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FACT SHEET

What is a critical incident?

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A critical incident is any event that's significant enough to overwhelm a person's normal coping strategies.

Am I having a normal response to a critical incident?

Individuals will experience a range of emotions following a critical incident. Some people may have little or no distress or disruption. Others may be completely overwhelmed and need time away from work. Initial emotional responses in the hours and days after a critical incident are NOT predictive of long-term outcomes. Try not to pathologise initial responses.

There may be many emotions and physical reactions that are commonly experienced following a critical incident:

An individual may experience all or none of the above. Individuals will respond to critical incidents in their own way.

Is it a critical incident?

A critical incident is determined and defined by the person having the experience. The goal is to provide psychological and physical safety immediately for the individual and the group. When people go into shock, feel shame or powerlessness, it can be very difficult to respond to questions or to make decisions. In this initial stage, sometimes gentle direction with the person is very helpful.

Will I recover from a critical incident?

Critical incidents are a distressing and challenging reality for clinicians but most individuals recover. It's important to know that despite feeling crippled by emotions and fear in the early days, the majority of clinicians do recover and resume full capacity work (Coughlan et al, 2017).

Clinicians who are well supported following a critical incident experience less trauma in the short and long term (Coughlan et al, 2017). For more information, please refer to the fact sheet on "How to support a colleague".

Reactions for anaesthetists

Consumed with guilt, shame, grief, and concern for the patient and their family as well as concerns for self and career.

A fixation with learning more about the patient, colleagues, the event, or the diagnosis.

Feeling powerless in the system.

Feeling empowered to change the system and be involved in future planning, education, or protocols.

When an incident has involved patient harm it's common to ruminate over the "what ifs" or imagine the outcome to be different.

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What is a critical incident?

A critical incident is any event that is significant enough to overwhelm a person's normal coping strategies. In anaesthesia that may include an adverse patient event, a near miss or medical error, equipment failure, being exposed to a confronting trauma or death, a clinical case that is chaotic and dangerous, exposure to a tragic or grief event, a conflict with a colleague, or being threatened or assaulted by a patient, their family, or a colleague[1]. Being involved in an internal or external disaster could also be a critical incident.

Australian and New Zealand College of Anaesthetists
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WHAT IS A CRITICAL INCIDENT IN ANAESTHESIA?

Anaesthesia is a high-risk profession. It carries an increase of an adverse event risk due to being a specialty that focuses on the airway and resuscitation when patients are typically critically ill or vulnerable[3]. Most anaesthetists are likely to suffer at least one adverse event and one intraoperative death during their career[3]. It's estimated that the incidence of perioperative crises is 2 per cent, resulting in stress, burden, and guilt and a complexity on how to manage and support staff[1]. Response to critical incidents are important predictors as to how individuals cope long-term. Provision of support from colleagues is very important. For some, the opportunity to discuss a critical incident with medical friends and health professionals is more important than support from family and friends who may not understand the context[4].

AM I HAVING A NORMAL RESPONSE TO A CRITICAL INCIDENT?

Individuals will experience a range of emotions following a critical incident. Some people may have little or no distress or disruption. Others may be completely overwhelmed and need time away from work. Initial emotional responses in the hours and days after a critical incident are NOT predictive of long-term outcomes. Try not to pathologise initial responses.

Common reactions to critical incidents include:

SHOCK

Disbelief it has occurred, unable to consolidate the experience, or feeling numb.

FEAR

Feeling anxious and concerned about the event, worry that their career has ended, or doubting clinical skills and knowledge.

ANXIOUS

Concerned about ever returning to clinical work, legal ramifications, personal vulnerability, or feeling panicked.

ANGER

Outrage at others, the situation, the system, or feelings of injustice.

POWERLESSNESS

Feeling helpless as to how to change the situation or gain control.

SHAME OR GUILT

Professional credibility concerns, worried how you're perceived by the wider team, or threat to personal identity.

SADNESS

This may be a loss and grief event across many domains – personal, work, identity, or sadness for the patient and their family.

Common symptoms following a critical incident:

- Feeling stressed, anxious, and teary.
- Sleep disturbance – either cannot sleep or extreme fatigue and wanting to sleep all the time.
- Intrusive thoughts and memories – constantly reliving or having flashbacks to the incident.
- Social withdrawal – not wanting to engage with others.
- Fear or difficulty with being on your own.
- Physical symptoms may include headaches, nausea, restlessness and irritability, diarrhoea or constipation, change in appetite (comfort eating or loss of), fatigue, heart palpitations, or strong startle reflex.
- Difficulty concentrating.
- Loss of confidence.

All these symptoms are associated with *acute critical stress* and are very normal reactions to an abnormal event. The level of distress for an anaesthetist will be influenced by several factors. Distress and stress can be influenced by the level of harm to a patient[5], previous experiences of loss, grief and trauma, the strength of an individual's support network and the stage of their career.

REACTIONS OF ANAESTHETISTS

Implications for someone following a critical incident at work are very different than for someone who is injured on a pedestrian crossing. Therefore, reactions may be complicated for someone in anaesthesia dependent on the nature of the critical incident and the potential implications for the patient, self, and career.

Common reactions include:

- Consumed with guilt, shame, grief, and concern for the patient and their family.
- Consumed with guilt, fear, shame, and anxiety about your career and how others will perceive you.
- A fixation with learning more about the patient, colleagues, the event, or the diagnosis.
- Feeling concerned or paranoid about what colleagues and others are saying about your involvement.
- Concern or terror about the informal or formal steps of investigations, hospitals, or coronial investigations.
- Feeling powerless in the system.
- Feeling empowered to change the system and be involved in future planning, education, or protocols.
- When an incident has involved patient harm it's common to ruminate over the "what ifs" or imagine the outcome to be different.
- Fear of litigation or punishment.

Coping strategies may be either defensive (denial, distancing, discounting) or constructive (accepting responsibility where appropriate, planning, problem solving and future focussed)[4].

IS IT A CRITICAL INCIDENT?

A critical incident is determined and defined by the person having the experience. The goal is to provide psychological and physical safety immediately for the individual, and the group. When people go into a shock, feel shame or powerlessness, it can be very difficult to respond to questions or to make decisions. In this initial stage, sometimes gentle direction with the person is very helpful.

SUPPORT FOLLOWING A CRITICAL INCIDENT

It's well documented that clinicians who are well supported following a critical incident experience less trauma in the short and long term[4]. Transparency and honesty that the event has occurred is an important first step. Hospitals and clinics should be striving to maintain a supportive culture of disclosure to ensure ongoing quality improvement, learning, and support of colleagues. Hospital systems by their very nature may have processes that those involved in critical incidents find challenging.

Explaining what routine process is, what escalation is and what an investigation is to those involved is important. Morbidity and mortality meetings are an essential point of learning following any event or case. Junior and vulnerable colleagues need to be supported, protected from politics, and provided psychological safety during the process. Otherwise, the meetings may cause further harm[4]. Support needs to be implemented as soon as possible after the event with someone the individual trusts.

It's really important to connect the person with people they trust quickly. In the first hour or two, people in shock find it hard to access language and speech so don't pressure them to talk. Acknowledge and validate feelings, emotions, and reactions. Try and help guide the person through a balance of providing information about the situation and having some time to process or think about something else. Be guided by the person's questions and reactions to strike this balance.

Over the longer term, stay in touch with the person and create space for them to talk about the event when they feel the time is right. Encourage them to keep to their normal routine. Encourage movement, exercise, and some time in natural light. Encourage the person to eat well and engage in good sleep hygiene. In the following weeks, try and help the person engage in the normal activities of life they enjoy like sport or crafts. Reassure the person that recovery is the norm.

HELPFUL ENGAGEMENT FOLLOWING A CRITICAL INCIDENT

The intention here isn't to take over or intimidate. The intention is to let your colleague know that however they're feeling at the moment is normal. You acknowledge and validate their experience. You're a safe and non-judgemental person to talk to.

Here's some suggestions of helpful things to say:

- *"That may have been new or a first for you. It would be normal to be confronted by that. Let's go and sit somewhere quiet for a moment".*
- *"That was very chaotic. You sit here and I'm going to get a coffee/water for you and let's talk about what just happened".*
- *"I just heard what happened. I'm here if you want to talk".*
- *"I don't know how you're feeling but if this was me, I would appreciate a friend".*
- *"I don't know what to say right now. I'm just so glad that you told me".*

It's sometimes helpful to share personal anecdotes of your own critical incidents. If you choose to share, be mindful that you've given the other person space to talk. That they're in a position to hear and absorb your story. That it's not told in a competitive tone or with a message that your story was worse and so they're overreacting.

UNHELPFUL ENGAGEMENT FOLLOWING A CRITICAL INCIDENT

It's really unhelpful when someone is in crisis or overwhelmed with emotions to be told:

- *"Oh I've seen worse than that".*
- *"If you can't cope with that, anaesthesia's probably not for you".*
- *"Get yourself together, you have another case in 20".*
- *"If you're that upset you'd better go home".*
- *"This will be a great case for morbidity and mortality meetings".*
- Going into your own "war stories" with poor insight into how the stories are being received by the individual.

WHEN CAN YOU SAFELY RETURN TO WORK AFTER A CRITICAL INCIDENT?

This is a very personal decision. This is an important decision that needs to be made in collaboration with departmental heads and line managers. Sometimes individuals may need assistance to make this decision. For some people, getting straight into the next case and being able to focus on something else may be very reassuring and grounding. For others, an immediate return to work may be dangerous for the patient, team, and clinician. Assessing whether you're safe, or your colleague is safe can be really challenging.

Some questions to ask yourselves or others:

- When I think about the event now what are my physical reactions? Do I have a steady hand? A clear mind? Do I feel in control?
- Am I well rested?
- Have I been able to eat?
- Is my mind cluttered with intrusive thoughts of the event? How fearful am I that it will happen again?
- While I still may have emotion and grief about the event, will it impact the clinical work I need to do now?
- Would I want a colleague who felt the way I currently do to be clinically involved with someone I loved?

WILL I RECOVER FROM A CRITICAL INCIDENT?

Critical incidents are a distressing and challenging reality for clinicians but most individuals recover. Critical incidents, particularly those which cause harm to patients, are frightening, distressing, and potentially a life changing event for a clinician. It's important to know that despite feeling crippled by emotions and fear in the early days, the majority of clinicians do recover and resume full capacity work[4].

Resources

Nijs K, Seys D, Coppens S, Van De Velde M, Vanhaecht K. Second victim support structures in anaesthesia: A cross-sectional survey in Belgian anaesthesiologists. Int J Qual Health Care. 2021; 33(2).

Tanabe K, Janosy N, Vogeli J, Brainard A, Whitney G. Caring for the caregiver following an adverse event. Paediatr Anaesth. 2021; 31(1):61-7.

Arriaga AF, Szyld D, Pian-Smith MCM. Real-time debriefing after critical events: Exploring the gap between principle and reality. Anesthesiol Clin. 2020; 38(4):801-20.

Coughlan B, Powell D, Higgins MF. The second victim: A review. Eur J Obstet Gynecol Reprod Biol. 2017; 213:11-6.

Van Gerven E, Bruyneel L, Panella M, Euwema M, Sermeus W, Vanhaecht K. Psychological impact and recovery after involvement in a patient safety incident: A repeated measures analysis. BMJ Open. 2016; 6(8):e011403.

Brene Brown video – Empathy versus sympathy

Learn the difference between empathy and sympathy in four short minutes and why we want to empathise with others rather than sympathise.

brenebrown.com/videos/rsa-short-empathy/

Supporting someone with acute critical stress

(This video focuses on patients though is brilliant for clinicians as well)

This teaches about acute critical stress and how it affects people in the short and long term.

www.aftertrauma.org/news/blog/post/53-the-impact-of-acute-stress-new-video

TED Talk – A strategy for supporting and caring for others

Here a policeman talks about how having to tell relatives that their loved one has died and teaches about the importance of sitting in the moment and forming human connection rather than trying to solve anything or just fall back on policy.

www.ted.com/talks/jeremy_brewer_a_strategy_for_supporting_and_listening_to_others?language=en

Three secrets of resilient people

This incredible TED Talk tells the story of a clinician working in the Christchurch earthquakes who then suffered her own personal devastation. She shares how she survived and what she learned along the way.

www.youtube.com/watch?v=NWH8N-BvhAw

Wellbeing for the broken

This is a blog written by a clinician following a devastating event at work. It's written as a reflection in the height of the crisis when sleep and life were very difficult.

www.stemlynsblog.org/wellbeing-for-the-broken-part-1-liz-crowe-for-st-emlyns/

Wellbeing for the broken: Part two

This blog describes clawing your way back to wellbeing after a devastating event, the lessons learned and what wellbeing may now look like.

www.stemlynsblog.org/wellbeing-for-the-broken-part-2-st-emlyns/

REFERENCES

Note: Linked to ANZCA library full-text where available.

1. Nijs K, Seys D, Coppens S, Van De Velde M, Vanhaecht K. Second victim support structures in anaesthesia: A cross-sectional survey in Belgian anaesthesiologists. Int J Qual Health Care. 2021; 33(2).
2. Tanabe K, Janosy N, Vogeli J, Brainard A, Whitney G. Caring for the caregiver following an adverse event. Paediatr Anaesth. 2021; 31(1):61-7.
3. Arriaga AF, Szyld D, Pian-Smith MCM. Real-time debriefing after critical events: Exploring the gap between principle and reality. Anesthesiol Clin. 2020; 38(4):801-20.
4. Coughlan B, Powell D, Higgins MF. The second victim: A review. Eur J Obstet Gynecol Reprod Biol. 2017; 213:11-6.