



# How the personal and professional impact of adverse events on doctors damages safety culture

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## Context and problem

Multiple factors have been identified to explain the low rates of incident reporting among doctors. These include fear of blame, lack of confidence in change, negative experiences of previous investigations and psychological effects, ie the ‘second victim experience’.<sup>1</sup>

### Box 1: Definitions of ‘adverse event’ and ‘near miss’

An adverse event is ‘an injury related to medical management, in contrast to complications of disease’, whereas a near miss is ‘a serious error or mishap that has the potential to cause an adverse event but fails to do so because of chance or because it is intercepted’.<sup>2</sup>

## Study design

A confidential, modified email survey<sup>3</sup> was sent to 11,810 members and fellows of the Royal College of Physicians (RCP),<sup>4</sup> using standard definitions (Box 1) to ask participants about their experiences of adverse events and near misses (Table 1). Those who had experienced such an event or near miss were directed to complete further questions.

Table 1: Types of event experienced by participants (n=1,463)

Type of event	%	n
Adverse event with serious patient harm	51.1	748
Adverse event with minor patient harm	55.6	813
Near miss with potential for serious patient harm	61.0	892
Near miss with potential for minor patient harm	55.1	806
None of these	10.7	157

## Demographics

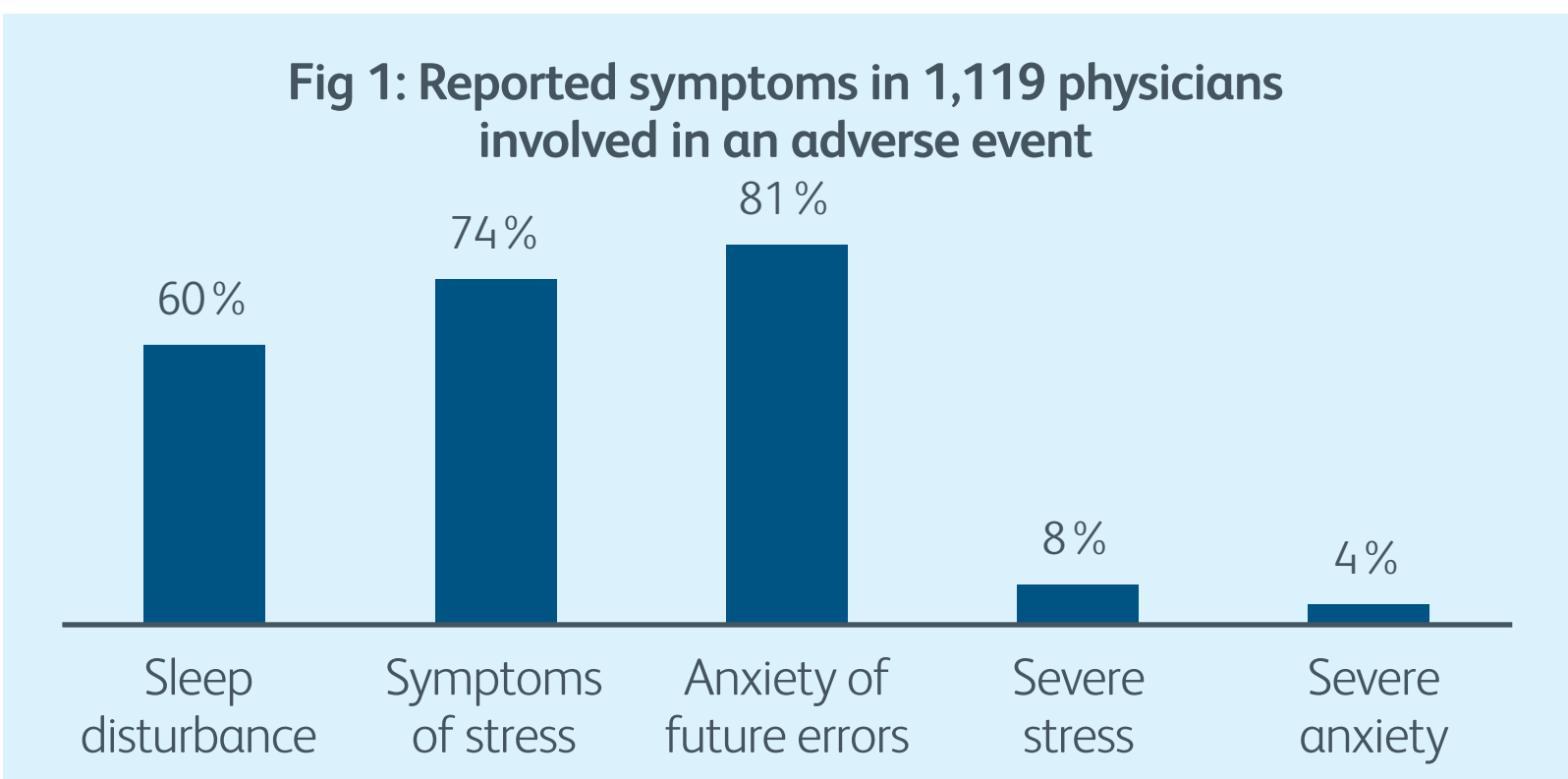
The mean age of respondents was 47 years, 38 % were female and all internal medical specialties were represented. The sample (Table 2) was broadly reflective of consultant members of the RCP.<sup>5</sup>

Table 2: Demographic information

Demographic	% of respondents	n
<b>Years in practice (n=1,703)</b>		
<2 years	0.5	9
2–10 years	7.6	129
>10 years	89.7	1,527
Retired	2.2	38
<b>Age (n=1,668)</b>		
<25 years	0.1	2
25–34 years	3.5	59
35–44 years	32	534
45–54 years	37.9	632
55–64 years	23.1	385
>64 years	3.4	56
<b>Gender (n=1,667)</b>		
Male	62.2	1,037
Female	37.8	630

## Results

A low number of participants (1,755) accessed the survey, answering at least one question. A precise response rate is impossible to determine, as it is not known how many recipients saw the survey but decided not to participate.



The sample of 1,463 participants was involved in at least one adverse event or near miss. Of these, 1,119 believed that there had been an impact on their lives (Fig 1, Table 3); 1,172 out of 1,313 respondents did not feel that healthcare organisations adequately supported doctors dealing with adverse events, while 1,142 said that if they were allocated a mentor, they would contact that mentor about an adverse event.

## Incident reporting

Overall, 1,141 respondents reported an incident using the national system: 512 were dissatisfied with how their report was dealt with. In total, 364 did not report an incident. Free-text responses revealed beliefs that nothing would improve as a result; that reporting was an onerous process; and that punitive action was feared.

## Discussion

Most of the sample of consultant physicians do not feel confident when reporting an incident, owing to personal psychological effects or a lack of confidence in incident reporting. The data suggest that consultants have no greater resilience to such events than other staff. Senior doctors have a strong influence on the culture in the healthcare system, and as such their negative experiences are likely to impact on the people whom they supervise.

Table 3: Personal and professional outcomes of an adverse event or a near miss (n=1,463)

Outcome	%	n
Lower confidence in ability as a doctor	63.2	886
Difficulty sleeping	59.9	840
Reduced job satisfaction	48.5	681
Affected relationships with colleagues	25.5	358
Damaged professional reputation	20.1	282
Other personal or professional outcomes	15.8	221
Anxious about potential for future errors	81.5	1,192
Generally distressed (depressed, upset or angry)	73.6	1,077
Generally anxious (nervous, panicky or tense)	68.0	995
Negative towards yourself	27.3	399
More confident in your abilities	7.5	110
Determined to improve	80.6	1,179

## Conclusion

Healthcare organisations, policymakers and professional bodies have a responsibility to develop supportive systems for clinicians who are involved in adverse events, in order to foster a transparent culture in which lessons are learned.

## Declarations of interest

None to declare.

### References

- 1 Wu AW. Medical error: the second victim. *BMJ* 2000;300:726.
- 2 World Alliance for Patient Safety. *WHO draft guidelines for adverse event reporting and learning systems: from information to action*. Geneva: World Health Organization, 2005.
- 3 Waterman AD, Garbutt J, Hazel E *et al*. The emotional impact of medical errors on practicing physicians in the United States and Canada. *Jt Comm J Qual Patient Saf* 2007;33:467–76.
- 4 Harrison R, Lawton R, Stewart K. Doctors’ experiences of adverse events in secondary care: the professional and personal impact. *Clin Med* 2014;14:585–90.
- 5 Federation of the Royal College of Physicians of the UK. *Census of consultant physicians and medical registrars in the UK 2011*. London: RCP, 2013.