Leadership: Assuring respect and compassion to clinicians involved in medical error

The last 15 years have seen an exponential increase in research on and attention to medical error and patient safety in health care. Grounded in ethical practice, respect and compassion, we are learning to acknowledge our patients' unnecessary suffering. More and more often, we tell patients and their families *what* happened, *why* it happened and *what's being done* to prevent it from happening again. We are learning to apologise. This respectful acknowledgment for the "first victims" of medical error – patients and families – has developed for many reasons. Reactively or proactively board, executive and clinical leaders are accepting their fundamental responsibility for the quality and safety of care, declaring the current state of suffering and harm unacceptable, and setting bold aims for a safer, more respectful healthcare system.

Far less progress has been made on behalf of respect and compassion for the "second victims" of medical errors: the healthcare workers. These are the physicians, nurses and other clinicians and trainees who are at the so-called "sharp end" of medical error – the ones who "did it." The review article in this issue by Schwappach and Boluarte, entitled "The emotional impact of medical error involvement on physicians: A call for leadership and organisational accountability" [1] makes a clear, sobering case for a dramatically different leadership response to medical error. The authors document the suffering, distress, distance and absence of support, burnout and other effects of medical errors on clinicians. The data in this report, combined with stories offered by clinicians, together call for a more effective approach to this problem.

Almost every physician and nurse has their story, their case and their night. They remember the details as if it were yesterday, even if it was 10 or 20 years ago. They tell their stories with an intensity of emotion that brings tears to the eyes of both, the storyteller and the listener. Many have never shared their stories with anyone; some, with only a spouse or close friend. These stories usually end with expressions of shame, isolation and lack of closure. The counsel received at the time of the incident, if any, included: "Stuff happens," "You can't dwell on it," "You'll just have to do it better the next time," and "Go back to work." Leaders also offered little solace: "Who did it?" "Are they still with us?" "Just fix it!" and "I want no more errors!"

Healthcare leaders have a moral and ethical responsibility to support clinicians who were directly or indirectly involved in a medical error. Errors are most often ultimately the failure of leadership, organisations and systems – not the staff at the front line. For too long, leaders have expected staff to do no harm and to perform their tasks perfectly 100 percent of the time. While clinicians dutifully and passionately embraced their responsibility, it is irrational to expect individual workers to perform flawlessly in defective organisations. No matter how good our staff members are, everyone makes mistakes. They suffer from a condition called "being human." Systems are too complex to expect merely amazing people to perform perfectly 100 percent of the time no matter how hard they try. Given that the vast majority of errors are due to failures of bad systems and not bad people, providing support to clinicians and other staff at the sharp end of medical care is simply the respectful and compassionate thing to do.

A growing list of leadership initiatives and expectations, many of them addressed in the review article, seek to mitigate the impact of medical errors on clinicians. At the top of this list is the expectation that leaders will establish and nurture a culture of quality and safety that is anchored in respect, trust, human rights, repentance and forgiveness. Those who practice within a fair and just culture will find that systems support safe practice and mitigate the chances of errors reaching patients and causing harm. Leaders must commit resources to this effort and establish peer support groups and other resources to help clinicians deal with the emotional burden of clinical care, including preventable adverse events. Leaders must respond promptly and proactively in the event of an error or accidental injury, ensuring that affected staff members are treated with respect, compassion and support from leaders and their colleagues. Leaders must establish an organisational expectation that anything less than a supportive response is unacceptable.

As healthcare leaders, we can not ignore the findings of Schwappach and Boluarte; we must take action. Assuring that our workers (and patients and families) are treated respectfully and compassionately is our responsibility.

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Reference

1 Schwappach DLB, Bolvarte TA. The emotional impact of medical error involvement on physicians: a call for leadership and organizational accountability. Swiss Med Wkly. 2009;139 (1–2):9–15.