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Original Contributions

SUFFERING IN SILENCE: MEDICAL ERROR AND ITS IMPACT ON HEALTH CARE PROVIDERS

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Abstract—Background: All humans are fallible. Because physicians are human, unintentional errors unfortunately occur. While unintentional medical errors have an impact on patients and their families, they may also contribute to adverse mental and emotional effects on the involved provider(s). These may include burnout, lack of concentration, poor work performance, posttraumatic stress disorder, depression, and even suicidality. **Objectives:** The objectives of this article are to 1) discuss the impact medical error has on involved provider(s), 2) provide potential reasons why medical error can have a negative impact on provider mental health, and 3) suggest solutions for providers and health care organizations to recognize and mitigate the adverse effects medical error has on providers. **Discussion:** Physicians and other providers may feel a variety of adverse emotions after medical error, including guilt, shame, anxiety, fear, and depression. It is thought that the pervasive culture of perfectionism and individual blame in medicine plays a considerable role toward these negative effects. In addition, studies have found that despite physicians' desire for support after medical error, many physicians feel a lack of personal and administrative support. This may further contribute to poor emotional well-being. Potential solutions in the literature are proposed, including provider counseling, learning from mistakes without fear of punishment, discussing mistakes with others, focusing on the system versus the individual, and emphasizing provider wellness. Much of the reviewed literature is limited in terms of an emergency medicine focus or even regarding physi-

cians in general. In addition, most studies are survey- or interview-based, which limits objectivity. While additional, more objective research is needed in terms of mitigating the effects of error on physicians, this review may help provide insight and support for those who feel alone in their attempt to heal after being involved in an adverse medical event. **Conclusions:** Unintentional medical error will likely always be a part of the medical system. However, by focusing on provider as well as patient health, we may be able to foster resilience in providers and improve care for patients in healthy, safe, and constructive environments. © 2017 Elsevier Inc. All rights reserved.

Keywords—medical error; resiliency; second victim; wellness

INTRODUCTION

Doctoring is a healing profession. Patient care and safety are essential foci for all medical personnel. However, humans are imperfect, and errors in medicine are inevitable (1,2). In fact, unintentional medical error is estimated to be the third leading cause of death in the United States (3). Certainly, patients are the primary victims of medical error. However, it has been demonstrated that medical error has substantial negative effects on the mental and emotional well-being of involved providers (4,5). These effects may include guilt, shame, anxiety, fear, depression, posttraumatic stress disorder, and even suicidality (4,6–8). It been demonstrated that

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unintentional error can have a lasting impact on some, including lack of concentration, depression, burnout, poor memory, decreased clinical confidence, and impaired work performance (4,5,9–11). Some physicians and other health care workers continue to relive the event and suffer from flashbacks, nightmares, and avoidance of situations associated with the trauma, which can lead to impairment in overall functioning and work performance (8). These fears and insecurities can last for long periods of time and significantly impair one's inner security (8). Some even leave the profession of medicine, which given the current physician shortage, is a considerable loss to communities (12,13).

METHODS

The objectives of this article are to evaluate and discuss the adverse effects that unintentional error may have on involved medical personnel. To accomplish this, a MEDLINE literature search was completed using terms and phrases “medical error,” “second victim,” “physician depression/suicide,” “posttraumatic stress and medical error,” and “physician wellness” to gather information regarding the adverse effects that medical error may have on health care providers, as well as potential solutions for mitigating these effects. All potential types of articles were included. Almost all studies found on literature search and included in this review are survey- or interview-based.

This review will discuss the effects of unintentional error on medical personnel, including the concept of the second victim (5). Possible reasons behind adverse emotional effects are also discussed, including the culture of perfectionism, individual blame, and the lack of support (1,2,5,6). Finally, potential solutions for helping physicians and other medical providers after unintentional error are proposed.

DISCUSSION

The Second Victim

Because medical error is an important cause of morbidity and mortality, many authors have suggested solutions for improving patient safety and reducing errors. Understandably, much of the literature has focused on patients and their families (2,14–17). The affected patients and their families are the primary victims of medical error (5). Yet there is another victim of medical error: the “second victim” (5). Second victims include physicians, nurses, or other health care providers who suffer mental and emotional distress from being involved in a medical mistake (5). There are various possible reasons for this including medicine's culture of perfectionism, shaming

one another, and individual blame (18,19). Despite attempts at change, some of these issues remain pervasive within the culture of medicine.

Culture of Perfectionism

Medical school trains physicians well in history taking, physical examination skills, and technical procedures. However, it does not adequately prepare students for dealing with real or perceived medical error (20). In fact, despite human fallibility, the medical education process and health care delivery system simply do not tolerate mistakes (5,18,21). In addition, in the past, medical education tended to place physicians in a silo and teach young physicians that they are the primary decision makers, rather than part of decision-making health care teams (22). Thus, when an error or adverse event occurs, it is typically blamed on the physician, the “primary decision-maker.” Examples of this include morbidity and mortality conferences, peer review processes, licensing issues, and hospital credentialing. Despite calls for identifying system errors rather than individual errors, the current structure, as discussed in more depth below, still assesses errors based on the individual (2,21,23). The focus remains on allocating blame rather than actual improvement in knowledge and skills (21). The singled-out physician may be left to feel as though he or she has personally failed and must strive for future perfection (22). In addition, this emphasis on individual accountability on the part of the physician is underscored by state practice laws, which place sole responsibility on the physician and not the overall care team (21,22). The culture of perfectionism therefore remains upheld.

In addition to medical training and practice environments, the general community, media, patients, and even physicians themselves expect perfection (5,19,24). Public scrutiny of any mistake can lead physicians to become more fearful of making future mistakes. This may fuel the inner perfectionism the physician has within himself or herself, which may lead to low self-esteem, guilt, self-doubt, and other maladaptive traits and behaviors (19,25). Perfectionism can be a positive trait when used for the pursuit of self-improvement and organization. However, perfectionism can also be maladaptive. When a perfectionistic physician experiences a mistake, he or she may develop lower confidence, poor work efficiency, indecision, fear of judgement, depression, and even suicidal tendencies (25–28). Without adequate support, this physician may feel alone and subsequently develop maladaptive coping techniques (25). These may include avoiding the issue, holding one's feelings inside, or using drugs and alcohol (29). David Hilfiker in 1984 stated this concept well: “We

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