



Peer Support: Mitigating the Emotional Toll of Medical Errors

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Team Sport



Senior Leadership

Quality and Safety

Risk Management

Psychiatry

MSCC and MSEC

EAP

Human Resources

Office of General Counsel

Patient

CRICO/RMF

**Family
Relations**



Institutions are...

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

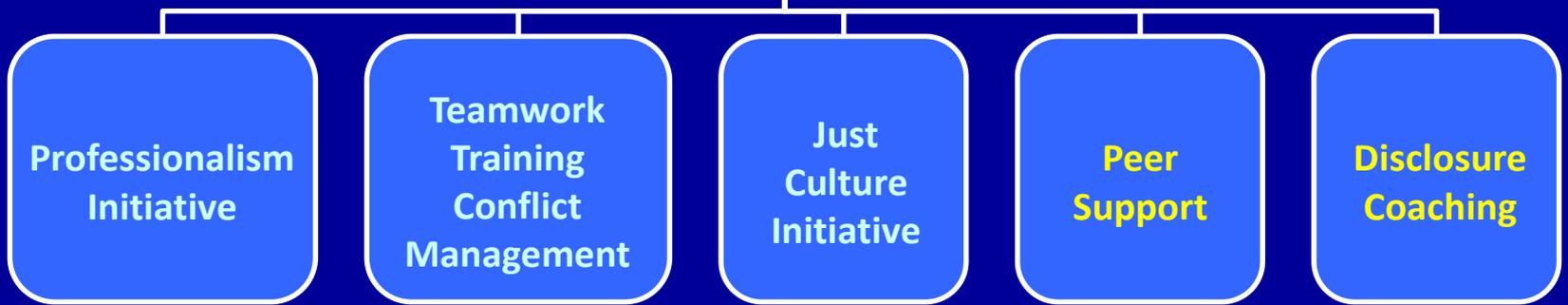
Parker Palmer. Quoted in Living the Questions,
Jossey-Bass, San Francisco, CA, 2005.





*The Center's mission is to encourage
a **culture** that values and promotes
**mutual respect, trust and
teamwork.***





Wellness



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...”

Helmreich, Davies.
Culture, Threat and Error: Lessons From Aviation.
Can J Anesth 2004; 51:6

Emotional impact of errors on clinicians

- Sadness
- Shame
- *Fear*
- *Anger*
- Isolation



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



**Many times reactions are
transient**

But sometimes recovery is thwarted...



**... causing harm to
clinicians and their patients**



Error impact

3,171 MDs surveyed in US and Canada

Impact of Errors on Physicians' Life Domains by Level of Error Severity*

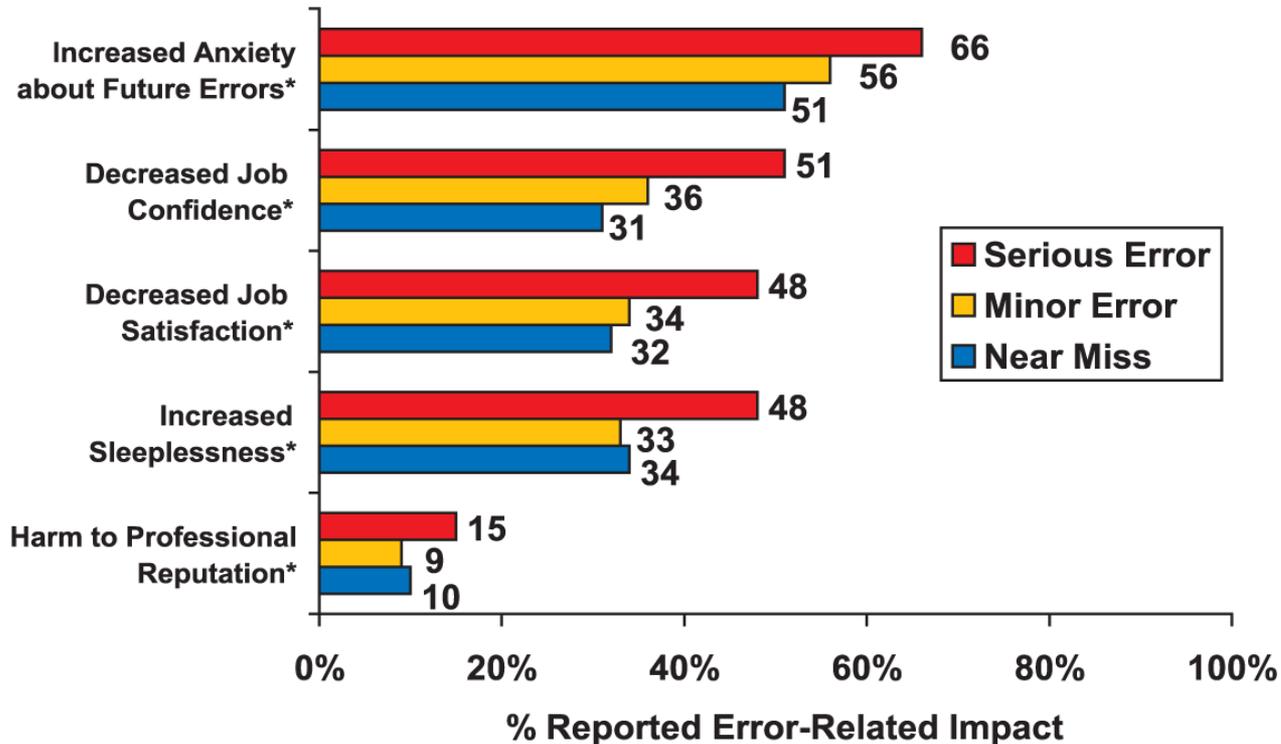


Figure 1. Physicians' lives were more likely to be affected as error severity increased.

* Chi-square tests; $p < .001$ level.

Waterman et al. Jt Comm J Qual Patient Saf. 2007 Aug;33(8).

Error impact

Following medical error

~30%

Experienced some negative impact on

Work performance or personal life

Colleague relationships

Harrison R, Lawton R, Perlo J, Gardner P, Armitage G, Shapiro J.
J Patient Saf. 2015 Mar;11(1):28-35.



Factors associated with perceived medical errors

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

Characteristic and Associated Factors	Odds Ratio*	<i>P</i>
Positive depression screen	2.217	<0.0001
Burnout	2.016	<0.0001

Shanafelt et al, Annals of Surgery, 2010



Burnout

Burnout is a syndrome of depersonalization, emotional exhaustion and a sense of low personal accomplishment that leads to decreased effectiveness at work.

Shanafelt, TD, Bradley, KA et al.
Annals. of Internal Medicine, Vol. 136, no 5. 2002.



Burnout and medical error

1% increase in

- Depersonalization \longrightarrow 11% \uparrow
 - Emotional exhaustion \longrightarrow 5% \uparrow
- likelihood of reporting having made an error

Burnout and depression = independent predictors of reporting a recent major medical error

Shanafelt TD, Balch CM, et al. Ann Surg 2010; 251(6)



Physician Suicide

40% ↑



The suicide rate among male doctors than among men in general



130% ↑

The suicide rate among female doctors than among women in general

Schernhammer E. NEJM 2005

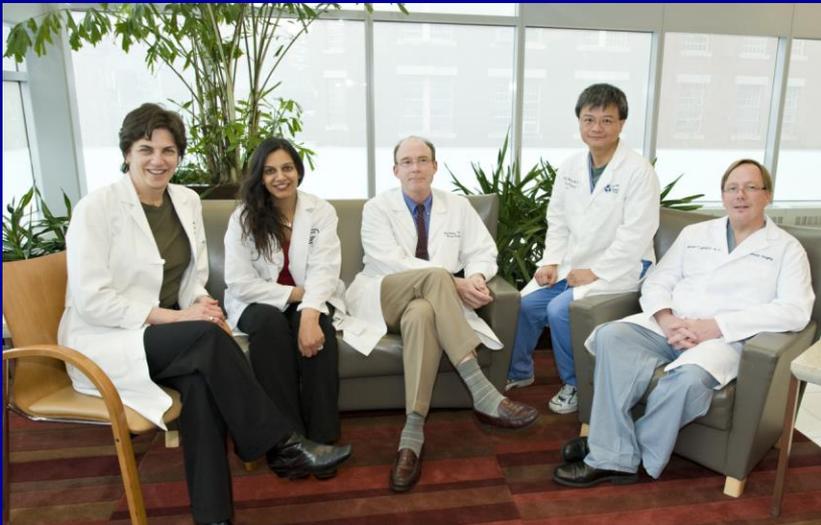


**Can't expect people who are
feeling unsupported and
isolated to deliver high quality
patient care or to sustain their
joy in work**



*So, how do we facilitate coping and **resilience** after adverse events?*

Group peer support



**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



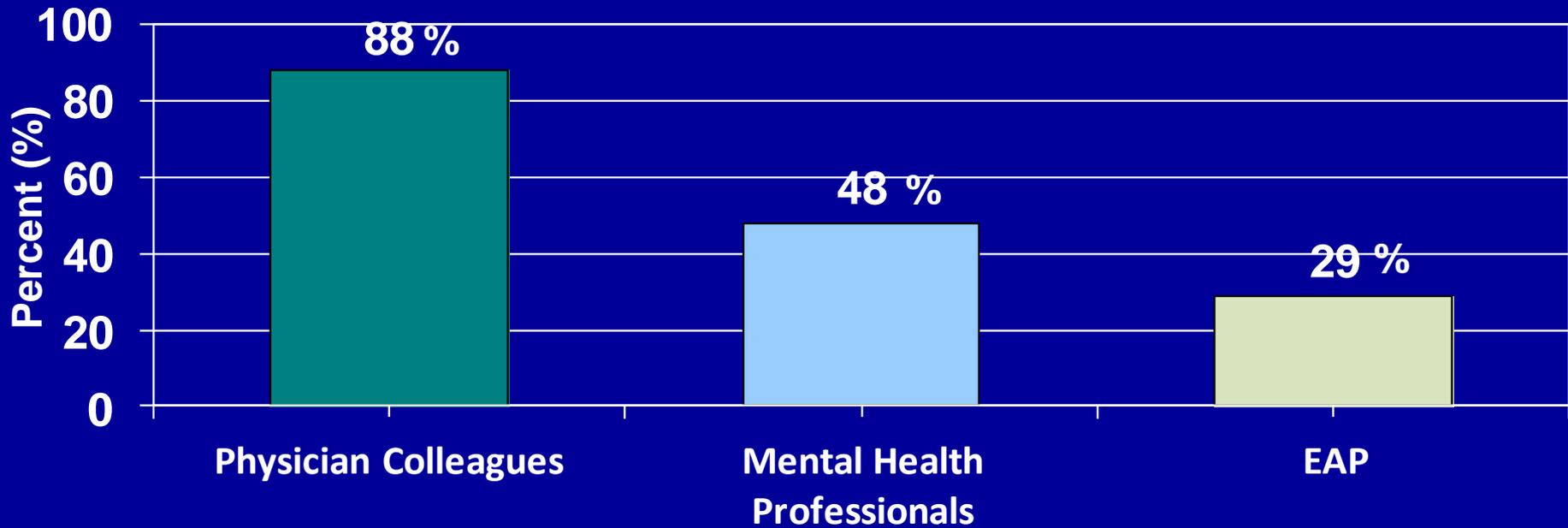
Hu J, Fix M, Hevelone N, Lipsitz S, Greenberg C, Weissman J,
Shapiro J. *Arch Surg* 2012

Barriers to seeking support

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



Sources of support



Factors associated with resilience after adverse events



Factors associated with resilience after adverse events

Talking about it
with colleagues

Dealing with
imperfection

Disclosure
and apology

Learning from the error/
understanding how to
prevent recurrences

Forgiveness

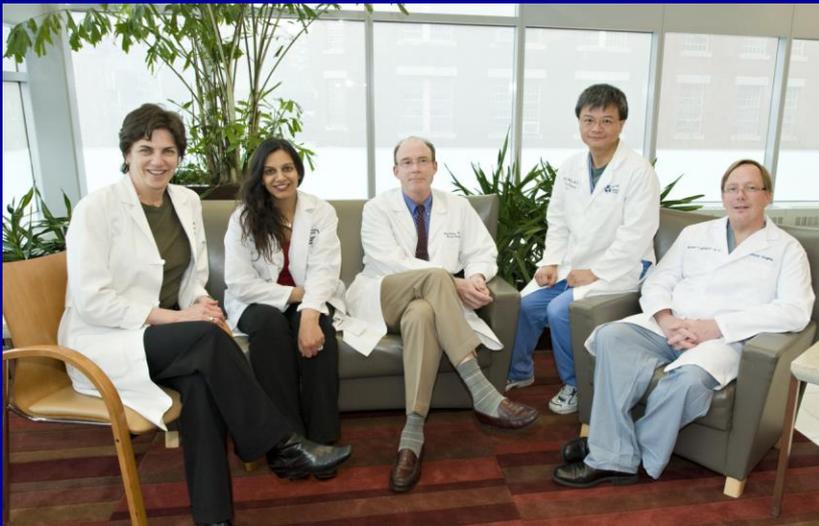
Sharing that learning with
colleagues and trainees

Plews-Ogan M, May N, Owens J, Ardelt M, Shapiro J, Bell SK. Wisdom in medicine: What helps physicians after a medical error. Acad Med. 2015 Sep 4.



We also offer 1:1 peer support

Group peer support



1:1 peer support



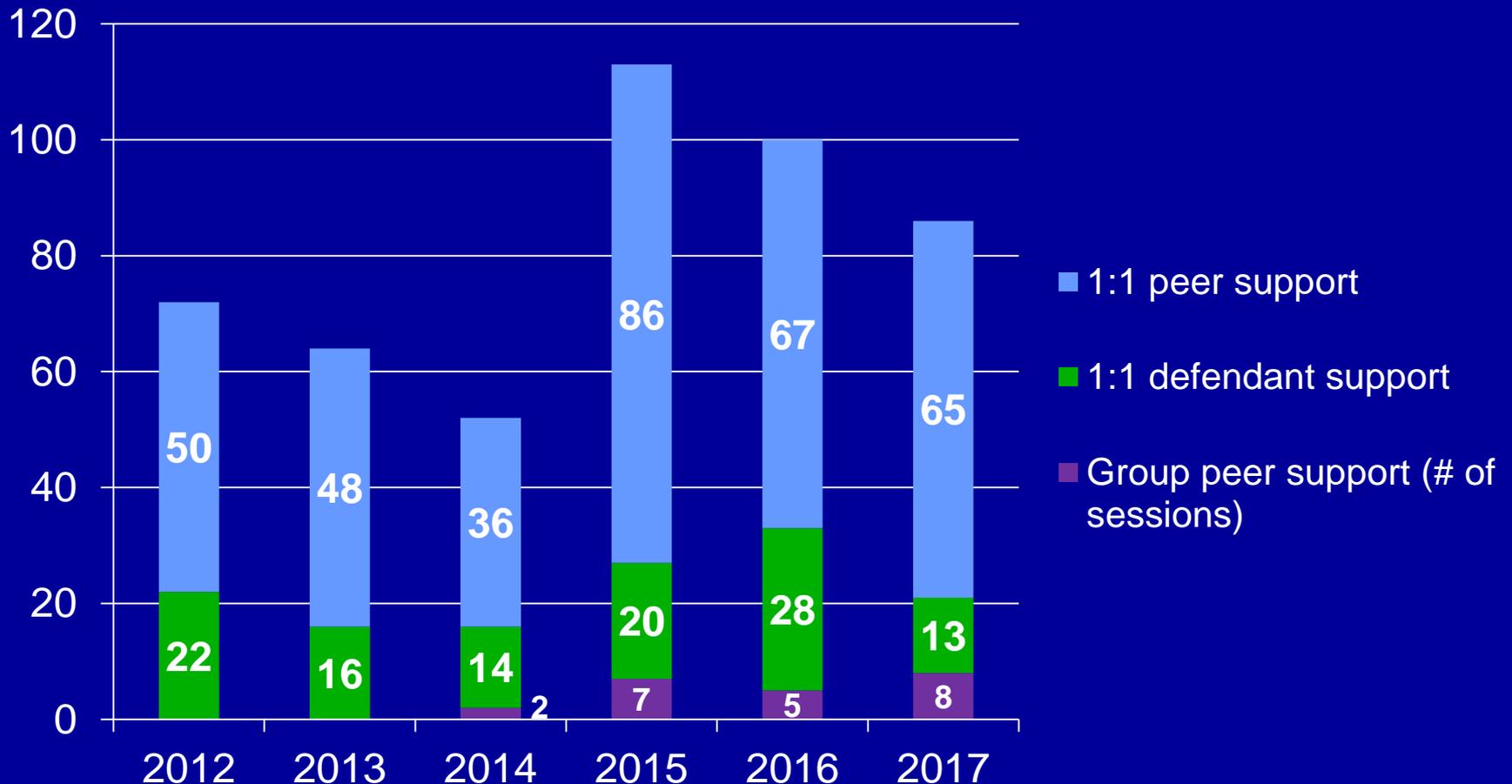
1:1 peer support fundamentals

- Listening: empathic, non-judgmental
- Sharing experiences
- Reinforce coping skills
- Encourage teaching and involvement in systems safety
- Resource information and referral



Peer and defendant support at BWH

2012 –2017 (n = 487)



Discoverability



Safety culture: Learning and growth mindset

- All feel safe talking about error
- Do not punish for human error (or for choices made in the face of legitimate competing priorities)
- Find and fix vulnerabilities in our systems and behaviors



Leonard MW, Frankel A. Patient Education and Counseling 80 (2010) 288–292

When else do we offer peer support?

- Adverse events
- Disclosure and apology conversations
- Board of Registration complaints
- Lawsuits
- Chronic stress
- Patient aggression
- Care of trauma victims
- Global crisis relief work



Peer support: A powerful culture change tool

Shame and blame



Promotes Just Culture

Personal invulnerability



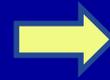
Human factors

Expectation of emotional denial



Normalizes reactions

Isolation



Community/solidarity

Self care is selfish



Gets you back to what you do well

Helps us show up with compassion
for our patients



Disclosure Coaching

Support clinicians in having transparent and empathic conversations with pts after errors





Communication & Resolution Programs (CRPs)

- Transparent with patients regarding adverse events
 - What happened/why
 - Was event preventable
 - How recurrences will be prevented
- Proactive and prompt offer of financial and non-financial resolution if unreasonable care

The Boston Globe **Metro**

Many Brigham workers sought help from peer counseling



DAVID L. RYAN/GLOBE STAFF/FILE 2015

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

Not victims

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

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

Palmer, P. Let Your Life Speak, Jossey-Bass,
San Francisco, CA, 2001.



***Thank you for your engagement and
commitment***

