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Perspectives

Managing medical and surgical error: an emotional survival guide

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ABSTRACT

Medical errors are common and often lead to feelings of self-doubt, helplessness, and guilt. Society thinks of physicians as healers, and physicians who see their role as offering a cure will always feel as if they haven't done enough. This article discusses five steps in the management of medical and surgical error: (1) care for the patient and family, (2) report to appropriate sources, (3) review the incident, (4) manage legal issues, and (5) engage in self-care. There is a focus on managing grief, with tips for coping.

KEYWORDS Coping; disclosure; grief; malpractice; medical error; reporting; self-care

An occurrence of a medical error is a time of heightened anxiety and uncertainty. This article was created to be a step-by-step guide to help physicians know what to do, what to expect, and what resources are available following a medical or surgical error. Having this plan and information can bring a sense of control during a time full of uncertainty or fear, enabling physicians to manage these events more confidently and cope effectively.

Often a stigma of failure is associated with errors, but it is important to remember that we are all human and errors are inevitable. Physicians must make decisions that balance risks and benefits, and mistakes or negative outcomes are sometimes part of that process. After experiencing errors, physicians often exhibit three explanatory styles identified by positive psychologist Martin Seligman.[1] First, they tend to view the situation as *personal*, blaming themselves entirely. Second, they may see the situation as *pervasive*, believing it will completely ruin their reputation or career, and they question their ability as a physician. Lastly, they may adopt a belief of *permanence*, thinking they will always feel this bad. Such explanatory styles can exacerbate the emotional toll of these events, causing the emotional impact to persist.

As many as 100,000 people die each year in US hospitals due to medical errors.[2] Based on a 2017 report,[3] 41% of patients reported experiencing an error during their own medical care or during the care of a loved one. The most common type of medical error is misdiagnosis, which includes failure to diagnose, incorrect diagnosis, or

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Table 1. The most common medical errors as reported by patients in a 2017 survey*

Error	Percentage reporting
Misdiagnosis of a medical problem	59
Mistake during a test, surgery, or treatment	46
A diagnosis that didn't make sense	42
Not treated with respect	39
Given wrong instructions for follow-up care	29
Administered the wrong medication dosage	28
Received unneeded treatment	27
Given instructions by different providers	24
Got an infection after a hospitalization or treatment	24
Received the wrong medication from a doctor	18
Test results that were lost, delayed, or not shared	17
Received the wrong medication from a pharmacy	9
Fell down or out of bed	8
Got a bed sore	8
Accidentally took too much medication	5

*Source: Americans' Experiences with Medical Errors and Views on Patient Safety.[2]

delayed diagnosis (*Table 1*).[3] In addition, the health facility where the patient was treated informed the patient of the error only about a third of the time.[3] Based on these data, it is not a matter of "if" but "when" errors will occur in one's career.

A multi-institutional study found that 45% of residents reported involvement in serious medical or surgical errors; 34% disclosed a serious error to a patient, and 63% disclosed a minor error.[4] Only 33% of residents reported receiving any training in error disclosure. Consequently, 92% of residents expressed a desire for new or additional training in error disclosure.

In medical culture, error is often associated with shame and blame, directed both inward and toward others. Why does this happen? Physicians have a strong desire to help and take mistakes personally. Alternatively, shifting blame to someone else can serve as a defense mechanism. It's easy to believe that "I would never make a mistake like that." However, while we need to be accountable for our own actions and not be nonchalant about errors, taking on excessive shame and blame for things beyond our control only leads to rumination and being stuck in the experience. This prevents us from learning and moving forward.

Mistakes happen even to the best physicians. Shame fosters secrecy. It's natural for humans to keep mistakes hidden or concealed. However, secrecy results in underreporting of errors, as well as isolation. This impairs our own and others' ability to learn from mistakes and prevent future errors. Physicians have a professional responsibility to openly discuss errors to improve patient safety.

This article explores five steps in managing medical and surgical error. Step 1 involves providing immediate care and support for the patient and their family. During this step, it's crucial to discuss the event openly with them. Reporting, which is step 2, entails disclosing the incident to relevant parties, including notifying supervisors. Step 3 focuses on reviewing the error. Here, the health care provider will engage in debriefing sessions with peers or supervisors to analyze what went wrong. The goal is to learn from the mistake and develop strategies to prevent similar errors or adverse events. Step 4 revolves around legal counsel. Depending on the situation, legal advice may or may not be required. However, it's important to know who you can turn to for guidance and what to anticipate throughout this process. Lastly, the fifth step entails coping with the error. It's crucial to manage your emotional response to prevent negative impacts on your mental well-being and to help you move forward. Understanding these steps will enhance your sense of comfort and control when faced with such circumstances.

STEP 1: CARE FOR THE PATIENT AND FAMILY

The first priority after a medical or surgical error is to address the patient's physical needs and respond promptly. This includes assessing the safety of the patient and the environment, removing any hazards, such as trip hazards or faulty equipment, and providing immediate support. Initial efforts also include offering support to the patient and family and any staff who require it. The next step is communicating and responding to the patient and/or their family. It is important to recognize that different families and patients may react differently. Initially, some may not want to talk to the physician. It is crucial to remain available even if the family rejects your initial attempt at contact.

One key aspect to consider is emotional regulation. Having this conversation can be challenging, and physicians may experience common emotional responses such as shame, fear, guilt, isolation, and a sense of failure. Typically, there isn't much time to fully process these emotions before entering the room. Therefore, it is essential to manage these emotions sufficiently so they do not hinder the conversation. It can be helpful to take a few deep breaths beforehand and focus on the short-term goal of effectively communicating the facts. Reflect on your emotions and consider how they might affect the conversation. Do they make you more defensive? Do they make the other person angrier? It is important to allow yourself to feel the emotions and not suppress or ignore them. While physicians are often adept at suppressing their emotions during the immediate conversation, these emotions will need to be addressed later. If you ignore them completely, they may resurface at inconvenient times. Set aside time at the end of the day or week, if needed, to process these emotions.

Information should be disclosed to the patient and family in a planned and organized manner. However, it is crucial that the healthcare provider has all the necessary information or is able to communicate what is not yet known. Avoid speculating or embellishing just to provide comfort to the family. Instead, inform them of the steps being taken to gather more information. Ongoing communication is vital as the understanding of the cause of the event evolves. It is also important to correct any inaccurate information from previous conversations as new information emerges. Remember that disclosure is a process, not a one-time event. Expect that new information will be learned along the way.

An effective disclosure requires several types of information. First, explicitly state that an error has occurred. While physicians may agree that harmful errors should be disclosed, they may choose their words carefully and only provide a partial disclosure in practice. For instance, they may acknowledge that an adverse event has occurred but not mention that it was due to an error. Second, explain the details of the error and what it means for the patient's prognosis. Third, discuss why the error occurred. Fourth, explain how similar errors will be prevented in the future. Patients and family members want to know that steps are being taken to prevent recurrence. Lastly, offer an apology.

Many factors can contribute to a successful conversation, and many can hinder it. First and foremost, it's important to remember the golden rule: treat others the way you would like to be treated. Put yourself in the shoes of the patient or family member. You would want to receive information in a clear and empathetic manner. The ultimate goal is to have a compassionate and transparent discussion with the patient or their family about what happened.

There are some do's and don'ts for disclosure (*Table 2*). First, have the conversation. Patients and families have the right to know, and having upfront conversations can prevent any confusion. Be mindful of the location and choose a private space. It's important to minimize distractions and respect their privacy. The family needs your undivided attention during what may be one of the worst moments of their lives. Planning the conversation beforehand is also important. Prepare what you want to say and how you want to say it. Consider who should be present in the room. It can be helpful to include team members from relevant disciplines, such as a pharmacist or nurse supervisor or someone with a good rapport with the patient. However, be cautious not to include too many people, as it may overwhelm or intimidate the patient.

Allow sufficient time. A rushed conversation can come across as disrespectful to the patient or family. Communicate clearly, avoiding complicated explanations. Help the family understand the situation. Pay attention to your nonverbal cues, such as eye contact and body language, to show respect. Welcome their questions. Let them know how they can reach you or when you will follow up in case they think of a question later. Expressing empathy and sympathy is what will make patients and families feel most understood. Sympathy can often be seen as an admission of guilt, so it's important to apologize appropriately by saying, "I'm sorry that this happened" instead of prematurely taking responsibility for causing or doing something. It's also crucial to allow their reactions, even if they differ from what you expect. Patients and families may respond with anger, sadness, or numbness, and it's important to remember that you can't control their reactions, only how you show up and present yourself. While it's important to allow them to express their emotions, it's necessary to ensure your safety if their anger becomes aggression toward you. Additionally, explain the plan for prevention and how you will address and prevent similar concerns in the future, as this is what families and patients want to know.

In terms of don'ts, avoid speculating or elaborating in an attempt to comfort. This can lead to confusion or self-incrimination. If you don't know the answer to a question, it's okay to acknowledge that and promise to follow up when you have the information or explain the steps being taken to find the answer. Stick to what you know and resist the

Table 2. Do's and don'ts of disclosure of medical errors to patients and families

Do's	Don'ts
• Have the conversation with patient/family	• Don't speculate or elaborate; stick to the facts
• Choose a private location	• Don't use too much jargon
• Minimize distractions	• Don't stand or cross your arms
• Plan the conversation beforehand	• Don't rush or discourage questions
• Allow time for conversation	• Don't ask for forgiveness
• Involve multiple team members	• Don't ignore your emotional response
• Communicate facts clearly	
• Sit down at eye level with the patient/family	
• Welcome questions	
• Express empathy and sympathy	
• Apologize and be honest	
• Allow their reactions	
• Explain what more is being done or how the institution will learn from the event to prevent recurrence	

temptation to fill in the gaps just to placate the family or patient. Moreover, avoid using excessive jargon, as it can hinder understanding during an already emotional conversation. Individuals' ability to comprehend complicated explanations can be diminished when emotions are heightened. In addition, don't rush or discourage questions, as doing so may convey that the conversation is not a priority to you. It's essential to remember that it's not the patient's responsibility to forgive or console you, so refrain from asking for forgiveness. Express gratitude if they offer it, but don't seek it from them. Finally, acknowledge and allow space for your own emotional response to these incidents. It's normal to experience various emotions simultaneously, and it's important to address them when the time is right and prevent them from becoming overwhelming.

STEP 2: REPORT TO APPROPRIATE SOURCES

The next step in managing a medical or surgical error is reporting and disclosure. Regardless of the tangible consequences of a medical error, practitioners have an ethical duty to inform their patients about any significant clinical oversights. They also have to notify the rest of the care team. This is not easy, as it demonstrates one's fallibility to colleagues. However, it is critical to communicate with the team so as to handle any immediate, significant, negative patient outcomes and prevent further mismanagement. The third form of disclosure involves documenting and reporting the error. Proper documentation and reporting of medical errors are essential to avoid further complications in patient care. This helps independent healthcare providers who assume care of the patient and can improve patient well-being by enhancing hospital-wide safety measures.

Both the aspects of reporting what happened and documenting the event must be addressed in the reporting and disclosure process. It is essential to follow institutional guidelines for disclosure, ensuring that information provided to the patient is honest, timely, consistent over time, and personal. The entire healthcare team needs to be aware of institutional policies. At Baylor Scott and White Health, staff members are encouraged to report events or hazardous conditions. However, reporting an event does not imply negligence or any improper act. The reporting process is not intended for punitive purposes or as a means of airing interpersonal disagreements after a medical error.

The reporting process provides specific event information to facilitate follow-up and monitor trends and identifies opportunities for improving clinical service processes to enhance patient safety. Again, this reporting process is not punitive but rather aims to assess events and prevent future occurrences. It should not be perceived as a shame or blame approach.

After a medical or surgical error, a root cause analysis is often conducted to identify the cause of the error and improve processes and systems.[5] The Joint Commission requires a root cause analysis following a sentinel event. The analysis focuses on systems and processes rather than blaming individuals. Don't be ashamed if a root cause analysis is needed after an event you were involved in. Improvements resulting from the analysis help prevent repeated errors throughout the hospital and enhance patient safety.

STEP 3: REVIEW THE INCIDENT

Step 3 involves reviewing the incident with colleagues and peers. Debriefing or reviewing after any critical event, whether it resulted in a negative or positive outcome, is helpful for future learning. Debriefing can be done immediately after the event or in the days, weeks, or months that follow. Debriefing in a nonpunitive, nonthreatening environment that involves the expertise of fellow clinicians and team members is a useful tool for improving one's medical practice. Yet debriefing with colleagues is not the same as a root cause analysis. Root cause analysis is conducted by a risk management team. Both debriefing and root cause analysis involve identifying challenges, barriers, or issues related to the event, which can then be discussed further in analysis and committee meetings.

Collaborative dialogue with expert colleagues and team members enhances our understanding of what happened and allows for a comprehensive investigation or evaluation of the incident. This analysis helps team members identify any contributing factors, such as issues with procedures, environment, equipment, people, or policies. Debriefing conversations also help clarify any misconceptions or misunderstandings and improve the recall of the event for team members. In highly stressful experiences like medical errors, our memory can be impaired, making it easy to forget certain aspects of what happened.

Debriefing conversations can facilitate learning and education. These conversations help all participants, as well as others, gain a better understanding of the event to avoid similar errors. The conversations can also aid in developing a plan to address any system issues, make improvements, or fill gaps in staff knowledge. Occasionally, a review can uncover additional errors or system issues that may not have directly contributed to the event but still need attention to promote safety and efficiency.

Furthermore, review conversations can be therapeutic for those involved. Sharing and discussing the event with others, particularly those who have experienced similar situations, can reduce feelings of isolation that physicians commonly experience after making errors. This, in turn, can help individuals cope with the event and reduce stress. Additionally, the therapeutic aspect of these conversations validates the traumatic experience and provides an outlet for expressing and processing grief.

Review conversations can also enhance communication among team members. Research has shown that reviewing events with others in clinical settings improves communication and encourages a team-based approach to patient care. In contrast, a lack of communication is a significant factor

contributing to medical errors and negative patient outcomes.

Finally, review conversations may decrease errors. The shared learning and improved communication that result from these discussions have a positive impact on reducing medical errors.

Various formats are available for debriefing or reviewing events with colleagues, and each has benefits. The one-on-one format allows for discussions with a trusted colleague, such as an attending, mentor, or staff member involved in the event. While it is highly beneficial, it may not be legally protected. Team debriefings involve individuals who were directly involved or members of the team. This format may also lack legal protection. The third format is the mortality and morbidity conference. In this forum, adverse events, complications, and errors that contributed to a patient's illness or death are reviewed with peers. Lessons learned from these conversations are used to make recommendations and prevent future errors. If you are unsure about debriefing with colleagues, it is advisable to seek guidance from risk management staff or a lawyer.

Characteristics of the environment and conversation surrounding debriefing can either facilitate or hinder discussion. If psychological safety is absent, individuals tend to be hesitant about sharing, fearing how mistakes could impact their reputation, career, legal standing, or finances. The lack of open and honest conversations surrounding these events inhibits learning for everyone and fails to support the ultimate goal of enhancing patient safety.

First and foremost, the environment should be free from judgment. Peers should refrain from criticizing one another for mistakes or decisions made at the time of the error. The environment should also be nonpunitive, as the fear of repercussions or consequences can stifle communication relating to the incident. Additionally, the environment should be nonthreatening, providing a psychologically safe space for engaging in difficult conversations. Another key point is the absence of blame or finger-pointing. Adopting a just culture approach encourages a balanced perspective, where individuals can take accountability for their own contributions to the error without placing blame on solely one person. Next, we want to move away from perfectionism, judgment, or criticism of mistakes. Perfectionism can lead to black-and-white thinking about errors. A common example of this would be thinking, "I made a mistake, so I'm a bad physician," or "I never make a mistake, so I'm a good physician." This type of negative belief increases shame related to errors or any unsuccessful patient outcomes. Effective debriefing conversations should avoid accusatory questions and instead use questions as a tool to understand what happened, what contributed to the decisions made at the time, or the circumstances surrounding the error. Criticism, judgment, and accusatory questioning can all hinder learning, as people tend to become defensive or shut down, disrupting open communication.

It's also important to avoid hindsight bias. While it's easy to look back on our own or someone else's choices and say something should have been done differently, participation in these conversations is encouraged and valuable. We should welcome any feedback.

Creating and promoting this kind of environment takes intentionality during the debriefing conversation. It's important to acknowledge how you tend to perceive those who experience a medical or surgical error. Do you try to identify the person or people at fault? Do you criticize their choices, thinking, "I wouldn't have done it this way" or "Why did they do X, Y, Z?" Additionally, consider what your nonverbal communication says to the person sharing the incident. Are you rolling your eyes or sighing, or are you showing understanding? If you find yourself judging or criticizing these mistakes or thinking the person should have known better, challenge that part of yourself. Be mindful about how you communicate about peers who experience errors, as this contributes to creating a safe versus an unsafe environment.

Not only is having the right environment crucial for an effective debriefing conversation, but it's also important to have a clear direction to guide the conversation. *Table 3* lists debriefing models and sample questions for debriefing. While there isn't necessarily one right way to debrief, these popular models share core components that overlap. For instance, all of the models prioritize psychological safety to ensure a beneficial environment for these conversations. They also elicit reactions from participants and encourage feedback. Additionally, each model includes a case description, considering all relevant facts and details. They involve analysis of the events and conclude with a summary.

Table 3. Models and questions for review conversations

Variable	Description
Debriefing models	• Plus-delta • PEARLS (Promoting Excellence And Reflecting Learning in Simulation) • 3D Model • Seven-Step After-Action Review
Simple and effective debriefing questions	• What went well? • What could have been done better? • What should we do differently next time?

Even if a team is not using one of the developed models, simple questions can guide a review conversation. It's important to focus on what went well, not just the negatives. Learning from the positives is valuable too. Additionally, we want to explore what could have been done better. Next, we should consider what should be done differently in the future. This requires critical thinking. Ultimately, reviewing and critiquing with peers and trusted colleagues fosters safety and promotes future learning. Understanding the methods for debriefing and creating an atmosphere conducive to patient safety and learning is crucial.

STEP 4: MANAGE LEGAL ISSUES

It is normal to start asking yourself about legal implications after a medical or surgical error. It is important you direct these questions to attorneys identified by your employer or insurer.

A liability suit is very stressful. First, it challenges your self-perception of your competency. Research has shown that it can decrease self-esteem and damage your sense of honor and reputation. As individuals face a medical or surgical error, feelings of guilt, shame, and blame arise. These emotions can lead to isolation, excessive self-blame, and fear about the repercussions of litigation, such as damage to your reputation and increases in malpractice insurance premiums. These reactions are all normal. They also cause a sense of loss of control, which increases anxiety and stress. Trust in oneself may be diminished; you may question your skills and knowledge. Beyond self-judgment, you may begin to feel judged by others. This can have long-term consequences on your well-being. Going through a lawsuit can be traumatizing in itself. Additionally, having to repeatedly retell the story can retraumatize you. The effects of a liability suit may persist for years. Professional counseling is vital in helping you navigate these challenges and develop strategies to manage them. Based on this need, the next section discusses self-care for recovery from medical or surgical errors.

STEP 5: ENGAGE IN SELF-CARE

Much sadness and emotional distress arises from a patient's adverse or sentinel event. It's crucial to know how to take care of yourself during this period and progress through the healing process. A powerful connection is formed between physicians and their patients. Thus, it is normal to go through a period of grief. However, managing this process and finding a direction for coping with grief can be challenging for many physicians.

Doctors should not hesitate to seek help if they are struggling after an error or the death of a patient. While doctors become accustomed to the possibility of adverse events and death, they also recognize the importance of achieving a balance between retaining compassion and maintaining enough emotional distance to effectively carry out their duties. The grief response in physicians appears to be particularly intense in those who experience a sudden and acute error on a patient. However, at any stage of their career, physicians may be deeply affected by the death or trauma of a patient. The hidden curriculum in medicine teaches doctors to distance themselves and create protective boundaries, but the conventional thinking that displaying emotion is unprofessional and a sign of weakness needs to change.

Physicians and grief

Psychologists describe grief as a complex set of responses to losses that create an emotional and spiritual transition in their lives. Grief is most commonly thought of as a natural emotional reaction to loss; it's the psychological response to trauma or death. It involves a feeling of hollowness, often marked by preoccupation with the image of the patient who has suffered.

Psychologists have described grief as a total human experience with four dimensions: feelings, physical sensations, cognitions, and beliefs. Avoidance of pain is characterized by intense feelings of sadness, disbelief, and incomprehension of the event. You will experience physical sensations such as feeling ill and having headaches, fatigue, loss of appetite. Also, there are cognitive components associated with the reality of the situation and often feelings of helplessness. Finally, we reach accommodation of our behaviors, in which we adjust and begin to develop normal behaviors once again. Two other dimensions could be added: a spiritual or philosophical dimension, which can be used to restructure healing, and an interpersonal dimension.

Grief may be associated with intense pain, and some believe that grief needs to be fixed or overcome. Give yourself permission to be less than perfect during the process of recovery. Take your time. There's no one right way or wrong way to grieve.

Traditionally, stages of grief were identified: denial, anger, bargaining, depression, and acceptance. People do not go through these stages in an orderly fashion. Grief can also be understood as a set of tasks; that may be a less prescriptive and more gentle approach. The four tasks are as follows: (1) accept the reality of the error as an inherent part of being a doctor; (2) work through the pain of grief; (3) adjust to the environment you have to continue working in; and (4) heal emotionally and accept that at some point you're going to have to move on with life. Expect an emotional rollercoaster of unpredictable highs, lows, and setbacks. In addition, try not to fall into the trap of internalizing how you should be feeling rather than accepting how you really feel.

Grief is an active process. Time in itself does not heal; it's what you do with the time that makes it meaningful. One factor that can complicate your grief after a medical error is the inability to distinguish normal grief from grief that's not normal. After the medical error, many physicians who are grieving mistake normal grief for clinical depression. You can think about the difference between grief and depression in this way: in grief, you don't usually experience the loss of self-esteem and refusal to accept help. With grief, the world looks poor and empty; with depression, you feel poor and empty.

One physician described making a medical error as "not like losing your car keys. It's like the laws of gravity have been repealed. We need to reclaim the law of gravity to survive." The feeling can be paralyzing.

Moreover, there is also anticipatory grief, which is grieving not only for what happened but also for what the future will look like. Physicians may mourn the past of being a safe and competent physician and worry whether that can ever be regained. They may mourn for the present: Is the error or death an end of capabilities or an ongoing experience of erosion of practicing medicine? Finally, they may mourn the future: the loss of confidence, self-esteem, and related losses such as loneliness. Many physicians go through each one of these steps and question themselves through the whole process.

It is common for a physician's life to feel upended after a medical error. Life is like one day leaking into another. Now is a time to be intentional about taking care of yourself daily—listening to your body, nurturing your spirit, and tending to your soul. This is also a time to establish boundaries to protect your peace of mind and conserve your energy. Remember, you are more than just a professional in this moment; you are a human being facing a tragedy alongside others.

Another type of grief is called disenfranchised grief. This refers to the sorrow people feel from a loss that cannot be openly acknowledged, publicly mourned, or socially supported. Hopefully, no physician will have to go through that.

Coping with grief

Managing emotions after a medical error is difficult, regardless of the circumstances. Physicians develop coping mechanisms throughout their careers to help alleviate this difficulty. Here are some suggestions for coping with grief. First, take it slow; don't rush the healing process. Your body needs time and energy to recover. Medical errors are an

Table 4. Tips for managing grief after a medical error

Category	Tip
Expectations	• Expect to experience feelings of guilt from possibly not being able to have done more, as well as anger and despair. • Expect to cry; don't hold back your tears. • Recognize that what you are feeling is normal. Don't judge yourself or misinterpret your grief reactions. • Recognize that there is no timetable for grieving. The average is 18 to 24 months, but the period can be shorter or longer. Pressuring yourself to move on can slow the healing process.
Communication	• Listen to your colleagues and those who may be counseling you. • Recognize that you need to feel the error is acknowledged; don't be afraid to talk about it. • Listen compassionately; you can receive help from others who have gone through similar struggles. • Express your concerns for recovery and the patient. • Talk about the clinical situation and the patient. This is a way to process and accept the error, and with each retelling, the pain will lessen. By sharing what happened patiently and compassionately, you are helping yourself heal.
Self-talk	• Acknowledge the situation to yourself with phrases like "I'm very sad." Don't be afraid to use the word "mistake," as it shows you are open to talking about what happened. • Accept your feelings and know that it's okay to express and feel emotions, and even break down from time to time. • Don't try to reason with yourself on how you should or shouldn't feel. Also to be avoided are phrases such as "It's part of God's plan," "I have so much to be thankful for that I shouldn't be sad." • Recognize that it's okay to say to yourself, "I'm not sure what to feel, but it's important for me to know I care."
Assumptions	• Don't assume that others will know how you feel at any given time, unless they have experienced a similar issue. • Watch for assumptions related to outside appearances. You may look okay on the outside, but internally you may be suffering. Try not to be offended when a colleague compliments your appearance. This can put pressure on you to maintain appearances and hide your true feelings.
Receiving help	• Recognize that it may be difficult for friends or colleagues to ask if they can help you. You might feel guilty about receiving attention or fear being a burden. • Be consistent when responding to offers of assistance from colleagues or family members. Let them know you appreciate their support, even if you're not ready to accept it. • Recognize that it's okay to ask your colleagues or friends to listen to your feelings openly so that they don't manifest in unhealthy ways later on.
To keep in mind	• Certain times and days will remind you of what happened. • It's common to feel depressed, confused, and disconnected from others. • Symptoms that don't gradually improve may be a sign that grief has evolved into a more serious problem like clinical depression. These symptoms include excessive bitterness, anger, guilt, an inability to enjoy yourself, withdrawal, hopelessness, and trouble sleeping. • Be present, look for sources of reassurance, and don't hold onto preconceived notions about how grief should look or how long it should last.

unfortunate part of a physician's life, and trying to bounce back too quickly can lead to long-term impairments. Second, minimize decision-making. Try to limit the number of new responsibilities you take on during this time of recovery. Give yourself the space and time to heal. Third, accept help and support when offered. In addition, actively seek out help. Consider reaching out to counseling services or finding support from others.

Expressing your emotions when grieving is healthy. It is important to just let emotions happen. It makes you human and empathetic because it takes time to get over a mistake, and it's okay to remember the patient who was impacted. Healing takes time, and you should not put a timeframe on it. It has to run its course. If you try to suppress it, it will manifest itself in maladaptive ways. Crying helps. You should not feel ashamed of it; it's part of being human. Try to find time to schedule comforting activities where you can relax and take your mind off of things. In addition, look for help from spiritual advisors or counselors.

Other suggestions relate to general wellness: get enough rest; try to eat balanced meals and have good nutrition; keep a journal; engage in moderate exercise to work off frustration and promote sleep; and try not to feel guilty for enjoying time with family and friends. Take time to reflect. All physicians will process a medical error in their own personal way and will have internal coping mechanisms that work for them.

It is important for physicians to ensure that their attitude is in line with the healing process, because behavior and attitude are more important than words. People are going to observe you and how intentional you are and if you're struggling and suffering. *Table 4* details more tips for healing.

In summary, be comfortable with expressing your emotions. Remember that emotions are not always rational. Be patient and take the time to listen to your feelings, as that is what matters most. Support yourself through the pain without overprotecting or rushing yourself. Allow yourself to lean into the pain and actively participate in the grief process. You can support yourself by accepting and not judging yourself; reaching out to others who have experienced medical errors; and listening to those who are trying to help you without judgment. Allow family members to voice their concerns or share their stories.

You are human and mistakes happen. Culture, religion, and family background will impact your grief process. Learn to recognize difficulties in grieving and seek help when needed. Hug your family and your dog and take deep breaths. Talk to your loved ones and tell them you love them. Rely on your faith. Mistakes, like life and death, are natural milestones. Remember that it didn't take an hour for the mistake to happen, so it won't take an hour to recover from the pain. One recommended book is Atul Gawande's *Being Mortal*. Health systems also have a variety of resources, such as well-being sites, employee assistance programs, peer support, and behavioral support e-visits. There is a National Physician Support Line at 1-888-409-0141 with psychiatrists who assist with the emotional and mental health needs of physicians and medical students.

Grief becomes a tolerable and creative experience when shared with someone who truly understands. Being a doctor is emotionally punishing, but connecting with your patients, colleagues, and loved ones as a fellow human being is what renders it not merely a job, but an incomparable vocation.

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