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F van Pelt

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Peer support: healthcare professionals supporting each other after adverse medical events

F van Pelt

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Correspondence to:
F van Pelt, Department of
Anesthesiology, Perioperative
and Pain Medicine, Brigham and
Women's Hospital, 75 Francis
Street, Boston, MA 02115, USA;
fvanpelt@partners.org

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ABSTRACT

The patient safety movement in healthcare is beginning to openly acknowledge the need to support the human side of adverse medical events in conjunction with evidence-based improvement initiatives. While medical literature has sporadically reported on the emotional impact of adverse events on healthcare professionals, little has been documented on the implementation of support services following these events. This article describes an adverse medical event where open communication and apology catalysed the development and implementation of a structured peer support service for care providers at the Brigham and Women's Hospital following adverse events. The Peer Support Service bypasses the stigmas that limit the utilisation of formal support services and offers care providers a safe environment to share the emotional impact of adverse events while serving as a foundation for open communication and a renewal of compassion in the workplace. As the breadth of stressors impacting healthcare professionals is revealed, the Peer Support Service is being recognised as a vital hospital-wide service. It also appears to offer an important leap forward in the critical areas of patient safety and quality of care.

The "veil of silence" that has shrouded adverse medical events for many decades is now recognised as a significant hindrance to the transformation of patient safety and quality of care. In addition to limiting transparency, apology and accountability, the culture of silence obscures the tremendous impact that adverse medical events have on patients, families and the involved healthcare professionals. Efforts to call attention to this devastating emotional impact on healthcare professionals have occurred sporadically in the medical literature for more than 20 years and have been largely disregarded by the healthcare community.¹⁻⁵

This article describes an adverse medical event and the ensuing apology and open communication between doctor and patient that catalysed the development and implementation of a structured peer-based support service for care providers following adverse events. The Peer Support Team model provides caregivers with a safe environment to share the emotional impact of adverse events and serves as a foundation for open communication and a renewal of compassion in the workplace. It also appears to offer an important leap forward in the critical areas of patient safety and quality of care.

THE EVENT

On 18 November 1999, I was providing anaesthetic care for a 37-year-old woman undergoing a total

ankle replacement. I placed a popliteal fossa nerve block preoperatively with bupivacaine and there was no deviation from the standard of care. Within moments, the patient experienced a grand mal seizure and progressed to cardiac arrest. After approximately 10 min of resuscitation the patient remained unresponsive. A fully prepped cardiac operating room was fortuitously available and our patient was rushed into the room, where she underwent a sternotomy for emergent cardiopulmonary bypass. The patient's cardiac rhythm was restored and after being weaned off of the bypass machine she was taken intubated to the cardiac intensive care unit (ICU).

The aftermath

As is typical during medical emergencies, we were focused on the resuscitation with our emotions on hold. Only after the patient had been stabilised on bypass did the impact of what I had just done begin to sink in. I felt personally responsible for what had happened and compelled to communicate with the family. I thought I would be able to provide a factual account of the event to the husband but to my shock, the husband came at me with full emotional and physical force; fortunately the orthopaedic surgeon intercepted him. I was now forced to confront my own emotional distress and I realised my complete lack of training in how to manage this situation. In an instant, the years of clinical training, my board certification and the respect of my colleagues as a competent anaesthesiologist had become irrelevant and meaningless. I felt lost and alone.

The following day I was doing cases as though nothing had happened. No one mentioned the event as I performed my clinical duties with numb detachment. In spite of the previous communication disaster, I still felt compelled to reach out to the patient in spite of the obstacles. There were three communication barriers:

- ▶ risk management's request that I leave communication with the patient to them;
- ▶ the ICU team's desire not to be pulled into the aftermath;
- ▶ the husband's request that I keep my distance.

From the risk management perspective, everything was proceeding according to plan: the patient had been successfully isolated, treated and released from the hospital without further incident or bad publicity. Still, I knew this "business as usual" approach had left me adrift and alone in dealing emotionally with the event. Surely the patient too must be having her own emotional challenges.

My profound sense of responsibility broke through my fear and compelled me to do the right

thing. I chose to write the patient a letter of apology without informing the hospital and invited the patient to open communication if and when she was ready.

Contact

Six months after the event, Linda Kenney called me. I gave her the factual account of the event and she related that the event had only been described once to her during her hospital course and then as an allergic reaction to anaesthesia. Linda shared her emotional experience and asked me to share mine. When she surprisingly offered me forgiveness, I felt an incredible emotional release. I had my life back and I could talk openly about what had happened.

When we met in person 2 years after the event, Linda described her frustration and anger at my institution's refusal to communicate with her about the event. She shared the uncompassionate, legally parsed letter that she had received from hospital administration, a letter that had made her angrier than ever before and she commented that she now understood why patients sue. Two things stood out for me:

- ▶ that healthcare had strayed from compassionate care in a profound way;
- ▶ that the wall of silence that was there to protect against lawsuits was in fact a major contributor to them.

BARRIERS TO CHANGE

Many issues contribute to the silence that isolates caregivers from patients and families following adverse events. Although fear of litigation remains a primary barrier, the culture of medicine and the absence of systems thinking are important and less visible obstructions.⁶⁻⁹

"Numbing" down

Care providers are taught to distance themselves emotionally from their patients through empathy: understand and acknowledge how your patients feel without personal involvement. With time, many care providers become experts at suppressing their ability to feel, and the compassion that initially attracted care providers to healthcare is supplanted with detached professional competence. This process of numbing down blunts the ability of the caregiver to experience the emotional impact that adverse events have on patients, families and themselves. In addition, if disclosure or apology is offered to a patient and/or family member, the detached caregiver may lack the authenticity that is critical during this kind of conversation.^{10 11} The absence of authenticity is perceived immediately and quickly erodes the crucial element of trust between patient, family and caregiver.

Absence of systems-based thinking

It is well known in both theory and business practice that in excess of 90% of the results that are experienced in healthcare are a function of the systems in which caregivers work, not their individual efforts.^{12 13} This fact is not well understood in healthcare and is at direct odds with the generally held belief in individual responsibility.¹⁴ Worse, systems that compromise the quality of care are, for the most part, *invisible* to care providers. Hence, the source of problems and adverse events are never addressed. Instead, caregivers are blamed for "mistakes" that are out of their control rather than looking first to less than optimal systems as the source of 90% of poor outcomes and inefficiency.

The unreliable nature of care processes (systems) reinforces the caregiver's autonomous approach to patient care. The misplaced focus on the caregiver as the source of error rather than systems in which the caregiver must deliver care is a natural sequelae and preserves the culture of blame, shame and incompetence. This isolates the care provider and continues to discourage the disclosure of near-misses and error, thereby limiting any true understanding of systems challenges and the possibility of a permanent corrective intervention.

MAGNITUDE OF THE CHALLENGE: UNDERESTIMATING THE SIZE OF THE IMPACTED POPULATION

The magnitude of adverse events that patients, families and care providers are exposed to is sobering. For the Institute of Medicine's estimated 100 000 annual patient deaths attributable to medical error,¹⁵ associating two family members and two care providers with each death puts annual exposure to at least 400 000. Using the Institute of Health Improvement's estimated 15 000 000 annual incidents of harm, 6 000 000 of which result in harm severe enough to impact hospital stay,¹⁶ the number of those directly affected reaches at least 30 000 000 annually (table 1).

MEDICALLY INDUCED TRAUMA SUPPORT SERVICES

In May 2002, Linda founded Medically Induced Trauma Support Services (MITSS, see www.mitss.org), whose mission is to "Support Healing and Restore Hope" to all affected by adverse medical events.¹⁷ Initial efforts to engage hospitals were met with great resistance. After presenting a keynote address with the patient at the 2004 National Patient Safety Foundation Congress in Boston, what followed was a surge of media publicity and invitations to present the MITSS story nationally and internationally. While Linda focused on developing MITSS programmes around awareness, advocacy and direct support, I began to develop emotional support services for healthcare professionals at my institution.

PEER SUPPORT

The impact of adverse medical events on caregivers has been powerfully described in the medical literature, notably by Hilfiker in 1984, Christensen in 1992, Newman 1996 and Wu in 2000.^{1-4 18} In spite of the repeated outcry, the paucity of structured emotional support services for care providers by healthcare organisations is striking and sobering.⁵

The Peer Support Team task force

In June 2004 Janet Barnes, Director of Risk Management, and I were charged by Dr Anthony Whittemore, Chief Medical Officer, to create a task force to develop and implement a support service for care providers. We were intrigued by the support model being utilised by Kaiser Permanente under the leadership of Tony Devencenzi, Director of the Employee

Table 1 How many are affected by medical error each year?

Deaths due to medical error	98 000/year ¹⁵
Affected family members	>196 000/year*
Affected clinicians	>196 000/year*
Patients surviving "significant" medical error	>6 000 000/year ⁹
Affected family and clinicians	>24 000 000*
Total affected	>30 000 000/year

*Assumption: the patient has at least two family members and two caregivers closely involved with their care.

Table 2 Survey of operating theatre staff (%) regarding emotional support following adverse medical events: April 2005

	Actively offered	Offered after I asked	Found on own	Not available	Utilised
Formal emotional support	11	11	25	53	10
Informal emotional support	27	11	46	16	59
Opportunity for time off from clinical duties	0	3	8	89	0
Help in communicating with patient and family	14	17	19	50	37
Personal legal advice and support	11	14	19	56	29

Source: Brigham and Women's Hospital Operating Room, April 2005. N = 78.

Assistance Program (EAP).⁵ Devencenzi noted that one of the persistent barriers to caregiver participation was the stigma of accessing formal support through EAP and mental health services. Our internal survey affirmed that only 10% of care providers who were offered or who found formal support services actually utilised them (table 2).

We focused on training care providers (peers) as the primary contact for their colleagues following adverse events by applying a methodology that for more than a decade has been successfully implemented with first responders (police, fire, emergency medical services).^{19 20} Our sense was that a common clinical background would provide the necessary credibility and safety to overcome the "therapy" stigma and to enable these challenging conversations. To defuse the fear of lawsuits, the programme would work outside the quality assurance (QA) process. By supporting care providers directly, we knew that the long-term benefits would also extend to a focus on improving emotional support to patients and families; it is a widely recognised principle that the quality and satisfaction of patient care is directly impacted by caregiver satisfaction.^{21 22} Thus the concept of the Peer Support Team (PST) was created.

A multidisciplinary task force was formed, comprising care providers and representatives from our formal support services, including EAP, social work, ethics, chaplaincy, patient relations, risk management, psychiatry and MITSS. The multidisciplinary structure solidified the relationships between care providers and formal support providers and served as a cornerstone in developing a seamless peer support model and infrastructure.

Peers support peers

A vital hallmark of the PST is to identify and recruit credible care providers to serve as trained peers. Participants must be respected for their clinical skills as well as for their ability to listen without judgement; they are the "go-to" people in the organisation. The service is voluntary, confidential and immediately available (box 1); it is completely separate from the QA process.

Box 1 Hallmarks of the peer support team model

- ▶ Credibility of peers
- ▶ Immediate availability
- ▶ Voluntary access
- ▶ Confidential
- ▶ Emotional "first aid" (not therapy!)
- ▶ Facilitated access to next level of support (eg, Employee Assistance Program)

PST training

Andrea Stidsen, Director Partners EAP, Allison Lilly and Henri Menco, Operations and Quality Managers Partners EAP, played critical roles in developing the PST training programme. The training teaches "emotional first aid", enabling caregivers to listen, assess, and support colleagues one-on-one and to refer those in need to the next level of care. The training is based on the combination of best practices in critical incident response and evidence-informed "psychological first aid".²³

Education and promotion

A proactive educational approach was required to introduce the PST model into a medical culture that has traditionally suppressed the emotional impact of unanticipated outcomes. Open letters of endorsement and support written by the chief medical officer and the chairman of the hospital doctors' organisation were critical in demonstrating institutional commitment and the absence of conflict with the existing QA processes.

A defining adverse event

A pivotal adverse event solidified the support initiative when a clinical colleague presented as a patient and experienced near death during an operative intervention. We were suddenly resuscitating a member of our care provider family without an emotional shield. In contrast with the event that I had experienced six years earlier, the PST was activated and a safe haven was set up for the care providers. With the permission of the family, regular updates were provided to operating theatre staff about our colleague's condition, minimising the speculation that usually surrounds adverse events. One-on-one peer support and group sessions were offered in the days and weeks that followed and fortunately our colleague made a complete recovery.

One of the remarkable outcomes that manifested during group sessions was a true sense of *esprit de corps* between all of the team members. This healing and pulling together, a trait of all great teams, transcends the immediate event and can serve as a catalyst for cultural change in the long term.

PST launch, July 2006

The PST was officially launched in the operating theatre environment at the Brigham and Women's Hospital in July 2006. The service is available 24 h a day, 7 days a week, and is accessible through an organised and visible infrastructure. Confidentiality is maintained throughout the support process without record keeping or written documentation. In addition to regular one-on-one support (two to five per month), there have been more than 20 group support sessions since inception. With its initial success, the PST is expanding into other

departments including obstetrics/gynaecology, emergency medicine and the intensive care units. The PST has been formalised as the Brigham and Women's Hospital Peer Support Service under the sponsorship of the chief medical officer and the chief nursing officer and is administered within the hospital's EAP department.

PEER SUPPORT: CHALLENGES AND NEXT STEPS

Even as the peer support service continues to expand, considerable challenges remain. Physician culture in particular remains resistant to acknowledging and sharing the emotional impact of adverse events. Continued effort is being made to educate care providers about the importance of support and to reinforce the hospital's endorsement of these services as part of the routine response to adverse events. Attention is also being placed on supporting caregivers enveloped in the stress of malpractice litigation. It is critical to create a safe institutional environment that is committed to the well-being of caregivers as the underpinning for this cultural transformation.

Although it is commonly assumed that patients and families are receiving appropriate emotional support following adverse events, the structured PST model has exposed a gap in the patient/family support infrastructure. One of the great challenges in providing this structured emotional support is the need for an organisation to actively execute on its policies of open communication and apology. In addition to an active commitment to disclosure and apology, Brigham and Women's Hospital has started to develop an Early Support Activation (ESA) with MITSS for patients and families in conjunction with the hospital's departments of social services and patient relations. The long-term strategy is to have a comprehensive emotional support response for patients, families and care providers.

CONCLUSION

The open communication and apology that followed the adverse event in 1999 served as a powerful catalyst for the development and implementation of peer support at Brigham and Women's Hospital. The Peer Support Service provides accessible emotional support for care providers by eliminating the stigmas associated with formal support services and by creating a credible and safe forum for healthcare professionals to have these conversations. Peer support is utilised over a broad range of incidents, from personal crisis and adverse events to support during malpractice litigation. Importantly, the collaborative design with existing formal support services now provides facilitated access for those in need of greater support. Peer support has enabled the further development and much-needed emotional support services for patients and families.

The need to improve support services for care providers following adverse medical events has been pointed out again in a new study published in the August 2007 issue of the *Joint*

Commission Journal on Quality and Patient Safety.²⁴ It is clear that sustainable improvement depends on the integration of a supportive and compassionate work environment with systems-based thinking. This balance creates the opportunity for *being* the change rather than *doing* the change.

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