Royal College of Surgeons of England
ADVANCING SURGICAL CARE

SUPPORTING SURGEONS AFTER ADVERSE EVENTS

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The Royal College of Surgeons of England

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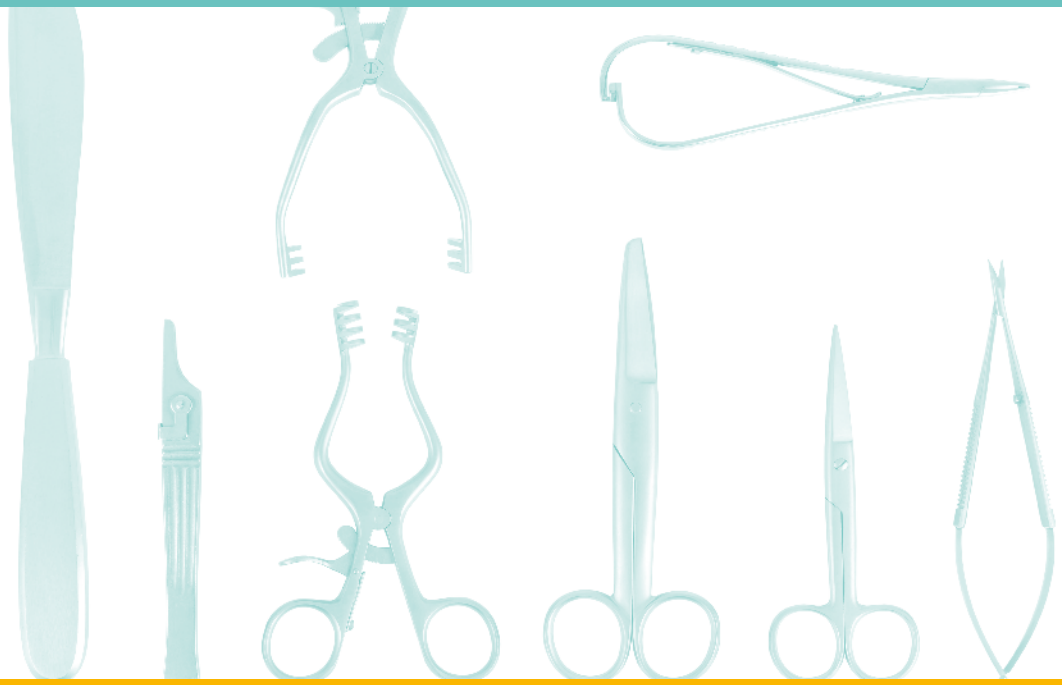
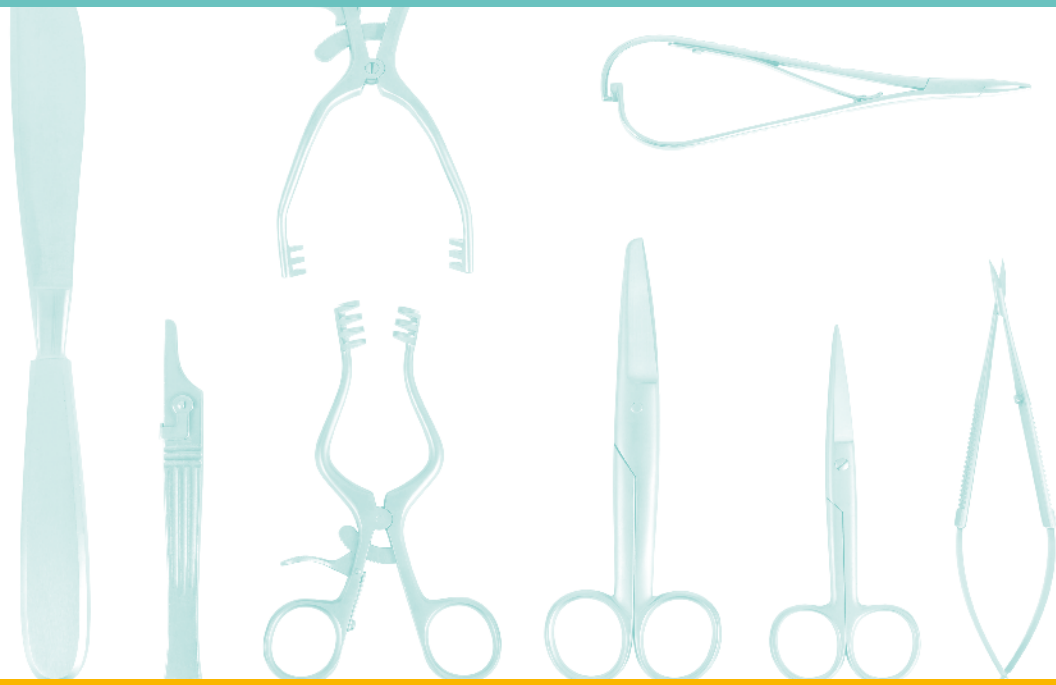
SUPPORTING SURGEONS AFTER ADVERSE EVENTS

A Guide to Good Practice

In partnership with
Bournemouth University





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Bournemouth University

This guide has been produced in collaborative partnership between the Royal College of Surgeons of England and the University of Bournemouth Surgeon Wellbeing Research Team.

RCS Professional and Clinical Standards
December 2020

Contents

1. How this guidance was developed

This good practice guide has been developed through collaboration between Bournemouth University's surgeon wellbeing research team (www.surgeonwellbeing.co.uk) and members of The Royal College of Surgeons of England (RCS England) quality improvement directorate.

It has been supported by a surgical adverse events first aid response (SAEFAR) working group comprising:

- Professor Kevin Turner (Chair), Consultant Urological Surgeon and Visiting Professor, Bournemouth University
- Dr Helen Bolderston, Clinical Psychologist, Bournemouth University
- Mr Andrew Miles, Consultant General Surgeon
- Mr Steve Garnett, Consultant Urological Surgeon
- Dr John Jones, Consultant Gastroenterologist
- Dr Michael Devlin, Medical Defence Union
- Dr Judith Johnson, Clinical Psychologist, University of Leeds and Bradford Institute for Health Research
- Lucy Warner, NHS Practitioner Health Programme
- Jill O'Regan, British Medical Association
- Dr Angela Busutill, Clinical Psychologist, Sussex Partnership NHS Foundation Trust
- Ralph Tomlinson, RCS England
- Katerina Sarafidou, RCS England

With contributions from:

- Professor Siné McDougall, Professor of Psychology, Bournemouth University
- Mr Neil Burgess, Consultant Urological Surgeon
- Dr Michael Peters, British Medical Association
- Miss Sally Deverill, Specialty Trainee in Urology
- Tom Rapanakis, British Medical Association
- Miss Gemma Scrimgeour, Core Surgical Trainee

We would like to thank all those who have supported the development of this good practice guide as well as all the surgeons who completed Bournemouth University's surgeon wellbeing survey.

2. Purpose of this guidance

Adverse events are part of surgery. We know that adverse events have an impact on the wellbeing of surgeons, and that this impact affects them personally and professionally. Despite this, the profession has been slow to recognise the breadth and depth of the impact on surgeons in the UK, and slower still in considering how it should respond. This evidence-based document builds on existing RCS England guidance (*Good Surgical Practice* and *Duty of Candour*),[1,2] and aims to provide advice on how adverse events affect the surgical workforce and what might be done to minimise the impact of an adverse event on surgeons while supporting patient safety. Adverse events will always occur but if we can mitigate their impact on surgeons, then surgeons will be better able to care for their patients, and lead satisfying and productive professional lives.

In this guidance, we first review what is known about the impact of adverse events on surgeons in the UK by asking:

- How are surgeons affected by an adverse event and why are surgeons worthy of particular attention?
- What support exists already, how do surgeons perceive it and to what extent do they engage with it?
- What does a supportive organisational culture look like?

Next, we look in detail at the response to an adverse event and consider:

- How should surgeons look after themselves when something goes wrong?
- How should an employing organisation look after a surgeon? What are the roles and responsibilities of the medical director and senior managers?
- What are the regulatory and medicolegal issues?
- What additional issues arise for doctors in private practice and for doctors in training?

Lastly, we propose a key new role focused on the wellbeing and immediate needs of a surgeon involved in an adverse event: the 'first responder'. Each trust should train key staff in this role in advance of any adverse events, allowing an immediate response to a future unexpected event. Specifically, we address:

- What is the first responder role?
- Who could undertake this role, and how should they be chosen and trained?
- How might employing organisations develop this role? What are the practicalities of delivering a first responder programme? How could the role be reviewed and developed locally and nationally?

Although this guidance has a surgical focus, we expect that it will be directly relevant and easily transferable to other medical specialties and healthcare professionals.

3. Defining the challenge

3.1 CREATING A MORE SUPPORTIVE RESPONSE TO ADVERSE EVENTS

Things go wrong in surgery. When this happens, the impact on patients, their carers and their families is often dramatic; they are the first casualties of an adverse surgical event. Putting things right and prioritising the wellbeing of the patient should be the primary concern of all healthcare providers but when something goes wrong, healthcare providers are affected too. They have been described as the 'second victims'.[3] The term 'second victim' has stirred some controversy and alternatives such as 'second casualty' have been suggested.[4] Whatever descriptor is used, the concept is simple: healthcare providers involved in an adverse event commonly suffer psychologically and professionally. Their social interactions may be negatively impacted and mental or physical health problems may develop or be exacerbated.[5]

Strikingly, clinicians coping with the aftermath of an adverse event might be more likely to make a subsequent error.[6–8] The nature and trajectory of a doctor's response to adverse events has been explored to some extent, and there is also some guidance about how the impact of these consequences might be reduced.[9] Much of the research and guidance to date is from North America, however, and very little of it looks in detail at the particular issues facing surgeons.

Data from the UK show that adverse events have a profound impact on surgeons, with surgeons experiencing guilt, high levels of worry and rumination, and crises of confidence.[10] Additionally, conducted between 2016 and 2019, a national survey of the impact of adverse events on surgeons in the UK demonstrated a high incidence of post-traumatic stress symptomatology among surgeons, with rates equivalent to those experienced by military personnel returning from conflict zones (unpublished data, Bournemouth University's surgeon wellbeing research team). This survey and multiple anecdotal reports have highlighted that there is a need for guidance to help surgeons and those who employ them to navigate the numerous issues that arise in the aftermath of an adverse event.

> *'It always feels callous to talk about the impact on yourself as the surgeon when you know the family have suffered so much more. Unfortunately, my trust didn't really know how to handle me or the process and I was not well supported.'*
>
> **Anonymous surgeon**

Specifically, surgeons have told us:

- There is a lack of knowledge about what processes should be followed after an adverse event
- There is no clear timeline
- There is a lack of emotional and practical support for affected surgeons
- There is little guidance for those who do wish to provide this support
- Too often, existing responses focus on statutory responsibilities, investigations or disciplinary processes and too rarely, on the wellbeing of the surgeon involved
- There is no clarity around whether the surgeon should continue to work and if not, how the surgeon's return to work should be supported

> *'We all hide our grief, suffer in silence. The pain can be close to debilitating.'*
>
> **US surgical trainee, BISA study[11]**

When a surgeon is impacted by an adverse event, multiple stakeholders can become involved: the surgeon themselves, their clinical or medical director, their trust (or other employing organisation), their medical defence organisation (MDO), their trade union, their surgical college or their specialty association. Each of these stakeholders may have responsibilities to fulfil and input to offer. Simultaneously, the surgeon will be facing multiple personal and professional challenges such as the immediate needs of the patient and/or carers involved, the personal emotional impact, concerns about reputation, confidence issues, fears and uncertainty about complaints and litigation, and questions about how and when to continue working, and in what context.

In 2018, Bournemouth University's surgeon wellbeing research team and RCS England jointly convened a working group to provide guidance to surgeons and their employers in this situation. The group recognises that every situation will be unique and that no guidance can cover all possibilities. Nevertheless, current provision is inadequate and to date, there has been no detailed consideration of these issues in a UK context. This guidance aims to address gaps in current understanding and provision in the aftermath of an adverse event, with a particular focus on the wellbeing of the surgeon involved.

3.2 WHY FOCUS ON SURGEONS?

Surgeons are poor users of existing support services. For example, only 4.3% of the users of the Practitioner Health Programme (an NHS funded programme for doctors with mental health and addiction problems) are surgeons even though surgeons make up 11% of UK medical practitioners. In this context, surgeons have been described as 'a hidden minority within a hidden minority'.[12] In 10 years of providing care for doctors with mental illness, the NHS Practitioner Health Programme has seen 143 surgeons. Ninety per cent of these surgeons were supported with conditions that fell within a mental health definition and nine per cent presented with addiction problems.

Surgeons tend to have lower rates of reported mental illness than other specialties and this is certainly the case in the Practitioner Health Programme. Surgeons' lower rates of presentation could be related to factors that reduce the development of mental illness (eg better resilience to cope with occupational stress). Surgeons might also be protected by their close working relationships with others, allowing for sharing of distress, successes and general support. So perhaps surgeons genuinely have a lower rate of mental illness than other doctors. However, other work has shown high levels of suicidal ideation (especially in older surgeons) and significant levels of distress, anxiety and/or burnout.[13] Consequently, it seems likely that surgeons are a hidden group within medicine, with a great reluctance to seek help for mental health problems.

In addition, data from Bournemouth University's surgeon wellbeing research team have shown that a substantial minority (42.5%) of surgeons do not speak to anyone at all about the impact that an adverse event has had on them, not even to colleagues or family members and definitely not to formal sources of support.

All doctors (and indeed, all healthcare professionals) are likely to be affected by an adverse event at some point. Furthermore, the definition of a surgeon has become a little blurred since many doctors who are not surgeons also undertake interventional procedures with significant risk (anaesthetists, cardiologists, gastroenterologists, radiologists etc). Nevertheless, the link between action (or inaction) and outcome is perceived to be particularly direct in surgery, and as a group, surgeons are profoundly affected by adverse events (data not yet published, Bournemouth University's surgeon wellbeing research team) and are particularly unlikely to make use of available support. It is therefore important that the needs of surgeons are specifically addressed.

3.3 WHAT IS A SIGNIFICANT ADVERSE EVENT?

There are technical definitions of significant adverse events in surgery. (See the RCS England guidance on *Duty of Candour*[2] for the definition of a safety incident in line with current legislation in the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014, regulation 20.)

For the purposes of this document, we recommend taking a broad approach to the understanding of adverse events to ensure that support and engagement with support is not delayed or overlooked because of concerns that the event might not meet an agreed threshold definition.

Generally, it will be obvious whether an intraoperative or postoperative event has the potential to impact a surgeon sufficiently to prompt the need for support. Practical working definitions might be 'unexpected death or serious injury to a patient before, during or after surgery' and also 'any serious or significant event during surgical care that causes the surgeon significant distress'.

We consider that most surgeons are likely to be impacted by an adverse event at some point in their careers. The extent to which they are affected will depend on multiple factors (including the nature of the event, their own personality traits and resilience, and the nature of the support they receive). Surgeons impacted by an adverse event may not be best placed to determine their need of help; there is a risk that if responsibility for initiating engagement with support mechanisms rests with individual surgeons, then surgeons in need of support will not receive it. For this reason, once a significant adverse event has occurred, it is key that there is a default response that includes an agreed minimum level of engagement by the surgeon with support mechanisms.

4. A supportive culture

4.1 SUPPORTING WELLBEING ACROSS THE WHOLE ORGANISATION

In healthcare, like in all other safety critical working environments, adverse events will occur.

The best healthcare organisations will consider what systems they have in place to minimise the chance of an adverse event occurring, how well they are prepared for these adverse events in advance of them happening and how they will respond to them when they do take place.

Time spent doing this 'anticipatory' clinical governance work will assist healthcare organisations to provide an environment that promotes the wellbeing of their surgeons and the surgical care teams that support them, along with other clinical and non-clinical staff. Detailed recommendations on building a culture of learning and openness that supports surgeons and surgical teams when an adverse event has occurred can be found in the RCS England guidance on *Duty of Candour.*[2]

The government has also recognised that such a culture should not be so risk adverse as to stifle innovation. Indeed, controlled risk taking is encouraged, but in an environment that focuses first on patient safety and next on teamwork, breaking down hierarchies, and engaging and motivating staff.[14]

4.2 SURGICAL SERVICE LEVEL

Integrating these cultural aspirations into a surgical service means that the members of the surgical team will be prepared for, and clear about how to react when an adverse event occurs. They will be clear on the steps that need to be taken to protect patient safety and to support those involved. They will know how to respond, what to do, and who to involve and at what time. They will have prepared for this eventuality ahead of time in the same way that a service might rehearse how they might respond to a major local incident.

4.3 SENIOR MANAGEMENT LEVEL

For the management team, these aspirations mean having in place an infrastructure that informs them immediately of any serious adverse event involving surgery. This will take place whether an adverse event occurs during the organisation's standard working day or 'out of hours'. A well designed infrastructure will ensure that the healthcare organisation's medical director is fully briefed on what has happened in a timely way, and that this medical director is supported by a team of clinical directors who know what to do and the sort of actions they will need to consider taking if an adverse event occurs.

4.4 SHOCK AND DISTRESS

It is important to recognise and acknowledge explicitly that an adverse event in surgery can cause major shock and distress among all those involved. Healthcare in general (and surgery in particular) have been slow to recognise the need for better understanding of this and to develop improved approaches. This is changing, however, and it is important for individual surgeons and surgical care teams to take time to understand that this is a subject that deserves their thought and attention.

It is also important to acknowledge that reactions of shock and distress are 'normal' for surgeons and their team members following an adverse event, and that there is clear evidence that many surgeons have experienced these feelings. A surgeon experiencing feelings of acute distress following an adverse event is not alone and can be supported to work through these circumstances.

4.5 DIFFERENT NEEDS TO BE MET AND ROLES TO BE FULFILLED

When an adverse event has occurred, there are multiple different needs to be responded to and multiple roles to be fulfilled. The central focus of the organisation's response must be the health and wellbeing of the patient involved, and supporting the patient's family and supporters to understand what has happened and what actions are being taken. At the same time, an organisation that supports employee wellbeing will be undertaking work that ensures that the surgeon and surgical care team involved are supported. The organisation will also be required to meet its clinical governance responsibilities, to meet regulatory and legal requirements, and to take action that promotes organisational learning and reduces the risk of a similar event occurring again.

Surgeons involved in an adverse event should understand that while they are an important part of the event, they will be one of many different focuses that their employing organisation and its staff need to have in discharging a range of responsibilities. Through this guidance, we are seeking to build improved awareness of the need to provide better support to surgeons and their surgical care teams when an adverse event occurs, and an important part of this is recognising and understanding the complexity of the circumstances that will follow an adverse event, and the time and care that are required to work through them.

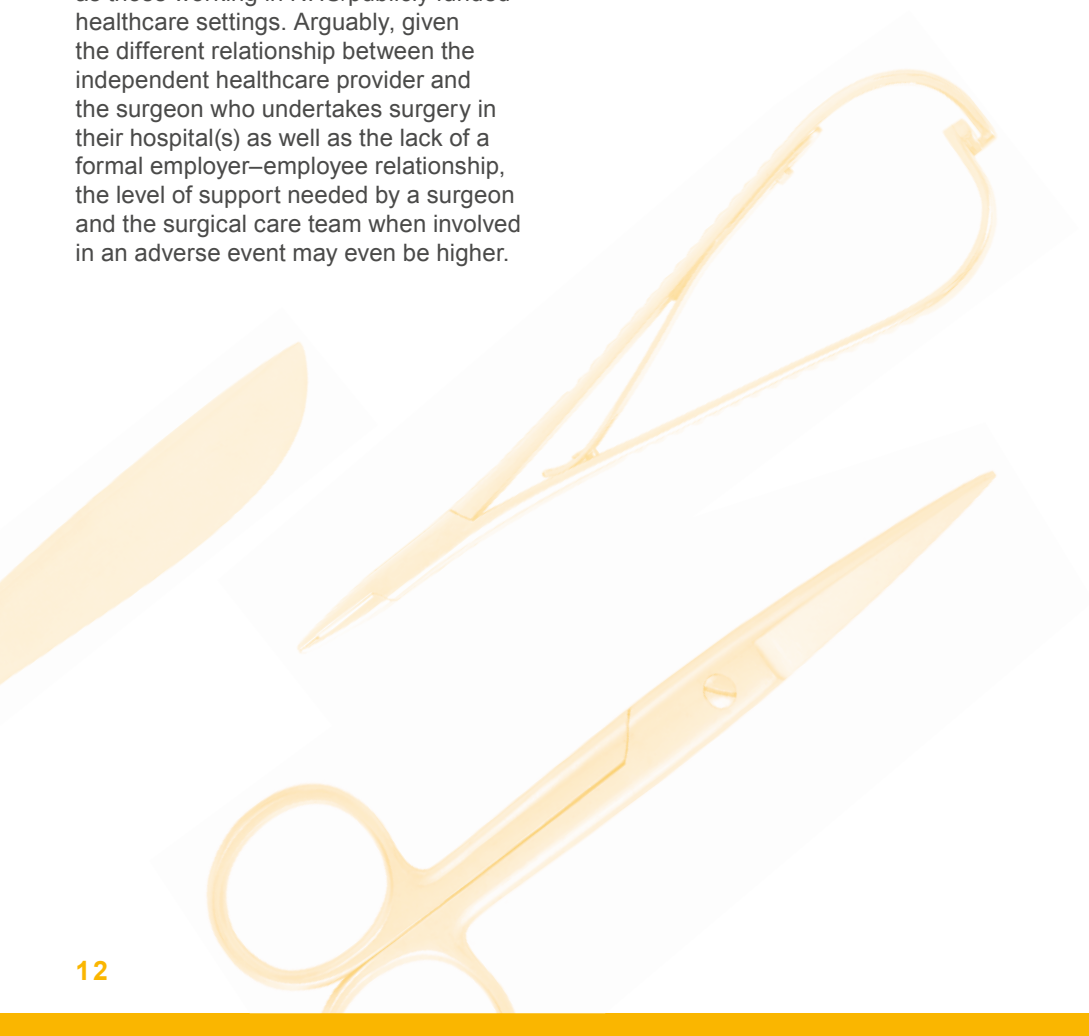
4.6 SURGERY IN THE INDEPENDENT SECTOR

This document has primarily been written with the NHS and publicly funded healthcare environment in my mind. However, it is recognised that adverse events in surgery can occur in any setting, and it is recommended that the principles set out in this good practice guidance are considered and acted on in any environment where surgery takes place.

Although operating in a different context, surgeons working in the independent sector will need at least as much support as those working in NHS/publicly funded healthcare settings. Arguably, given the different relationship between the independent healthcare provider and the surgeon who undertakes surgery in their hospital(s) as well as the lack of a formal employer–employee relationship, the level of support needed by a surgeon and the surgical care team when involved in an adverse event may even be higher.

We therefore recommend that the senior medical managers of all independent healthcare providers review this document and actively consider the steps they can take to provide support to surgeons and their surgical care teams when adverse events occur.

All surgeons practising in the independent sector should ensure that they have appropriate indemnity cover, and they should be mindful of the fact that MDOs and other providers of medical indemnity insurance may differ in the level of support and advice that they offer to doctors after an adverse event.



5. Advice for surgeons involved in an adverse event

5.1 SUPPORT FOR YOUR MENTAL HEALTH AND WELLBEING

While it is concerning that surgeons have generally underused mental health support services, many excellent resources are already available and surgeons are encouraged to make use of existing resources. For example, see the British Medical Association's wellbeing services and its list on sources of support.[15]

Surgeons and those who look after them should consider specifically the risk of self-harm and suicide. Doctors have high rates of suicide[16] and the impact of an adverse event may make this more likely.[17]

Locally, you may wish to access your trust's occupational health service or your own general practitioner. Your MDO may be a further source of support.

Many healthcare organisations also make use of evidence-based group resources including Schwartz Rounds® (www.theschwartzcenter.org) and Balint groups (www.balint.co.uk).

Whatever services that you access following your involvement in an adverse event, it is crucially important to prioritise taking care of yourself, and your own physical and psychological wellbeing in particular.

5.2 THE FIRST RESPONDER ROLE

A primary outcome of the new approaches described in this document is the recommendation that employing organisations train a group of first responders. This role is explored in detail below but in essence, it means that a surgeon involved in an adverse event will be linked to another doctor as a source of support and guidance.

First responders will usually be surgeons in the same organisation whose role is to provide rapid support to surgeons with a key focus on the immediate wellbeing of the surgeon. First responders will have had some training in supporting surgeons in this situation, and they will be able to guide you through the issues that you need to consider and the actions you may need to take. We hope your clinical or medical director will be able to rapidly link you to a first responder and you should endeavour to meet them in the first 24 hours after an incident.

5.3 BE AWARE OF AND REFLECT ON YOUR BEHAVIOUR AND ITS IMPACT

RCS England's invited reviews of individual or service-wide surgical practice (www.invitedreviews.rcseng.ac.uk/) show that demonstrating poor individual and interpersonal behaviour can have a significantly negative impact on individual surgeons' careers as well as the safety of patient care.

When working under pressure, some of the qualities that an individual will have relied on to become a highly trained, autonomous surgical professional (eg strong, independent decision making) can be magnified and manifest themselves in personality traits that create a negative atmosphere. Individuals may become dismissive of other healthcare professionals. Behaviour can become highly variable, and can range from being compliant and non-confrontational to being aggressive and demanding.

The insight that individual surgeons have into the strengths and weaknesses of their surgical practice (and the impact of their behaviour on people around them) is central to whether concerns about performance can be resolved. Individuals who have concerns raised about them can sometimes demonstrate little self-awareness or appreciation of the significance of the situation or the seriousness of the concerns. They may be unwilling or unable to accept challenge and criticism of their performance. They can find it extremely difficult to be dispassionate about their circumstances and see them from the perspective of those affected or to be able to adapt their position and see the situation from the point of view of an objective, neutral observer.

While it is recognised that being involved in an adverse event has the potential to put a surgeon (and the surgical care team) under a unique degree of stress and strain, it is also important to emphasise the need to ensure that those involved continue to display professional behaviours towards one another and interact in appropriate ways.

This is not to say that surgeons and surgical care teams should not show emotion or describe the feelings that they are experiencing to one another. Being able to display both empathy and sympathy towards those involved in the adverse event will be important in the process of supporting them to work through these circumstances.

]It is important, however, that all those involved in an adverse event are aware of their own behaviour, and reflect on the impact of their behaviour on the other people who have been affected.

6. A medicolegal perspective

A significant aspect of a surgeon taking steps to support their own wellbeing involves them seeking advice from their MDO. The General Medical Council (GMC) advises: 'You must make sure that you have adequate and appropriate insurance or indemnity arrangements in place covering the full scope of your medical practice in the UK.'[18] The following advice is provided by those with experience of supporting surgeons when adverse events occur from a medicolegal perspective.

6.1 SEEK ADVICE EARLY

Contact your MDO as soon as you can. All the MDOs can offer advice 24 hours a day, every day of the year. Your initial call may require follow-up in writing (eg a report of what happened, copies of relevant medical records and updates on developments). This is important because serious patient safety incidents, especially those resulting in a patient's death, can in some circumstances result in multiple medicolegal challenges and having access to expert advice at the outset is essential.

6.2 CLINICAL RECORDS

Despite the distress and worry of being involved in a serious patient safety incident, you should maintain accurate and contemporaneous notes of what happened as well as what you did in the medical records. Never amend a clinical record.

On the rare occasions where it is necessary to add to the records, this must be done formally, as a post-dated entry, but seek advice from your MDO before you do so.

6.3 DRAFTING A STATEMENT/DETAILED ACCOUNT OF WHAT HAPPENED

Your detailed account of what happened is distinct from the clinical record. Your employing organisation will ask you to prepare this statement and your MDO can give you detailed guidance on how to do this. Try to accomplish this as soon as you can, usually within the first 24 hours; the circumstances will be fresh in your mind and you are more likely to remember important details.

Draft a chronological account of what happened. Make it clear what you did, who you spoke to and what advice you received. Include any discussions you might have had with the patient or the patient's relatives both before and after the incident. The statement is best thought of as a factual narrative. Avoid opinion and conjecture when creating this account. Your statement is likely to be the basis of what you say in a variety of medicolegal settings so it needs to be accurate and consistent.

6.4 DUTY OF CANDOUR

Your professional duty of candour will apply whenever something goes wrong and a patient suffers harm or distress. However, if it is a serious patient safety incident, it is likely that the healthcare organisation's statutory duty of candour will also apply. You will need to follow the reporting procedures that apply. Patients and their relatives will expect an explanation of what went wrong (or as much as is known at the time), an apology, and an indication of what might be done to put things right. Being honest with patients is the right thing to do. If you are unsure about what to say or do, or how to approach this, speak to your MDO. A useful guide to disclosing adverse events can be found in the RCS England guidance on *Duty of Candour*[2] or in a visual summary produced by the National Institute for Health Research (www.secondvictim.co.uk/wp-content/uploads/2019/04/GUIDANCE-DOCUMENT.pdf).

6.5 THE RESPONSE OF YOUR ORGANISATION

Following the introduction of this guidance, our hope is that after an adverse event, your organisation will have put you in touch with a first responder, and that this person will be available to provide you with personal and pastoral support.

Alongside this, senior managers can also often be good at supporting staff when there is a serious patient safety incident. It can be common for staff to be given a 'recovery period' after such an incident, especially those resulting in the patient's death. Where this happens, it is considered to be a 'neutral act', and its purpose is to support the doctor's health and wellbeing.

Your employer will be required to gather information about the event and consider whether a formal investigation needs to be undertaken. As well as seeking help from your MDO, you may also need advice from the British Medical Association or another trade union. Again, make contact as soon as possible, particularly if you are aware that there might be a disciplinary process.

It may be appropriate that you are referred to the occupational health team. You may benefit from some time off work and if you do take time off, then they will be able to advise you on the support that you might need and the steps you will have to take in order to return to work.

Your medical director or another senior manager is likely to want to meet you to discuss next steps. If this is the case, it would again be important to seek advice from your MDO and the British Medical Association prior to the meeting. You may wish to take an advocate or senior colleague with you and your organisation will have a policy in this regard. Your MDO and the British Medical Association will be able to liaise to support or represent you as best fits the circumstances of your case; they will ensure that proper procedures are followed, including ensuring that there is clear documentation of any discussions and planned next steps.

7. Advice for medical managers

7.1 MEDICAL DIRECTOR

As a medical director, you play a defining role in your organisation's response to an adverse surgical event. Some parts of this role you will undertake directly while other aspects you will delegate, ensuring that you retain clear oversight and responsibility. You have a responsibility to consider the impact of an adverse event on all of the roles (clinical and non-clinical) that an involved surgeon undertakes. You should also consider whether you need to share information with the responsible officer in other organisations where the surgeon works.

7.2 WORKING WITH YOUR CLINICAL MANAGEMENT TEAM

A key first task is to speak to the clinical director responsible for the service that the event has occurred in and ensure that the first part of the organisation's response is in place. This may include agreeing that the surgeon needs to be released from the immediate clinical environment for an initial 'recovery period'. It should be emphasised to the surgeon that this is a neutral act. In the interests of the surgeon's wellbeing, it is recommended that the surgeon undertakes a modified job plan for an initial two weeks to support the surgeon's recovery from what has happened and assisting you as medical director to develop the organisation's response to the event. It is recommended that this modified job plan releases the surgeon from any operating for at least one week.

Where the circumstances of the event are sufficiently serious that you are required to consider restriction of surgical practice or exclusion from work, it is important that the requirements of national guidance such as *Maintaining High Professional Standards in the Modern NHS*[19] are followed by you and your organisation.

Ask your clinical director to begin developing a management plan that enables your organisation to maintain a high quality service while providing support to the surgeon and the other surgical care team members involved.

7.3 MAINTAINING A CONSIDERED AND BALANCED APPROACH

By having the opportunity to pause and carefully consider the emerging information that you have about the event that has occurred, you will be able to determine what an appropriate and proportionate response is. This will help you maintain safe patient care while at the same time making considered and well balanced decisions about the surgeon and the surgical care team.

You will need to think through what work the surgeon is able to undertake and (depending on the surgeon's individual response to the circumstances and their level of insight about what has occurred) whether you will need to take any action to restrict the individual's practice or exclude them from work. These are very rare steps, only to be taken when there is no other

way to keep the surgeon working in some capacity and it is impossible to maintain the safety of patients or support the individual surgeon's own wellbeing without doing so. During this time, you should help the surgeon to find ways in which they can maintain contact with professional colleagues.

Taking a considered and balanced approach (and avoiding hasty decisions) will hopefully prevent the discussion of the event that has occurred becoming adversarial.

7.4 APPOINTING A FIRST RESPONDER

A primary outcome of the SAEFAR process is the recommendation that employing organisations train a group of first responders in advance of any adverse events. You have a responsibility to promote and advertise the first responder process, and to ensure that your clinical directors and clinical teams are aware of its existence. As medical director, you should determine who will be the named first responder for a surgeon involved in an adverse event. Smaller organisations may need to consider how they might share this role across a network. You should ensure that the first responder makes contact with the surgeon within 24 hours of the event, that the first responder process is in addition to any other actions that you (or the responsible officer) are undertaking, that it is confidential and that its focus is on the surgeon's wellbeing.

7.5 MAKING CONTACT WITH THE SURGEON

You should make contact with the surgeon within 24 hours of the event.

In your conversations with the surgeon, it is important to show that you recognise that the surgeon may be experiencing shock and distress, and that this is a natural and normal state to be in.

You should explain that you are making contact with them because the event has occurred and because you are leading the organisation's response to it. You are not expecting an immediate rational analysis of the event.

You should also explain that a serious event involving a surgeon is not the same as a serious concern about a surgeon. In addition to undertaking an assessment of the event that has occurred and the most appropriate response to it on behalf of the organisation, you will be seeking to understand the impact this has had on them as the surgeon (and their wider team members) and how the organisation can best support them. You should explain that an important part of the organisation's response to what has occurred will be based on your understanding of the impact of the event on them as a surgeon and on the wider surgical team as well as what the organisation can do to support them.

7.6 CREATING TIME AND SPACE

You should make clear that whatever specific next steps you decide to take in relation to the event, it is your normal practice when any adverse event occurs to advise a 'recovery period' for the surgeon involved. The purpose of the recovery period is for the surgeon to have some time and space to absorb what has happened, and to ensure that the surgeon is not immediately exposed to a similar situation. You should explain that in order to facilitate this, you have asked the clinical director to come up with plans for this and to minimise the surgeon's exposure to other immediate clinical risks. You should consider releasing the surgeon from operative work for at least one week.

7.7 INITIAL ASSESSMENTS OF INSIGHT AND SELF-AWARENESS

During your contact with the surgeon, you should make an initial assessment of the level of insight the surgeon has into the event. This assessment can then inform your decision making about what is a proportionate response while you complete your initial information gathering.

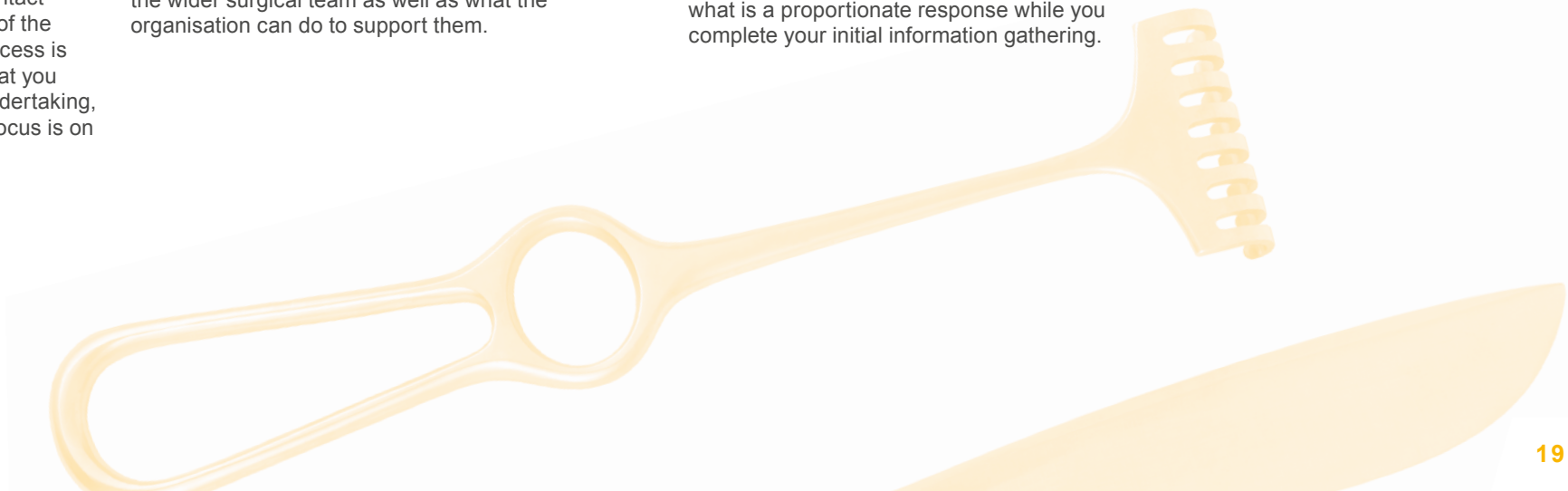
7.8 INITIAL INFORMATION GATHERING

It is important to explain to the surgeon that in order to help you make your assessment of the situation, you will need to use the next two weeks to gather information that will help you decide whether you need undertake a formal investigation into the event.

You should explain that this information gathering stage does not represent a formal investigation but supports your initial assessment processes. You will use this time to gather enough information to decide whether there are serious concerns about the surgeon's performance, conduct or health that require further formal investigation.

You should also explain that you do not take decisions in isolation, and that you will take appropriate advice from colleagues and other experts where this is needed. One step you may take to assist you with this is to set up a hospital decision management group in relation to the event.

If you are delegating further involvement to a deputy, you should also make this clear.



7.9 THE SURGEON'S RESPONSE

You should explain that an assessment of the surgeon's level of insight into the event, the surgeon's awareness of the significance of what has happened and their willingness to cooperate in the important actions that now need to take place form an important part of a medical director's decision making process.

If at any point in the information gathering stage you consider that the surgeon is not cooperating with your approach, you will have to consider whether a formal restriction of the individual's practice or exclusion from work is required.

If this becomes necessary, you would take care to ensure that you are following the guidance in *Maintaining High Professional Standards in the Modern NHS*.[19]

7.10 GMC/REGULATOR INVOLVEMENT

It is important to explain to the surgeon that your trust's relationship with the GMC has changed significantly since the establishment of the GMC's employer liaison service and the introduction of its employer liaison advisors. It would be very unusual for a doctor to be referred to the GMC by you as medical director after a single clinical incident.

You should explain that if the information you receive over the next two weeks raises concerns that do require further investigation, your intention would be to manage this through local trust employment processes, taking advice where appropriate from organisations like RCS England, NHS Resolution (practitioner performance advice service) or the GMC (employer liaison service).

Only if local processes do not appear to be sufficient to resolve the concern (or if you receive advice that it is necessary) would you consider a formal referral to NHS Resolution's practitioner performance advice service or the GMC.

7.11 EXCLUSION FROM WORK

You should explain that exclusion from work would normally only be considered in exceptional circumstances. If the concern is entirely about capability rather than conduct, it should almost always be possible to identify activities that can be undertaken while remaining in the workplace, even if significant restrictions to surgical work are required.

Again, if you were considering an immediate or formal exclusion, ensure you are following the national guidance on *Maintaining High Professional Standards in the Modern NHS*.[19]

7.12 SURGEONS EMPLOYED ON A TEMPORARY BASIS

Where a surgeon is employed in your organisation on a temporary basis, you should still endeavour to discharge your responsibilities to care for and support that surgeon. The extent to which you are able to do this will depend on the intended duration of that surgeon's employment. (For example, consider the difference between a long-term locum employed by your organisation and a locum surgeon supplied by an agency.) If you are not the responsible officer for that surgeon, you should ensure that their responsible officer is informed.

7.13 DOCTORS IN TRAINING

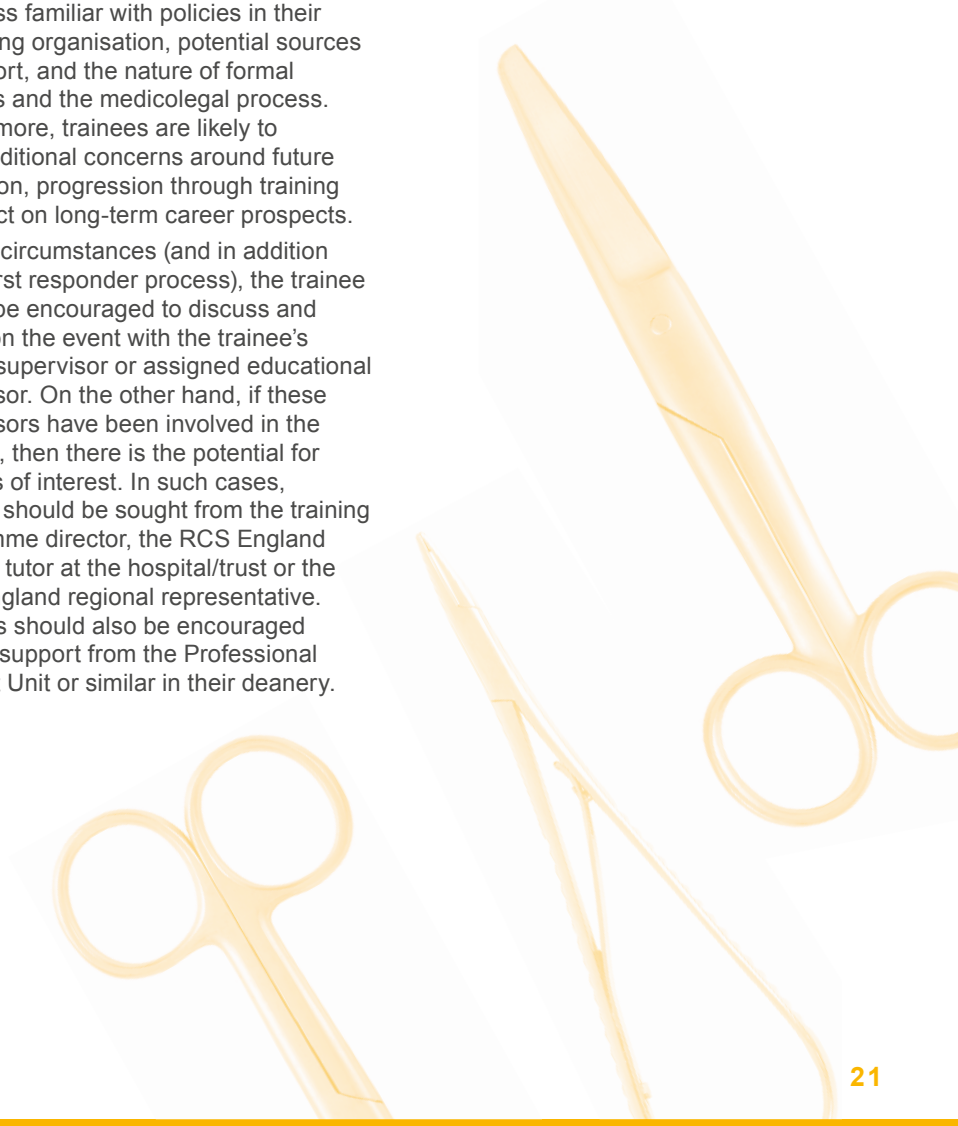
When trainees are involved in a significant adverse event, they may have been operating independently, operating under the supervision of a consultant or assisting a consultant.

While all of the advice for consultants also applies to surgeons in training, there are additional issues to consider when a trainee is involved. Trainees are likely to be less familiar with policies in their employing organisation, potential sources of support, and the nature of formal inquiries and the medicolegal process. Furthermore, trainees are likely to have additional concerns around future reputation, progression through training or impact on long-term career prospects.

In most circumstances (and in addition to the first responder process), the trainee should be encouraged to discuss and reflect on the event with the trainee's clinical supervisor or assigned educational supervisor. On the other hand, if these supervisors have been involved in the incident, then there is the potential for conflicts of interest. In such cases, support should be sought from the training programme director, the RCS England surgical tutor at the hospital/trust or the RCS England regional representative. Trainees should also be encouraged to seek support from the Professional Support Unit or similar in their deanery.

When compiling a record of an adverse event, trainees should be reminded to add to the reflective practice section of their portfolio on the Intercollegiate Surgical Curriculum Programme and to include the event in form R of their annual review of competence progression.

Healthcare organisations should ensure that their induction programme for surgeons in training includes information about the provision of the first responder scheme in that organisation.



8. The role of a first responder

In the immediate aftermath of an adverse surgical event, surgeons, understandably, may be very distressed and perhaps even struggling to function. Sadly, at this crucial time, many surgeons report feeling isolated and unsupported. The situation would be substantially improved through the provision of surgeon first responders in the surgeon's employing organisation. We strongly recommend that the first responder role and the allied supportive resources remain distinct from disciplinary processes.

> *'I felt and feel very guilty but I remain disappointed by the lack of support from my employer. I felt I was treated like a criminal first, rather than any duty of care to me as an employee doing his job. I found it very difficult to talk about at home. It was only the support of my colleagues that enabled me to get through that period.'*
>
> **Anonymous surgeon**

The medical director will have been informed of the occurrence of a significant adverse event. They will have already taken immediate steps to ensure the safety of the involved surgeon and continuity of the surgical service in the event that the surgeon is unable to continue working. The medical director will then initiate the first responder process.

This process might also be initiated or requested by surgeons themselves. Senior colleagues might also direct surgeons to the first responder service.

The main responsibility of a first responder is to arrange a face-to-face meeting with the surgeon within 24–48 hours of the adverse event. The meeting should be focused primarily on the wellbeing of the surgeon, with the first responder offering a compassionate and mature response to the surgeon's experience. The content of a surgeon's meeting with a first responder is confidential. The first responder will use the SAEFAR checklist (Appendix 1) to structure the meeting. Topics covered in the checklist include:

- Do you have support around you? What would make it easier for you to ask for support?
- Should you be stopping work temporarily or restricting what work you do? When should you start back at work? Who do you need to get agreement from for this plan?
- What happened? It is likely to be helpful to talk through and reflect on the events
- Providing information on the timeline for what needs to happen next in terms of legal and managerial requirements
- Signposting as needed to sources of support (eg general practitioner, occupational health team, employee support services accessed via the employing trust, local NHS mental health services, and specialist support provision for doctors such as the NHS Practitioner Health Programme and the British Medical Association's wellbeing services)
- Resource pack that includes contact details for relevant local and national support services
- Have you talked to the patient/family? If not, when are you doing so and what support do you need to do this? Could a surgical colleague participate in this with you?
- Have you talked to other clinicians involved?
- Prompt to consider contacting the MDO

The overall aim is for the first responder to be a kind, non-adversarial source of support and signposting, very early on in the process. It is not part of the first responder role to provide formal counselling or psychotherapy, or critical incident debriefing. Nor is it their job to give advice about or provide medication or other treatments. In such circumstances, first responders should direct surgeons to the occupational health team and other appropriate services for ongoing support. First responders should not be involved in any investigation or legal proceedings relating to the adverse event and should not have direct management responsibility for the surgeon.

The content of any meetings between the first responder and surgeon should be considered confidential. Any potential exceptions to this (for example, the possibility of notes made in the meeting being subpoenaed or a significant risk issue being identified) should be made clear to the surgeon prior to the first meeting. Employing organisations should consider supplying written information about their confidentiality policy. The first responder should make brief notes (at the end of the meeting, in the form of an action plan) using the SAEFAR checklist template provided (Appendix 1). These notes should be shared with the surgeon.

It is strongly recommended that healthcare organisations make the provision of this meeting as well as attendance by the surgeon mandatory. This recommendation is rooted in the evidence that surgeons rarely access appropriate support services regardless of how adversely they have been affected by experiences at work and that in the aftermath of a significant adverse event, employing organisations tend not to focus resources on surgeon wellbeing in a proactive and effective way.

First responders should be recruited into the scheme on a voluntary basis to ensure appropriate motivation. Healthcare organisations should have a selection and training procedure in place to ensure that people with the right qualities and capabilities are providing a high quality service.

8.1 HOW TO DEVELOP THE FIRST RESPONDER ROLE LOCALLY

The organisation and administration of the role will vary depending on opportunities and constraints in individual healthcare organisations. For example, a trust may decide that the first responder will provide a one-off meeting only or it may make provision for time limited, ongoing support. Healthcare organisations will also need to decide how many first responders are required to provide a responsive and sustainable local service.

Our working group has developed guidance for healthcare organisations about:

- desirable qualities and abilities of people taking on this role
- selection and training of first responders
- administration and organisation of the role

We also hope to provide support to healthcare organisations and individual first responders in the form of:

- nationally developed core materials such as the SAEFAR checklist
- an annual national SAEFAR skills development and good practice day for first responders
- six-monthly email contact, including relevant new materials, news and guidance
- email access to the members of our guidance development working group for consultation on challenging issues

First responder personal characteristics and capacities

- Compassionate, empathic, 'psychologically minded'
- Credible, competent, experienced, mature
  - This is likely to mean an experienced and respected surgeon
- Able to tolerate and allow distress
- Able to provide context and perspective on the event. For example:
  - 'Can you look at this in the context of surgery as a profession? Many surgeons share similar experiences'
  - 'Can you look at this in the context of your whole career? This is a single experience among many'
  - 'Can you look at this in the context of the whole event and the multiple people/systems/factors involved?' (The timing of this is important; refer to research on psychological first aid generally)
- Up-to-date knowledge of the SAEFAR checklist as well as relevant trust and national policies
- Awareness of own limitations and limitations of the role

Healthcare organisations that successfully adopt this model of support for surgeons can report on websites and other media that they work within the Bournemouth University/RCS England good practice guidelines. They will need to evidence successful engagement with the model on an annual basis through completion of a brief checklist and report this at a public trust board meeting.

Appendix 1: Checklist/ record of first contact with first responder

- Names of surgeon and first responder as well as their contact details
- Date and time of meeting
- Brief description of event
- Areas that should be discussed, recognising that the surgeon's thoughts on some of these issues are likely to be very preliminary (eg support that might be required to facilitate return to work) and are likely to change

What happened?	• Brief description of event
How are you now?	• Brief discussion of how the surgeon is currently coping (emotionally and psychologically) • Potential value in writing personal reflective notes to aid emotional processing should be discussed • It should be made clear that the General Medical Council has stated that it will not use personal reflective records in an investigation about a practitioner
Talking to patient or family	• Have you spoken to the affected patient and/or relatives? • How do you feel about this? • When are you due to do so? • Do you need someone to do this with you? If so, who?
Support	• What are your existing supports? • Are there barriers to you asking for support? Can these be overcome? • Are you aware of other support services? (general practitioner, occupational health team, existing employee support services in your organisation, NHS mental health services, specialist support services for doctors [eg the NHS Practitioner Health Programme, the British Medical Association's wellbeing services and its list on sources of support, available on the BMA website])

Working	• Can you review your immediate clinical commitments? How do you feel about fulfilling them? • If you are stopping temporarily, then who needs to know? (clinical director, medical director, human resources team, occupational health team) • What might need to happen before you come back to work? • What might need to be put in place when you do come back to work?
Timeline	• Outline and agree potential timeline
Talking to other professionals involved	• Do you need to speak to any other staff involved? • When are you due to do so? • Do you need someone to do this with you? If so, who?
MDO	• Consider speaking to your medical defence organisation
Record	• Both surgeon and first responder to keep a copy of this completed record

Appendix 2: SAEFAR good practice guidance implementation checklist

Organisations that employ surgeons may wish to confirm publicly that they have engaged with the surgical adverse events first aid response (SAEFAR) process and that they have adopted the SAEFAR approach to supporting surgeons after a significant adverse event.

The organisation should go through this checklist on an annual basis, address any gaps in SAEFAR provision and report compliance to the NHS trust board.

We have a cohort of SAEFAR first responders.	☐
Surgeons who experience a serious adverse event are contacted by a first responder within 48 hours of the event.	☐
Meetings with first responders are guided by the SAEFAR checklist.	☐
Our cohort of first responders meet each other at least annually to share learning and good practice.	☐
At least 75% of our first responders attend the annual national SAEFAR skills development and good practice day.	☐
100% of first responders attend the annual national SAEFAR skills development and good practice day at least every two years.	☐
The six-monthly update email from the SAEFAR working group is distributed to all first responders.	☐
On an annual basis, surgeons are reminded about the nature and availability of the SAEFAR process. All new trainees in the organisation are given information about SAEFAR provision.	☐
We have in place an infrastructure that informs senior managers immediately of any serious adverse event involving surgery.	☐
We have an up-to-date resource pack that includes contact details for relevant local and national support services.	☐

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