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"Remember that patient you saw...": Advice for trainees on coping after making an error.

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There is much education and training devoted to the avoidance, early detection and mitigation of errors in the Emergency Department. Despite this, errors remain a common occurrence and at times contribute to adverse events. Patients bear the bulk of this burden, but staff also suffer. This article provides 12 tips to help trainees cope in a productive way after making an error.

1. **Accept and understand your human fallibility.** The human brain is very powerful and flexible, but it is not foolproof. It is prone to error if interrupted, required to multi-task, tired, distracted, overloaded, bored, on automatic pilot, emotional, fixated, or confronted with something that looks routine on the surface, but is actually not. No human is immune. This, combined with the complexity, acuity and volume of patient presentations to the Emergency Department is a perfect recipe for error. Errors are inevitable. Doctors are fallible[1,2]
2. **Understand the nature of error.** Learn about error and patient safety. Without this knowledge, it is very difficult to analyse and understand your own errors in an accurate and productive way[2,3]
3. **Always do your best.** If you are conscientious about turning up to work well rested, make the most of your learning opportunities and do your best for all of your patients as a routine, then when things go wrong, at least you will know you have been trying.
4. **Use the retrospectoscope with care.** Often looking back on an incident, the right course of action at a given point in time has become obvious. The concept of

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signal to noise ratio is helpful here. When looking back it is easy to only see the 'signals' and ignore the 'noise'. However, at the time the error was made it may not have been possible to differentiate between signal and noise. This difficulty is known as hindsight bias[4]. The retrospectoscope is good for learning, but needs to be used with great care if making a judgement about where to find fault.

5. Understand the futility of thinking, "if only I…." Most errors are the result of multiple factors**.** Chances are that responsibility is shared across people and systems. Try to find the right balance: you don't want to blame others in order to protect yourself, nor do you want to take an inappropriately high level of attribution onto yourself. Identifying what you would do differently in a similar situation in the future is a good way to identify what you have control over and what you can improve upon.

6. Be a reflective practitioner, adopt a growth mindset. When analyzing an event, don't just ask yourself "*Did I make an error?*". Ask yourself, "*how can I improve?*" and "*how can we improve?* The problem with the first question is if the answer is no, learning opportunities will be lost. "*How can I improve?*" is a question to ponder even when care goes well. "*How can we improve?*" promotes learning and improvement at a team and system level. Realise that your clinical abilities are developed and grown through practice and effort[5,6]

7. Be honest. Apart from being the right thing to do, it feels good to be ethical and a person of integrity[7]

8. Be kind to yourself. Care for yourself as you would a good friend or colleague**.**

9. Know the difference between guilt and shame. Guilt is "I did a bad thing", shame is "I am bad"[8]. Shame is an unhealthy response; guilt and grief less so. All are common responses for healthcare workers after making an error that harms a patient[9,10]

10. **Talk candidly with your clinician peers.** Share your experiences, successes, failures and learning. It helps to talk and peers can be a great support. This is one of the ways senior Emergency Physicians cope and learn[11]

11. Seek counsel from a more senior doctor who has a good understanding of how errors occur. Often junior staff struggle to see the big picture, and can overestimate the gravity of their contribution. Senior staff have made plenty of their own errors and know that even the best of clinicians make mistakes.

12. Share what you have learnt once you feel ready. Become a teacher.

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Doctors need a good head, a warm heart and broad shoulders. The broad shoulders are required because we care for patients knowing that we will make errors despite our best efforts. It is inherent to the task of being a doctor, and requires courage, strength and humility. Perfect performance is simply not attainable. The best we can do is to *strive* for excellence while remaining open to learning and improvement. The advice in this piece is designed to help broaden your shoulders.

1. Reason J. A life in error: from little slips to big disasters: CRC Press; 2017.
2. Heard G. Errors in medicine: a human factors perspective. Australasian Anaesthesia. 2005(2005):1.
3. Runciman B, Merry A, Walton M. Safety and ethics in healthcare: a guide to getting it right: CRC Press; 2017.
4. Henriksen K, Kaplan H. Hindsight bias, outcome knowledge and adaptive learning. Quality and Safety in Health Care. 2003;12(suppl 2):ii46-ii50.
5. Klein J, Delany C, Fischer MD, Smallwood D, Trumble S. A growth mindset approach to preparing trainees for medical error. BMJ Quality & Safety. 2017;26(9):771-4.
6. Dweck C. Mindset: Changing the way that you think to fulfill your potential. updated edition: Robinson; 2017.
7. Manning Peskin S. My Human Doctor: Medical school teaches us to examine, to reserach, to treat. We don't learn to err and recover. The New York Times. 2018 October 4th, 2018.
8. Brown B. Daring greatly: How the courage to be vulnerable transforms the way we live, love, parent, and lead: Penguin; 2015.
9. Bynum WEI, Artino ARJ, Uijtdehaage S, Webb AMB, Varpio L. Sentinel Emotional Events: The Nature, Triggers, and Effects of Shame Experiences in Medical Residents. Academic Medicine. 2019;94(1):85-93.
10. Seys D, Wu AW, Gerven EV, Vleugels A, Euwema M, Panella M, et al. Health Care Professionals as Second Victims after Adverse Events: A Systematic Review. Evaluation & the Health Professions. 2012;36(2):135-62.
11. Harrison J, Molloy E, Bearman M, Ting CY, Leech M. Clinician Peer Exchange Groups (C-PEGs): Augmenting Medical Students' Learning on Clinical Placement. In: Billett S, Newton

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J, Rogers G, Noble C, editors. Augmenting Health and Social Care Students' Clinical Learning Experiences: Outcomes and Processes. Cham: Springer International Publishing; 2019. p. 95-120.

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