LETTERS

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CLINICIANS AFTER MEDICAL ERROR

Supporting "second victims" is a system-wide responsibility

The "second victim" phenomenon—the inability of clinicians to cope with their emotions after a medical error or adverse event—can be devastating for the clinician affected.[1] It also has implications for patient safety and safety culture, so responsibility for dealing with it goes beyond individual clinicians.

Second victim experiences are worse if clinicians have negative experiences of investigations or feel that they were dealt with in a punitive manner; these doctors become less likely to report future incidents and, if senior, their attitudes will influence the behaviour of junior staff.[2]

A Royal College of Physicians survey of 1755 senior physicians reinforces previous findings.[3] Most physicians had been involved in serious adverse events and most had experienced second victim effects; 60-75% described sleep disturbance, anxiety, or stress and a small but significant proportion described effects similar to post-traumatic stress disorder. Although most had used formal incident reporting systems only a minority described useful learning; 25% were involved in incidents that they knew they should have reported but didn't. Factors contributing to this included a belief that nothing would change, fear of punitive action, and the psychological effects of having been involved in a previous event.

Most physicians turn to friends and colleagues for support because only 5% have a formal mentor. However, 80% describe a determination to improve as a result of an adverse event, suggesting that in the right circumstances they could be engaged in a learning process.

A transparent NHS safety culture will be achieved only if we recognise and address the second victim phenomenon.[4] This is more than "clinicians unable to cope with their emotions after a medical error," although we recognise the importance of providing support, including mentoring to individuals. Because the attitude and behaviour of policy makers, regulators, and other external bodies can be part of the problem, these bodies must also be part of the solution.

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Full response at: www.bmj.com/content/350/bmj.h1982/rr-0.

1 Edrees H, Federico F. Supporting clinicians after medical error. *BMJ* 2015;350:h1982. (15 April.)

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Must "second victims" always be in the wrong?

Edreess and Federico discuss the support of clinicians after medical error—the "second victims."[1] The concept of second victims seems to revolve around medical error and the psychological consequences of these events on the clinician.

A surgeon's usual duties meet criterion A of the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5) for post-traumatic stress disorder (PTSD) and acute stress disorder (ASD).[2] There is an expectation that surgeons will be entirely habituated to this "run of the mill trauma," and that they will continue to deliver care in spite of preceding events.

Specialist training in surgery is known to be a stressful experience in which efficient and accurate learning are key to success.[3] The symptoms of PTSD/ASD disrupt sleep, mood, and concentration.[2] Clearly, PTSD/ASD among trainees is likely to be harmful to learning.

We agree that future studies should focus on organisational culture as well as individual clinicians' willingness to access support services. We would argue that waiting for error, rather than signs of stress, to trigger access to support may unintentionally give the impression that support is punitive or stigmatising. Using a validated scoring system,[4] we aim to increase our knowledge about the prevalence of PTSD/ASD-type symptoms in surgical trainees, current approaches to supporting trainees, and the uptake of such services.

This study uses a web based survey (www.surveymonkey.com/s/traumasurg). The results so far have been fascinating. Of 120 respondents, 42% report that their training has suffered as a result of PTSD/ASD symptoms, but only 15% have received any support. We would be grateful if any surgical (pan-specialty) trainees reading this letter could participate in our survey.

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AUSTERITY AND RISE OF FOOD BANKS

Paper on food banks does not justify a link to party politics

Your recent Editor's Choice singles out David Cameron as "flummoxed" by questions about food banks in the leaders' interviews.[1] You then imply "a link between the current government's austerity policies and food insecurity" when introducing Loopstra and colleagues' paper.[2]

This paper shows that food bank establishment and activity correlates with markers of economic hardship and previous local food bank activity. The evidence presented cannot be considered to have "underestimated the true burden of food insecurity in the UK" as the authors claim, and neither does it justify a link to party politics.

According to the Organisation for Economic Co-ordination and Development,[3] the proportion of people reporting not enough money to buy food fell from 9.8% in 2007

to 8.1% in late 2013. The Department for Environment, Food and Rural Affairs reports that food prices in real terms are now falling,[4] and that the share of income spent on food by the lowest income households has been stable since 2011, at around 16.5%. These sources were absent from the authors' list, of which 14% were articles from *The Guardian*. The authors do mention some primary sources that attempt to explore the complex individual situations leading to food bank use.[5 6] These report that although problems with the benefits system are common, they may relate to civil service failings rather than party policy, and are often secondary to debt (the "main reason for hunger" for a fifth of Trussell Trust clients 2006-11)[5] or addiction. Even these articles cannot answer the crucial question of whether users would have gone hungry if they had not accessed a food bank, or were instead using the service to subsidise other lifestyle choices.

Although it is essential to engage in public debate on socioeconomic policy, given the proximity to the general election, should *The BMJ* be more careful?

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1 Jackson T. Austerity and the rise of food banks [Editor's Choice]. *BMJ* 2015;350:h1880. (9 April.)

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ZOLEDRONIC ACID AND BONE DENSITY

News title on zoledronic acid and bone density was misleading

The title of this research news article—"Zoledronic acid increases bone density but does not reduce fractures in frail elderly people, study finds"—purports to represent the main message of Greenspan and colleagues' study.[1 2]

Although there is some clarification within the news article, Greenspan and colleagues were cautious in their interpretation of fracture rates, as reflected in their abstract.

They were even more guarded in the article's discussion section, pointing out the limits in their original study design and in its power to detect changes in bone mineral density (BMD). They also acknowledged that multiple possible confounders in the treatment group could have accounted for the discrepancy with other published research and called for a larger study specifically to examine the association between BMD, bone turnover, and fracture reduction.

In his commentary on the study, Lindsay also pointed out differences in the study groups, despite randomisation, that might have influenced the apparent fracture results, and he cautioned against changing clinical management solely on the basis of this study.[3]

Unfortunately the title of this news article might mislead some doctors who are not astute at interpreting the news item itself or not willing to spend time reading the original articles. Greaves's rapid response provides an excellent example of that possibility.[4]

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BENEFIT OF HEALTH APPS

Importance of distinguishing between different types of health app

Husain and Spence debate the same subject, whether healthy people can benefit from health apps, but actually discuss different things.[1] It is important to distinguish between apps that encourage behaviours that protect health, as described by Husain, and those that monitor physical parameters, as described by Spence. The first type carry little risk because they encourage behaviours with known health benefits, such as physical activity or smoking cessation; the second type are unlikely to help identify specific diseases and run the risks of unnecessary worry and misdiagnosis.

Modern societies actively market unhealthy lifestyles,[2] and the apps described by Husain may help to market healthy ones. Apps described by Spence, which continuously monitor physical parameters, are full of uncertainties, not least for the user. However, this technology is part of an irreversible societal shift that demands and makes use of constantly available information. If we continually broadcast and update aspects of our lives on social media, we will no doubt monitor our physical function if the data are available.

Whether apps that promote healthy behaviours work is another matter, but they are very different from those that continually monitor the physical state of healthy people. Doctors may have to explain the difference to their patients.

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1 Husain I, Spence D. Can healthy people benefit from health apps? *BMJ* 2015;350:h1887. (14 April.)

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Practitioners should embrace, not ignore, health apps

We are currently exploring two of the concerns raised by Husain and Spence—the regulation of health apps and evidence for their effectiveness.[1] Android and iOS app stores currently contain more than 100 000 health apps, and the number is constantly increasing.[2] The NHS Choices Health Apps Library contains verified apps with trusted information that are clinically safe and comply with data protection standards.[3] We have adapted the National Institute for Health and Care Excellence behaviour change guidance into a preliminary quality assessment framework for mobile apps aimed at behaviour change.[4]

When this framework was applied to the NHS apps library, we found that the apps tended to focus on initiating behaviour change rather than maintaining change or preventing relapse; very few have any form of evaluation of effectiveness planned, even though many collected outcome data through tracking and self reporting. App developers and researchers should try to fill these gaps, and clinicians could help to drive this change.

Our ongoing update of a systematic review shows that effectiveness depends on long term adherence.[5] Some short term effects are seen, but if the intervention is not adhered to in the longer term the impact is diluted. Apps were most successful when combined with measures such as reminder phone calls or regular one to one appointments, rather than standalone treatment.

Mobile apps have potential for both primary care practitioners and patients. In a time of increasing pressures on the NHS, value is placed on prevention over symptom management. The world of the worried well would be less likely if this new technology is embraced rather than ignored by practitioners, and if we work in partnership with patients, researchers, and designers to help evaluate how this technology can improve the health of our patients in the future.

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