Second Victim („Druga ofiara”)

Czyli lekarz, który popełnia błąd również potrzebuje pomocy

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Medical error: the second victim

The doctor who makes the mistake needs help too

Personal view
p 812

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 the group, making them feel less exposed.[5] It has been suggested that the only way to face the guilt after a serious error is through confession, restitution, and absolution.[6] But confession is discouraged, passively by the lack of appropriate forums for discussion, and sometimes actively by risk managers and hospital lawyers. Further, there are no institutional mechanisms to aid the grieving process. Even when mistakes are discussed at morbidity and mortality conferences, it is to examine the medical facts rather than the feelings of the patient or physician.

In the absence of mechanisms for healing, physicians find dysfunctional ways to protect themselves. They often respond to their own mistakes with anger and projection of blame, and may act defensively or callously and blame or scold the patient or other members of the healthcare team. Distress escalates in the face of a malpractice suit. In the long run some physicians are deeply wounded, lose their nerve, burn out, or seek solace in alcohol or drugs.[6] My observation is that this number includes some of our most reflective and sensitive colleagues, perhaps most susceptible to injury from their own mistakes.

What should we do when a colleague makes a mistake? How would we like others to react to our mistakes? How can we make it feel safe to talk about mistakes? In the case of an individual colleague it is important to encourage a description of what happened, and to begin by accepting this assessment and not minimising the importance of the mistake. Disclosing one's own experience of mistakes can reduce the colleague's sense of isolation. It is helpful to ask about and acknowledge the emotional impact of the mistake and ask how the colleague is coping.

If the patient or family is not aware of the mistake the importance of disclosure should be discussed. The physician has an ethical responsibility to tell the patient about an error, especially if the error has caused harm.[7] We should acknowledge the pain of implementing this imperative (as does the writer of this week's personal view, p 812). However, we can convey the great relief it can be to admit a mistake, and that, confronted by an empathetic and apologetic physician, patients and families can be astonishingly forgiving. Only then is it appropriate to approach the mistake with a problem solving focus, to explore what could have been done differently, and what changes can be made at the individual and institution level to prevent recurrence. In the case of the misread electrocardiograph the educational and emotional experience for the resident—and the team—would have been transformed if a respected senior clinician had led an open discussion of the incident and acknowledged the inevitability of mistakes.

Nurses, pharmacists, and other members of the healthcare team are also susceptible to error and vulnerable to its fallout. Given the hospital hierarchy, they have less latitude to deal with their mistakes: they often bear silent witness to mistakes and agonise over conflicting loyalties to patient, institution, and team. They too are victims.

I'll conclude with an assignment for the practising doctor: think back to your last mistake that harmed a patient. Talk to a colleague about it. Notice your colleague's reactions, and your own. What helps? What makes it harder? Physicians will always make mistakes. The decisive factor will be how we handle them. Patient safety and physician welfare will be well served if we can be more honest about our mistakes to our patients, our colleagues, and ourselves.

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Ten bardzo krótki artykuł ma bardzo dużo cytowań !
To znaczy, że jest ważny dla społeczności lekarskiej.

Podstawy

- W nowoczesnej medycynie nie ma miejsca na błędy.
- Jak się czuje lekarz, który popełni błąd ?
- Jaki lekarz czuje się bardziej winny ? (Ten, który się bardziej stara !)
- Mechanizm obronny.
- Co się dzieje z lekarzem, który popełnił błąd ?

Pytania:

- Co powinniśmy zrobić, gdy ktoś z koleżanek / kolegów popełni błąd ?
- Co chcielibyśmy aby zrobili inni jeśli to my zrobimy coś nieprawidłowo ?
- Jak spowodować aby bezpiecznie rozmawiać o błędach ?
- Opisać co się stało. Jak się czuje druga ofiara ? Poinformować pacjenta i rodzinę.
- Lekarze zawsze będą popełniali błędy. Problem polega na tym jak sobie będziemy z nimi radzili.

Analiza:

- Pacjent jest najważniejszą ofiarą zdarzenia niepożądanego w medycynie. Należy mu natychmiast pomóc !
- Czy tylko pacjent dotknięty błędem ? Nie, są również trzy elementy: lekarz, szpital, system opieki zdrowotnej.
- Skala problemu – oszacowanie - co siódmy pacjent, co drugi lekarz w ciągu ostatniego roku brał udział w zdarzeniu niepożądanym.
- Stres związany z błędem lub potencjalnym popełnieniem błędu ma aż 92% lekarzy w USA.
- Co wpływa na stres związany z błędem ? Ciężkość błędu, stopień odpowiedzialności lekarza, efekt dla pacjenta.

Analiza cd.:

- Uczucia „drugiej ofiary”: odpowiedzialność za zdrowie i życie pacjenta, panika, wstyd, gniew, uczucie porażki, depresja, utrata pewności siebie, a nawet PTSD. Kobiety – częściej zaburzenia emocjonalne, poczucie winy, utrata reputacji ?
- W drugim etapie – lęk przed powrotem do pracy !
- PTSD to niemożność przejścia przez etap takich uczuć jak gniew, smutek, lęk, poczucie winy, wstyd.
- Objawy to również – brak snu, uporczywe wspominanie tego co się stało, myśli samobójcze, zmniejszone poczucie swojej wartości i wewnętrznego bezpieczeństwa.

Etapy „recovery” (powrotu, powrotu do zdrowia, regeneracji) lekarza po zdarzeniu niepożądanym

Stage of Recovery	Summary
Chaos and Accident Response	Clinician experiences internal and external turmoil and may be in a state of shock in the midst of trying to both determine what happened and manage a patient who may be unstable or in crisis. Clinician is distracted and self-reflected, needs others to take over.
Intrusive Reflections	Clinician experiences feelings of inadequacy, self-doubt, and loss of confidence. Clinician engages in continuous re-evaluation of the situation through "haunted re-enactments."
Restoring Personal Integrity	Clinician seeks support from trusted persons, but may not know where to turn and may be fearful of how others will react. Unsupportive responses from colleagues can impair recovery, as they may intensify self-doubt and make it difficult for the clinician to move forward.
Enduring the Inquisition „przetrwanie dochodzenia”	Clinician braces for the institutional investigation, wonders about the impact on their job, licensure, and the potential for litigation. Clinician may be reluctant to disclose information for fear of violating privacy regulations.

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Stage of Recovery	Summary
Obtaining Emotional First Aid	Clinician feels uncertain about who is safe to confide in due to privacy concerns and not wanting to expose loved ones to pain. In the study, most clinicians felt unsupported or under-supported, partly due to ambiguity around whom to approach and what can be discussed.
Moving On	Clinicians feel internal and external pressure to "move on," and in the study had three forms of doing so: • **Dropping out:** changing their role, moving to a different practice setting, or leaving their profession • **Surviving:** "doing okay" after acknowledging mistake, but having a hard time forgiving self, finds it "impossible to let go" • **Thriving:** making something good come out of the event

Co robić ?

- „Second victims of errors have often suffered in silence.”
- Lekarze w USA domagają się powołania jednostek, które będą im pomagały w takich przypadkach.
- Stworzenie środowiska, które pomogły by czuć się bezpiecznie lekarzom, którzy popełnili błędy, może pomóc pacjentom, rodzinom, lekarzom i szpitalom !
- Z pewnością wiedza na temat tych zagadnień jest znikoma.

Co robić ?

- Naszym moralny obowiązkiem jest zmienić tą kulturę/środowisko opuszczenia, izolacji i karania na kulturę, która daje realne wsparcie dla zranionych lekarzy („wounded healers”).
- Osoby te mają prawo być traktowane z szacunkiem, brać udział w procesie nauki z błędu.
- Z pewnością „third victim” jest szpital, w którym doszło do błędu. Rana, która się tworzy może być zaogniona lub leczona, w zależności od zachowania naszych liderów.

Co robić ?

- Prawa „drugiej ofiary” to: traktowanie sprawiedliwe, szacunek, zrozumienie i współczucie, wsparcie, transparentność i możliwość współdziałania.
- Do zapamiętania: jeśli ktoś z naszego zespołu popełni błąd, to zachowajmy się w stosunku do niego tak, jakbyśmy chcieli aby w stosunku do nas zachował się zespół jeśli to my popełnimy błąd.

Literatura

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