gathered at Brigham and Women's Hospital Jan. 21 to remember Dr. Michael Davidson, who was fatally shot.
Important points

- Many individuals exposed to a traumatic event will not need any formal intervention
- Resource/Referrals should be offered to all
- Denial can be a healthy coping mechanism
- No one should be made to talk about an event
Peer support is so valuable because it *combats*:

- Culture of invulnerability: human factors
- Shame and blame: promotes Just Culture
- Expectation of emotional denial: normalizes rxns
- Solely personal responsibility: systems issues
- Isolation: community/solidarity
- Self care is selfish: it’s important so that you can get back to doing what you do well

*Helps us show up with compassion for pt*
Not victims

“we are not victims of that world, we are its co-creators.

…source of awesome responsibility…and profound hope for change.”

Thank you for your engagement and commitment
References

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Stressful events
In the preceding year

- Serious Adverse Pt Event: 53%
- Personal Stressor/Indicator of Distress: 57%
- At least one of these two: 79%
Willingness to seek support

- Legal situations: 73%
- Involvement in medical errors: 68%
- Adverse patient events: 65%
- Substance abuse: 68%
- Physical illness: 62%
- Interpersonal conflict at work: 54%
Potential impact on disclosure and apology

- Denial and defensiveness
- Self blame
- Speculation
- Not listening
Balance the tension between

systems issues

vs.

personal responsibility
Considerations

- Leadership engagement
- Selecting peer supporters
- Program awareness
- Fielding interventions
- Triggers
- Follow up
Team commitment

• Attend training
• Maintain strict confidentiality
• Available for Peer Support
...and commitment to team

- Peer support debriefs
- Build community: regular team meetings
- Acknowledgement re citizenship
- Wellness offerings
Shoulders
This is difficult, but it is so right
Peer Support Program
Group Support Model

1. Introduction
2. Discussion of the Event
3. Reactions/Concerns
4. Education
5. Conclusion and Resource/Referral

* Partners EAP
1. Introduction

- Manager Introduces
- Acknowledge the event
- Introduction of the Process
- Voluntary, Confidential
- Most Individuals Recover
- Sharing May not be Helpful
- Sign in Sheet
2. Discussion of the Event

Describe the event/case/situation and what your experience was.
3. Reactions/Concerns

What was your reaction to the event? What was the most difficult part of this for you?
4. Education

- Acknowledge symptoms described
- Normalize reactions
- Handout educational material
- Describe how reactions subside
- Suggestions on self care
5. Conclusion and Resource/Referral

- Allow appropriate time for closure
- Answer any unanswered questions
- Any additional comments
- Identify themes
- Reinforce coping and support systems
- EAP or Mental Health Resource/Referral
Positive Self-Talk

- I can cope
- I’ve dealt with this before
- It’s okay to make a mistake
- I’m in control
- Relax and take a deep breath
- I’m going to keep perspective on the situation
Questions?
OUR HOUSE RULES

I WILL........
1. DO EVERYTHING I CAN TO GO HOME SAFE
2. NEVER FORGET RULE #1
3. RESPECT MY WORKMATES
4. COMMUNICATE POSITIVELY WITH THOSE AROUND ME
5. CHALLENGE MY MATES TO DO THE RIGHT THING
6. PRESENT FIT FOR DUTY & READY TO DO MY BEST
7. NEVER TAKE SHORT CUTS AT THE EXPENSE OF SAFETY
8. LEAD BY EXAMPLE & BE PROUD OF MY WORK
9. SPEAK UP IF I SEE SOMETHING NOT QUITE RIGHT
10. STEP UP & HELP MY WORKMATES IF I SEE THEY NEED HELP
Thank you for your time and engagement
References


Van pelt, F. Peer support: healthcare professionals supporting each other after adverse medical events *Qual. Saf. Health Care* 2008;17;249-252


What is an Adverse Medical Event?

• An injury that was caused by “medical management” rather than the patient’s underlying disease; also sometimes called harm, injury or complication

• “Medical management” refers to all aspects of health care not just the actions or decisions of physicians or nurses

• An adverse event may or may not result from an error
What is a Critical Incident?

- Traumatic event that can temporarily overwhelm an individual
- Any situation in which one feels overwhelmed by a sense of vulnerability/lack of control and potential to interfere with one’s ability to function either at the time of the crisis or at some later time
Critical Incidents*

- Adverse Medical Events
- Coworker Death/New Diagnosis of Coworker
- Patient Death
- Litigation
- Verbal/Physical Assault by Patient
- Multiple Losses
- Maternal/Child Death
- Needle Stick Exposure
- Impaired Coworker/Unethical Behavior
Creation of trust communities

“… begin to define and experience leadership as a collective project that derives its power and authority from a cooperative attachment to mutually defined commitments and values.”

- Diana Chapman Walsh

*Trustworthy leadership: can we be the leaders we need our students to become?*
Outcome Bias

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• We punish for mistakes where there is harm:
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This is, fundamentally, a culture change

“The organization's culture consists of patterns of relating that persist and change through ongoing interaction.”

- Tony Suchman, MD
Depression in Physicians

The lifetime prevalence of depression among physicians:

- 13% in men
- 20% in women

The lifetime prevalence of depression in the general population:

- 7%-25%

Frank E, Dingle AD. Am J Psychiatry. 1999
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The culture of medicine

We are trained to **never make mistakes**

We are predisposed to be perfectionists

Perfectionism is a vulnerability factor for

- depression
- anxiety
- burnout
- suicide

Safety culture impact
Naming adverse events leads to outcome bias and reinforces unhelpful cultural biases.

- Calamities
- Incidents
- Complications
- Negligence
- Malpractice
- Mistakes
- Errors
What we know but don’t act on

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