The Human Side of Errors

Confronting and overcoming the personal devastation associated with mistakes in healthcare.

By Scott Warner, MLT(ASCP)

As Billy Joel once sang, "You're only human, you're allowed to make your share of mistakes." We all make mistakes. But an error that adversely affects a patient outcome can be devastating, even career changing. By understanding the nature of errors, their emotional impact, and what you can do about it, you can survive the personal tragedy of making a serious error and become a better technologist.

Secondary Victims

Certainly, when a serious error occurs, the outcome can be tragic. But research has established that health professionals involved in the error are "secondary victims" because of its emotional impact and repercussions on the institution. One review of studies concludes these include shame, self-doubt, anxiety and guilt, consistent across professions.¹

A 2003 study reveals that over 80 percent of physicians experienced emotional distress after making an error, including anxiety about future errors, loss of confidence, decreased job satisfaction, insomnia and concern about their professional reputation. The more serious the error, the greater the distress.²

The Journal of The American Academy of Physician Assistants describes a six-stage process a caregiver experiences as "postevent trajectories," adding that healthcare workers at all levels experience shameful or negative emotions that can last months or even years. This adds stress that can trigger depression and burnout. At least, it leads to self-reflection and need for self-forgiveness.³

Nurses may feel guilty or terrified about making a medication error, becoming angry with themselves or losing confidence in their abilities. A lack of correlation between demographics and incident--medication errors can happen to anyone--and fear of punishment are a stressful combination; according to one source, 95 percent of medication errors are unreported because of the latter.⁴

While the laboratory is often in a supportive and not direct caregiving mode, our results directly affect treatment decisions. In transfusion medicine, errors can kill. The emotional impact can be damaging, making the technologist involved a "second victim."

Types of Errors

In part, there is more focus on doctors and nurses because laboratory workers are somewhat protected from the emotional impact of adverse outcomes by the nature of diagnostic testing. Consider these error categories defined by the US Department of Health and Human Services Agency for Healthcare Research and Quality:

- **Active Error**--these occur at the point of contact by the person closest to the patient and are generally obvious. They can be thought of as errors at the "sharp end" (e.g., surgery) but can
inaccurate procedures, lack of staffing) will lead to more active errors. Without awareness of the big picture, near misses are harder to spot.

Dealing With Errors
Still, laboratory errors are difficult to handle when a patient outcome is known (e.g., transfusion reaction caused by the blood bank) or unknown (e.g., a potassium error that changes treatment is not discovered for several hours). In many cases, especially in small hospitals, we know our patients personally and empathize with their suffering. A latent error can be just as damaging to the technologist on the bench as to a doctor or nurse.

Here are a few tips to help handle making errors:

• **Admit the error**—Not only is it better patient care to immediately admit what happened to those making treatment decisions, stepping up and taking responsibility helps build trust with your superiors, who understand that mistakes can happen.

• **Analyze the root causes**—It’s important to fix the immediate outcome (e.g., recalibrate the method, send corrected reports, etc.) but you also need to understand why the error occurred at all. Insist on being part of this discovery process.

• **Make changes**—To make sure you or another person does not make the same error, it’s crucial to change the system; making changes often is a multilayered and multidisciplinary process.

These steps involve emotional detachment by necessity, putting feelings of shame and guilt aside to help fix the system. After all, you won't be much use if you're an emotional train wreck after a serious error happens. But deferring emotional pain doesn't eliminate its impact. As soon as possible, seek support and help in dealing with negative emotions. Most organizations have an Employee Assistance Program; your Human Resources department can help. Rookie or experienced technologists will benefit from peer support. Don't underestimate the healing power of personal relationships. And correcting systemic processes that cause latent errors is a professional growth experience that will make you a better technologist, leading to better patient care.

**Scott Warner** is lab manager at Penobscot Valley Hospital, Lincoln, ME.
References


