The Second Victim: Running the gauntlet

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Objectives:

1. To review the concept of the *"**second victim**."*
2. To discuss the **impact of being involved** in an adverse event/patient safety incident on the healthcare provider.
3. To assess organizational support of second victims.
4. To examine **how to support healthcare second victims.**
5. To create a model of second victim support in your industry.

Who is the ***second victim?***

Medical error: the second victim

The doctor who makes the mistake needs help too

Wu, A. (2000). *British Medical Journal, 320,* 726-727.

When I was a house officer another resident failed to identify the electrocardiographic signs of the pericardial tamponade that would rush the patient to the operating room late that night. The news spread rapidly, the case tried repeatedly before an incredulous jury of peers, who returned a summary judgment of incompetence. I was dismayed by the lack of sympathy and wondered secretly if I could have made the same mistake—and, like the hapless resident, become the second victim of the error.

Strangely, there is no place for mistakes in modern medicine. Society has entrusted physicians with the burden of understanding and dealing with illness. Although it is often said that "doctors are only human," technological wonders, the apparent precision of laboratory tests, and innovations that present tangible images of illness have in fact created an expectation of perfection. Patients, who have an understandable need to consider their doctors infallible, have colluded with doctors to deny the existence of error. Hospitals react to every error as an anomaly, for which the solution is to ferret out and blame an individual, with a promise that "it will never happen again." Paradoxically, this approach has diverted attention from the kind of systematic improvements that could decrease errors. Many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster. And although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims.

Virtually every practitioner knows the sickening realisation of making a bad mistake. You feel singled out and exposed—seized by the instinct to see if anyone has noticed. You agonise about what to do, whether to tell anyone, what to say. Later, the event replays itself over and over in your mind. You question your competence but fear being discovered. You know you should confess, but dread the prospect of potential punishment and of the patient's anger. You may become overly attentive to the patient or family, lamenting the failure to do so earlier and, if you haven't told them, wondering if they know.[1–3]

Sadly, the kind of unconditional sympathy and support that are really needed are rarely forthcoming. While there is a norm of not criticising,[4] reassurance from colleagues is often grudging or qualified. One reason may be that learning of the failings of others allows physicians to divest their own past errors among

Facing Our Mistakes
David Hilfiker

"The drastic consequences of our mistakes, the repeated opportunities to make them, the uncertainty about our culpability, and the professional denial that mistakes happen all work together to create an ***intolerable dilemma*** *for the physician.* ***We see the horror of our mistakes, yet we cannot deal with their enormous emotional impact.*** *Perhaps the only way to face our guilt is through confession, restitution, and absolution. Yet within the structure of modern medicine there is no place for such spiritual healing."*

Hilfiker, D. (1984). Facing our mistakes. *New England Journal of Medicine, 310(2),*118-122.

The Two Sets of Victims

"There are ***two sets of victims*** *after a system failure or human error has led to injury, and we have not done a good job of helping either. The first group of victims is patients and their families; the second is the health care workers involved in the incident."*

Wears, R.L., Janiak, B., Moorhead, J.C., Kellermann, A.L., Yeh, C.S., Rice, M.M., Jay, G., Perry, S.J., & Woolard, R.(2000). Human error in medicine: Promise and pitfalls, part 1. *Annals of Emergency Medicine, 36(1),* 58–60.

Who is the ***second victim?***

- "A second victim is a health care provider involved in an unanticipated adverse patient event, medical error and/or a patient-related injury who become victimized in the sense that the provider is traumatized by the event. Frequently, second victims feel personally responsible for the unexpected patient outcomes and feel as though they have failed their patients, second-guessing their clinical skills and knowledge base."
- Prevalence: 10-50% over entire career

Scott, S.D., Hirschinger, L.E., Cox, K. R., McCoig, M., Brandt, J., & Hall, L.W. (2009).
The natural history of recovery for the healthcare provider ''second victim'' after adverse patient events. *Quality and Safety in Health Care, 18*, 325-330.

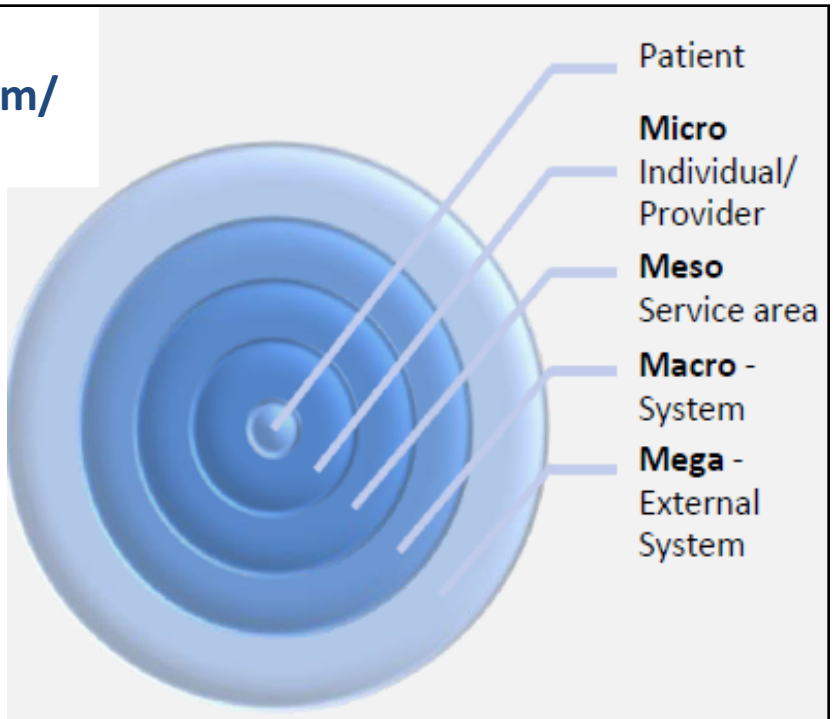
More ***victims?***

- *What about **no harm** patient safety incidents* and ***near misses****?*
- Third victim: healthcare facility
- Others? other patients
  community

Exercise: design second victim program/ intervention

Considerations:

1. Legislation
2. Regulation
3. Your "industry" or business
4. Own organization or institution
5. Own department or division



*Who is **your** second victim?*

Waking up the next morning: surgeons' emotional reactions to adverse events

Shelly Luu,[1] Priyanka Patel,[2,3] Laurent St-Martin,[2,3] Annie SO Leung,[1] Glenn Regehr,[4] M Lucas Mumaghan,[2,5,6] Steven Gallinger[6] & Carol-anne Moulton[2,6]

(2012). *Medical Education, 46,* 1179-1188.

Focus: emotional reactions to adverse events

Four phases:

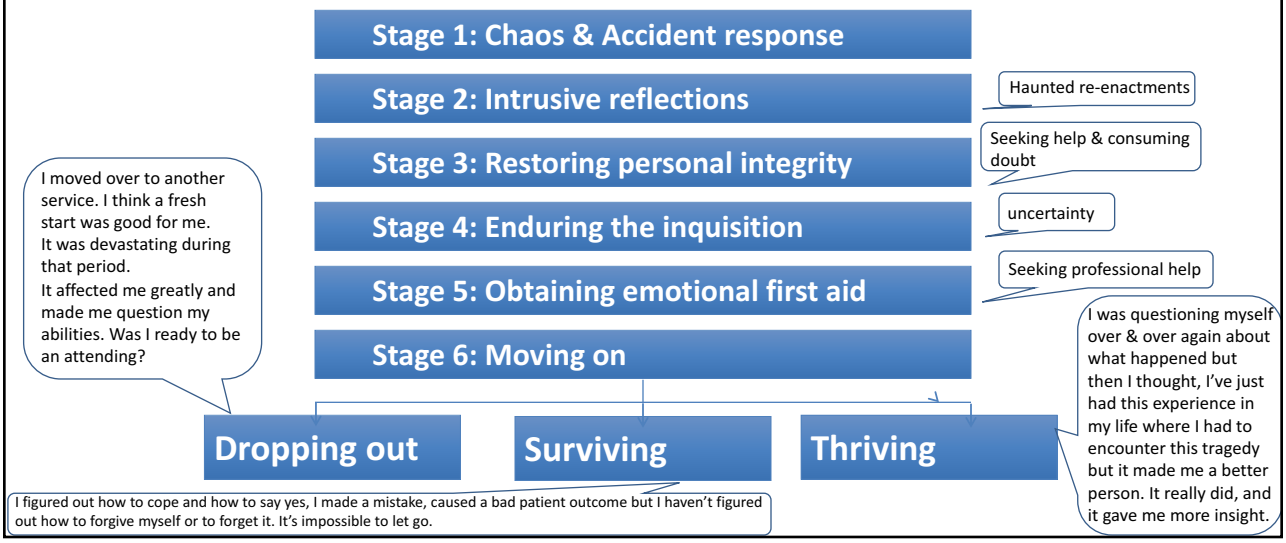
1. **The kick –** feelings of failure ("am I good enough?")
2. **The fall –** sense of chaos ("was it my fault?")
3. **The recovery –** reflection and moving on ("what can I learn?")
4. **The long-term impact –** impact on personal & professional identities

Importance of learning from the event

Little formal support

The natural history of recovery for the healthcare provider "second victim" after adverse patient events

Scott, S.D., Hirschinger, L.E., Cox, K. R., McCoig, M., Brandt, J., & Hall, L.W. (2009).
The natural history of recovery for the healthcare provider "second victim" after adverse patient events. *Quality and Safety in Health Care, 18,* 325-330.



The Emotional Impact of Medical Error Involvement on Physicians:
a call for Leadership & Organisational Accountability

Schwappach, D.L.B., & Boluarte, T.A. (2009). The emotional impact of medical error involvement on physicians: a call for leadership and organisational accountability. *Swiss Medical Weekly, 139,* 9–15.

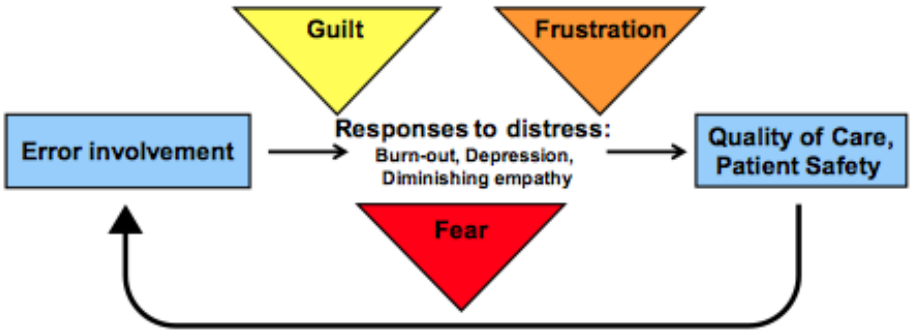


Figure 1
Reciprocal cycle of error involvement, emotional distress, and future errors.

Impact of Errors on Physicians' Life Domains by Level of Error Severity*

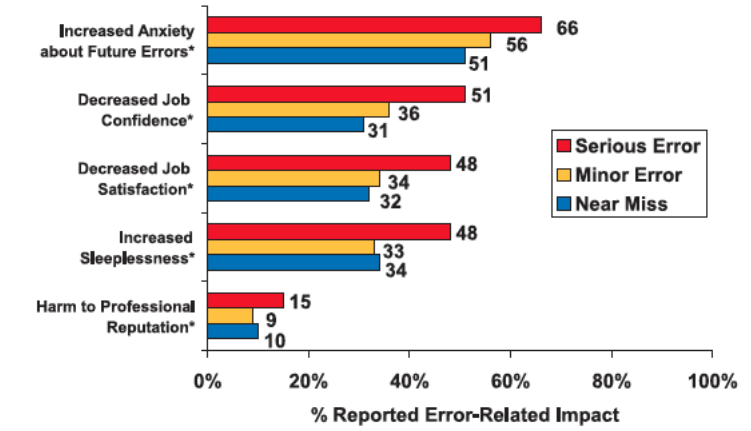


Figure 1. *Physicians' lives were more likely to be affected as error severity increased.*
** Chi-square tests; $p < .001$ level.*

Waterman, A.D., Garbutt, J., Hazel, E., Dunagan, W.C., Levinson, W., Fraser, V.J., & Gallagher, T.H. (2007). The emotional impact of medical errors on practicing physicians in the United States and Canada. *Joint Commission Journal of Quality and Patient Safety, 33*, 467-476.

Coping with medical error: a systematic review of papers to assess the effects of involvement in medical errors on healthcare professionals' psychological well-being

(2010). *Quality and Safety in Healthcare,19(6),* e43.

Reema Sirriyeh,[1] Rebecca Lawton,[1] Peter Gardner,[1] Gerry Armitage[2]

ABSTRACT

Background Previous research has established health professionals as secondary victims of medical error, with the identification of a range of emotional and psychological repercussions that may occur as a result of involvement in error.[2 3] Due to the vast range of emotional and psychological outcomes, research to date has been inconsistent in the variables measured and tools used. Therefore, differing conclusions have been drawn as to the nature of the impact of error on professionals and the subsequent repercussions for their team, patients and healthcare institution. A systematic review was conducted.

mechanisms that serve the needs of different people and reduce the emotional burden associated with making an error. Therefore, the research questions posed for this review were:

1. What is the impact of being involved in a medical error on the health professional?
2. How do health professionals cope in the short- and longer term when they have been involved in a medical error?
3. Are there any factors (referred to below as moderating factors) that influence the immediate response to error and/or the way in which individuals cope?

Coping with medical error: a systematic review

- Emotional response:
  - Severity of patient outcome
  - Institutional handling
- Psychological response:
  1. Patient outcome
  2. Patient relationship
  3. Team response
  4. Institutional handling
- Coping related to: disclosure, resolution of the incident
- Impact:
  - Positive
  - Negative
- ***Need for support***

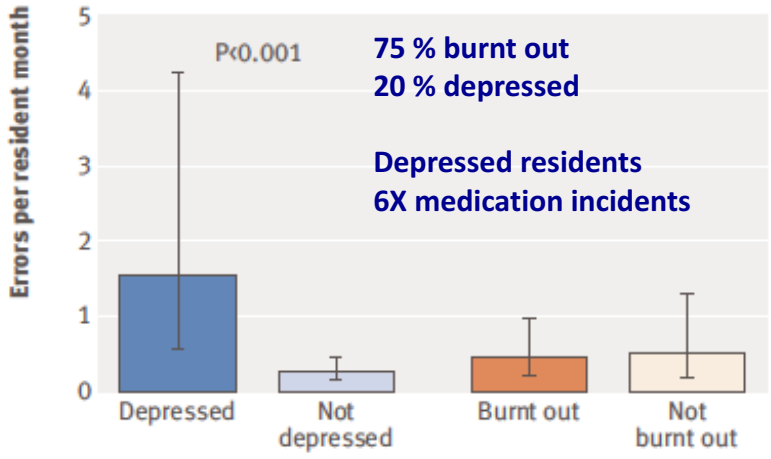


Fig 1| Rates of medication errors per resident month for depressed compared with non-depressed residents and for burnt out compared with non-burnt out residents. T bars indicate 95% confidence intervals. P value determined using Poisson cluster analysis

- 123 residents in 3 pediatric residency programs
- 50% participation rate
- depression (20%) & burnout (74%)
- 96% depressed also burnt out
- Half of the depressed residents unaware of their own depression
- Prescribing errors: total rate 1.2%
- Error rate/month:
  - Depressed: 1.55
  - Non-depressed: 0.25
  - Burnt out: 0.45
  - Non-burnt out: 0.53
- Residents who were depressed or burnt out:
  - Higher rates of self-reported errors
  - Poorer health

Fahrenkopf, A.M., Sectish, T.C., Barger, L.K., Sharek, P.J., Lewin, D., Chiang, V.M., Edwards, S., Wiedermann, B.L., & Landrigan, C.P. (2008). Rates of medication errors among depressed and burnt out residents; prospective cohort study. *British Medical Journal, 336(7642),* 488-491.

The Effects of the Second Victim Phenomenon on Work-Related Outcomes: Connecting Self-Reported Caregiver Distress to Turnover Intentions and Absenteeism

Jonathan D. Burlison, PhD, Rebecca R. Quillivan, MS,* Susan D. Scott, PhD,† Sherry Johnson, MSN,‡ and James M. Hoffman, PharmD*§*

Objectives: Second victim experiences can affect the well-being of healthcare providers and compromise patient safety. The purpose of this study was to assess the relationships between self-reported second victim–related distress to turnover intention and absenteeism. Organizational support was examined concurrently because it was hypothesized to explain the potential relationships between distress and work-related outcomes.

Methods: A cross-sectional, self-report survey (the Second Victim Experience and Support Tool) of nurses directly involved in patient care (N = 155) was analyzed by using hierarchical linear regression. The tool assesses organizational support, distress due to patient safety event involvement, and work-related outcomes.

Results: Second victim distress was significantly associated with turnover intentions ($P < 0.001$) and absenteeism ($P < 0.001$), while controlling for the effects of demographic variables. Organizational support fully mediated the distress–turnover intentions ($P < 0.05$) and distress-absenteeism ($P < 0.05$) relationships, which indicates that perceptions of organizational support may explain turnover intentions and absenteeism related to the second victim experience.

Conclusions: Involvement in patient safety events and the important role of organizational support in limiting caregiver event–related trauma have been acknowledged. This study is one of the first to connect second victim distress to work-related outcomes. This study reinforces the efforts health care organizations are making to develop resources to support their staff after patient safety events occur. This study broadens the understanding of the negative effects of a second victim experience and the need to support caregivers as they recover from adverse event involvement.

Key Words: adverse event, patient safety, second victim, medical error

(*J Patient Saf* 2016;00: 00–00)

Kimberly Hiatt

- 27 year nursing career at Seattle Children's hospital
- made a mathematical error (10 X) → overdose of calcium chloride in a critically ill infant.
- baby died 5 days later
- suspended and later fired
- unable to get another nursing job
- committed suicide 7 months after incident on April 3, 2011

More ***victims?***

- Third victim: healthcare facility
- Others? other patients
  community
  cost of training a nurse (2008) :
  CA$ 17, 552 – 37, 750

Second Victim Experience

Feelings	Thoughts	Intentions	Behaviours
Fear	*Confusion*	*Plans to leave occupation (15%; Scott)*	*Absenteeism*
Shame	*Self-doubt*	*Change in practice*	*Leaves profession/career change*
Guilt	*Second guessing knowledge/skills, career choice*	*Motivated to make amends*	*Increased likelihood of subsequent PSI*
Stigmatized	*Inadequacy*		*Defensive practice*
Anger	*Failure*		*Social withdrawal*
Anxiety, including re: future error	*Fixation*		*Avoidance*
Remorse	*Lack of closure*		*Work-home interference*
Sadness	*Thoughts of self-harm*		*Maladaptive/destructive behaviours: alcohol, drugs, suicide*
Reduced job satisfaction			*Seeks resolution: seeks help, reaches out to patients, families*
(PTSD)			*Transforms experience into learning/teaching*
Burnout			
Moral distress			

Shame and guilt

- Do these two terms refer to the same feelings/emotions?
- Or not?
- How are these two terms related?

Tangney, J.P. et al. (1996). Are shame, guilt and embarrassment distinct emotions? *Journal of Personality and Social Psychology, 70(6),* 1256-1269.

Facing Our Mistakes
David Hilfiker

"The drastic consequences of our mistakes, the repeated opportunities to make them, the uncertainty about our culpability, and the professional denial that mistakes happen all work together to create an intolerable dilemma for the physician. We see the horror of our mistakes, yet we cannot deal with their enormous emotional impact. ***Perhaps the only way to face our guilt is through confession, restitution, and absolution.*** *Yet within the structure of modern medicine there is no place for such spiritual healing."*

Hilfiker, D. (1984). Facing our mistakes. *New England Journal of Medicine, 310(2),* 118-22.

Shame and guilt

- Do these two terms refer to the same feelings/emotions?
- Or not?
- How are these two terms related?

- Both:
- are self-conscious emotions
  - "Heightened sense of awareness and evaluation of the self"
- involve social transgression

Tangney, J.P. et al. (1996). Are shame, guilt and embarrassment distinct emotions? *Journal of Personality and Social Psychology, 70(6),* 1256-1269.

"The experience of shame is directly about the ***self,*** which is the focus of evaluation. In guilt, the self is not the central object of negative evaluation, but rather the thing done or undone is the focus."

Lewis, H. B. (1971): Shame and Guilt in Neurosis, p. 30

Shame	Guilt
• "***I*** did that horrible thing, and therefore I am an unworthy, incompetent or bad person"	• "I ***DID*** that horrible ***THING***"
• Self is agent AND object of observation and disapproval	• Similar negative feelings
• Feelings of worthlessness and powerlessness	• Preoccupation with the thing done/undone
• Feeling of being exposed	• Focus is on other-oriented empathy
• Feeling of public disapproval	• Focus leads to tension, remorse, and regret over the "bad thing done"
• Desire for concealment/escape	
• Focus is on own distress	

So what?

- Design of interventions may need to be aligned with certain emotional responses
- Recognition that the threat of social disapproval and rejection is extremely distressing
  - Motivate support for those involved in patient safety incidents

Waterman, A.D., Garbutt, J., Hazel, E., Dunagan, W.C., Levinson, W., Fraser, V.J., & Gallagher, T.H. (2007). The emotional impact of medical errors on practicing physicians in the United States and Canada. *Joint Commission Journal of Quality and Patient Safety, 33,* 467-476.

The Emotional Impact of Medical Errors on Practicing Physicians in the United States and Canada

Amy D. Waterman, Ph.D.
Jane Garbutt, M.B., Ch.B.
Erik Hazel, Ph.D.
William Claiborne Dunagan, M.D.
Wendy Levinson, M.D.
Victoria J. Fraser, M.D.
Thomas H. Gallagher, M.D.

- **90% physicians surveyed disagreed that hospitals and healthcare organizations adequately support them in coping with stress associated with safety incidents**
- **82% somewhat or very interested in counseling**
- Barriers:
  - Taking time off work
  - Did not believe counseling would be helpful
  - Confidentiality concerns
  - Negative impact on record of employment
  - Negative impact in malpractice insurance costs
- 89% ever disclosed serious patient safety incident
- 18% received education or training
- 86% somewhat or very interested in receiving education/training

ORIGINAL RESEARCH

Suffering in silence: a qualitative study of second victims of adverse events

Ullström S, *et al*. *BMJ Qual Saf* 2014;**23**:325–331

Results Our findings confirm earlier studies showing that emotional distress, often long-lasting, follows from adverse events. In addition, we report that the impact on the healthcare professional was related to the organisation's response to the event. Most informants lacked organisational support or they received support that was unstructured and unsystematic. Further, the formal investigation seldom provided adequate and timely feedback to those involved. The insufficient support and lack of feedback made it more difficult to emotionally process the event and reach closure.

Discussion This article addresses the gap between the second victim's need for organisational support and the organisational support provided. It also highlights the need for more transparency in the investigation of adverse events. Future research should address how advanced support structures can meet these needs and provide learning opportunities for the organisation. These issues are central for all hospital managers and policy makers who wish to prevent and manage adverse events and to promote a positive safety culture.

Assessing the Perceived Level of Institutional Support for the Second Victim After a Patient Safety Event

Leroy Joesten, MDiv, BCC, Nancy Cipparrone, MA,† Susan Okuno-Jones, DNP,* and Edwin R. DuBose, PhD†*

Objective: The objective of this study was to establish a baseline of perceived availability of institutional support services or interventions and experiences following an adverse patient safety event (PSE) in a 650-bed children and adult community teaching hospital.

Methods: Investigators queried associates about their experiences after a PSE, what institutional support services or interventions they perceived to be available, and how helpful used services were. The investigators used an online modified version of a PSE survey developed by several health related organizations in Boston.

Results: One hundred twenty evaluable surveys were analyzed. Sixty-eight percent of respondents were nurses, 99% of whom were female. Only 10% to 30% of respondents reported that various support services or interventions were actively offered, and 30% to 60% indicated that they were not available. Respondents reported having experienced several distressing symptoms after a PSE, most notably, troubling memories (56%) and worry about lawsuits (37%). Less than 32% "agreed" or "strongly agreed" that they could report concerns without fear of retribution or punitive action. More respondents experienced support from clinical colleagues (64%) than from their manager or department chair (38%).

Conclusions: These results validate a need by associates for emotional support after a PSE and that associates' perception of available formal institutional support services or interventions is low.

Key Words: patient safety event, second victim, institutional support, culture of safety, just culture, emotional support

(*J Patient Saf* 2015;11: 73–78)

Medically Induced Trauma Support Services Staff Support Survey:
Items assessing:

- Process/policies for reporting and disclosure
- Guidance
- availability and usefulness of institutional support services for providers involved in PSI

Involvement of health-care professionals in an adverse event: the role of management in supporting their work force

Eva Van Gerven[1*], Deborah Seys[1*], Massimiliano Panella[1,2], Walter Sermeus[1], Martin Euwema[3], Frank Federico[4], Linda Kenney[5], Kris Vanhaecht[1,6]

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6 University Hospitals Leuven, Department of Quality Management, Leuven, Belgium

(2014). Polskie Archiwum Medycyny Wewnetrznej, 124(6), 312–20.

KEY WORDS

adverse event, health personnel, patient safety, quality, second victim

ABSTRACT

INTRODUCTION After an adverse event, not only patients and family members but also health care professionals involved in the event become victims. More than 50% of all health care professionals suffer emotionally and professionally after being involved in an adverse event. Support is needed for these "second victims" to prevent a further negative impact on patient care.

OBJECTIVES The aim of the study was to evaluate the prevalence and content of organizational-level support systems for health care professionals involved in an adverse event.

METHODS A survey was sent to 109 Belgian hospitals regarding 2 aspects: first, the availability of a protocol for supporting second victims; and, second, the presence of a contact person in the organization to provide support. A total of 59 hospitals participated in the study. Hospitals were asked to submit their protocols for providing support to second victims. A content analysis based on an Institute for Healthcare Improvement's white paper and the Scott Model was performed to evaluate the protocols.

RESULTS Thirty organizations had a systematic plan to support second victims. Twelve percent could not identify a contact person. The chief nursing officer was seen as one of the main contact people when something went wrong. In terms of the quality of the protocols, only a minority followed part of the international resources.

CONCLUSIONS A minority of hospitals are somewhat prepared to provide support for health care professionals. Management should take a leadership role in establishing support protocols for their health care professionals in the aftermath of an adverse event.

Correspondence to:
Kris Vanhaecht, RN, MSc, PhD,

Exercise: design second victim "program"

1. **Background:**
   - Industry
   - Organization
   - Any legislative/regulatory concerns
   - For whom?
2. **Needs assessment:**
   - Assess organizational readiness
   - Use of standardized/previously validated tool
   - Other data sources:
     - Direct observation
     - Incident report(s)
     - patient complaints
     - M&M rounds
     - Alerts/notifications
     - Published literature (e.g. case report, series, etc.)
     - Everyone is talking about THAT case….
3. **Taking stock of available resources:**
   - what do you have/utilize?
4. **Identify barriers & enablers**
5. **Engage stakeholder and enlist buy-in & support**
   - Elevator speech
6. **Program design & development**
7. **What else do you need/want that you do not have?**
   Timeline for implementation?
8. **Program evaluation:**
   - feasible? effective? & sustainable?

Management of incidents & disclosure should address

Impact of patient safety incidents on ~~patients~~ providers

- Physical trauma
- Emotional trauma: ~~patients~~ providers and families
  - Sad
  - Anxious
  - Depressed
  - Traumatized
  - Angry
  - Guilt (&/or shame?)
  - Fear (further harm; retribution from ~~providers~~ patients)
- Financial trauma: additional costs; lost income; ~~compensation~~ litigation (75 – 99% physicians experience at least one lawsuit)

TRUST: the 5 Rights for the Second Victim

Denham, C.R. (2007). TRUST: the 5 rights of the second victim. *Journal of Patient Safety, 3(2),* 107-119.

1. **T**reatment that is just:
   - Avoid stigmatizing
2. **R**espect
   - Avoid blaming-shaming
3. **U**nderstanding and Compassion:
   - Don't abandon the healthcare provider
4. **S**upportive Care:
   - Access to appropriate support services
5. **T**ransparency and the Opportunity to Contribute:
   - Culture of learning

Unmet needs of the second victim

- To be heard and to have distress acknowledged
- To be supported by colleagues, organization
- To make sense of what happened
- To have opportunities to transform experience into learning

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*"Medical school was also a very competitive place, discouraging any sharing of feelings. The favorite pastime…seemed to be sharing…the story of the patient who had been presented to one's team, and then describing in detail how the diagnosis had been reached…The storyteller, having spent the day researching every detail of the patient's disease, could, of course, dazzle everyone with the breadth and depth of his knowledge. Even though I knew what was going on, the game still left me feeling incompetent, as it must have many of my colleagues. I never knew for sure, though, since no one had the nerve to say so…**It almost seemed that one's peers were the worst possible persons with whom to share those feelings.***

Hilfiker, D. (1984). Facing our mistakes. *New England Journal of Medicine, 310(2),*118-122.

The role of talking (and keeping silent) in physician coping with medical error: A qualitative study

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ABSTRACT

Objective: The aim was to examine the role of talking (or remaining silent) in the physician's experience of coping with medical error.
Methods: Sixty-one physicians participated in in-depth interviews about their experience of coping with a serious medical error. We analyzed verbatim transcripts to develop a taxonomic analysis of talking domains to capture the physician experience of talking and coping with error.
Results: Talking (or not talking) about a medical error was an important aspect of the physicians' experience. After an error, honest conversations with patients and families, the medical team, colleagues, mentors, and others were critical early steps toward healing. Talking with others was important for processing and finding meaning. Many physicians used their stories to teach and help others. Some types of conversation were unhelpful, such as those that were cruel, insensitive, self-serving, and dishonest. Talking with well-intentioned colleagues and family members was often unhelpful if they minimized the error.
Conclusion: Physicians' opportunities to talk about their experience in a meaningful way is associated with their ability to recover after a serious medical error.
Practice implications: This work may inform institutional policies, practices, and training to help physicians effectively prepare for and cope with medical error.

Table 1
Talking that helped or did not help physicians cope with error.

Did not help		Did help
Silence	Unhelpful conversations	Helpful conversations
Silence	**Talking**	**Talking with patients & family**
From colleagues	Difficult conversations	Disclosure
From superiors	Cruel conversations	Forgiveness
Not talking	Insensitive, uncaring	Apology
To spouse	Self-serving	Explanations
To colleagues	Dishonest	Honesty
To family or patient	**Talking**	Conveying love for patient
Prohibited by lawyer	Unhelpful conversations with well-intentioned colleagues	**Talking with residents, team**
No one to talk to	**Talking**	Processing medically
	With patient's spouse	Processing emotionally Teaching, prevention
	Talking	**Talking with colleagues**
	With spouse	Support groups
	With my parents	Shared experience
	Talking	Reassurance
	With risk management	Disclosure
		Talking with mentor/specialist
		To learn about error
		What did I do wrong?
		Reassurance
		Talking with family, spouse
		Emotional support
		Physician spouses/family members could be reassuring
		Talking to God, prayer
		Grace
		Forgiveness
		Reminder of medicine as calling
		Talking to the interviewer
		Never talked before
		Want to help others
		Talking with risk management
		Talking to a therapist
		Non-discoverable
		Writing
		Felt need to tell story
		Can separate narrator from writer

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David Hilfiker

"Because doctors do not discuss their mistakes, I do not know how other physicians come to terms with theirs. But I suspect that many cannot bear to face their mistakes directly. We either deny the misfortune altogether or blame the patient, the nurse, the laboratory, other physicians, the system, fate—anything to avoid our own guilt."

Hilfiker, D. (1984). Facing our mistakes. *New England Journal of Medicine, 310(2),* 118-122.

Supporting involved health care professionals (second victims) following an adverse health event: A literature review

Deborah Seys [a], Susan Scott [e], Albert Wu [b], Eva Van Gerven [a], Arthur Vleugels [a], Martin Euwema [c], Massimiliano Panella [d], James Conway [f], Walter Sermeus [a], Kris Vanhaecht [a,*] (2013). *International Journal of Nursing Studies, 50(5),* 678-687.

Table 2
Overview of identified considerations and interventional strategies to support second victims.

Considerations
- Time between adverse event and support is crucial with 24/7 availability (Schelbred and Nord, 2007; Scott et al., 2010)
- Structured sessions need to be provided (Engel et al., 2006)
- Highly respected physicians or physicians in a senior position should be encouraged to discuss their errors and feelings (Levinson and Dunn, 1989)
- Programs which focus to prevent, identify and treat burnout (West et al., 2006)
- Promote empathy within the team (West et al., 2006)

Strategies
- Talk and listen to second victims (Arndt, 1994)

Organize and facilitate open discussion of the error (Engel et al., 2006; Fischer et al., 2006; Meurier et al., 1998)
- Share experiences with peers (Engel et al., 2006)
- Organize special conferences on the issue of second victims to increase awareness (Levinson and Dunn, 1989)
- Provide a professional and confidential forum to discuss their errors (Levinson and Dunn, 1989)
- Inquire about colleague coping (Wu, 2000)
- Expressive writing (Wu et al., 2008)

Education & Training:
How to support learners, colleagues & other providers?

Photo courtesy of Canadian Medical Protective Association

Training and Education

- Develop **programs in communication** with patients and families
- **Train** doctors and nurses in dealing with their own feelings.
- **Educate board and senior staff** to their responsibilities.
- Provide training as part of **orientation** and **annually** for all caregivers
- Develop a broad array of **interactive** training methods.
- Provide **"just-in-time"** training methods.
- Provide **expert assistance** for caregivers to call after a serious incident.
- Establish a cadre of **crisis communicators.**

When Things Go Wrong: responding to adverse events: a consensus statement of the Harvard Hospitals. Boston: Massachusetts Coalition for the Prevention of Medical Errors, 2006.

Peer Support for Clinicians: A Programmatic Approach

Jo Shapiro, MD, and Pamela Galowitz

(2016). *Academic Medicine, 91,* 1200-1204.

Abstract

Burnout is plaguing the culture of medicine and is linked to several primary causes including long work hours, increasingly burdensome documentation, and resource constraints. Beyond these, additional emotional stressors for physicians are involvement in an adverse event, especially one that involves a medical error, and malpractice litigation. The authors argue that it is imperative that health care institutions devote resources to programs that support physician well-being and resilience. Doing so after adverse and other emotionally stressful events, such as the death of a colleague or caring for victims of a mass trauma, is crucial as clinicians are often at their most vulnerable during such times. To this end, the Center for Professionalism and Peer Support at Brigham and Women's Hospital redesigned the peer support program in 2009 to provide one-on-one peer support. The peer support program was one of the first of its kind; over 25 national and international programs have been modeled off of it. This Perspective describes the origin, structure, and basic workings of the peer support program, including important components for the peer support conversation (outreach call, invitation/opening, listening, reflecting, reframing, sense-making, coping, closing, and resources/referrals). The authors argue that creating a peer support program is one way forward, away from a culture of invulnerability, isolation, and shame and toward a culture that truly values a sense of shared organizational responsibility for clinician well-being and patient safety.

Table 1

Important Components of the Peer Support Conversation

Component of peer support conversation	Sample language
Before the peer has agreed to the support conversation	
Outreach call (normalize the outreach and explain the program)	"We reach out to any clinician involved in an adverse or other emotionally stressful event, only because it can often be really stressful.… Every clinician I know has been in this position at some point in their career, and I have too.… We've found that most of us appreciate talking to a peer because it's hard for other people to know how this feels."
Once the peer has agreed to the support conversation	
Invitation/opening (provide an opportunity for the peer to talk openly about the event)	"Can you tell me about what happened?"
Listening	"How are you doing?"
Reflecting (honor, validate, and normalize the peer's emotions)	"These events can be really traumatic. As you know, as with most traumatic events, the difficult feelings usually slowly lessen over time.… The fact that you are upset shows that you are a caring, committed physician.… Everyone reacts differently to these events, so I am in no way saying that I know exactly what you are going through. But we do know that most of us have some common reactions."
Reframing (put the event in perspective)	"I'm going to tell you some things that you already know on an intellectual level, because sometimes it's important to hear them from a peer: Humans make errors at predictable rates; it's our job as an institution to create systems that prevent errors from reaching the patient.… You are not a bad physician; you have done so much good for people. You are not your error."
Sense-making (encourage the peer to use the event to make positive quality and safety changes, both personal and systems)	"If you can work with your program on looking at systems issues and also teach people about what you've learned, then you can help prevent your colleagues from making a similar error in the future, which is bound to happen if these issues aren't addressed."
Coping (elicit the peer's personal coping strategies, discuss his or her support system, and stress the importance of self-care and mindfulness)	"It's so important to do what you can to take care of yourself at stressful times like this.… What have you done in the past that has helped you through difficult times?"
Closing	"I really appreciate your willingness to share your thoughts with me.… Remember how much good you have done.… This happened because you are human, not because you are a bad clinician."
Resources/referrals (offer to all peers at the end of the conversation)	"As I mentioned, you will likely slowly start to feel better. But if you find that this gets under your skin in some way that is impairing your coping, please let us know.… We don't want you to suffer. You are not alone.… If you have any questions or concerns, let me know, and I'll make sure you get help from whomever you need."

Scott Three-Tiered Interventional Model of Second Victim Support

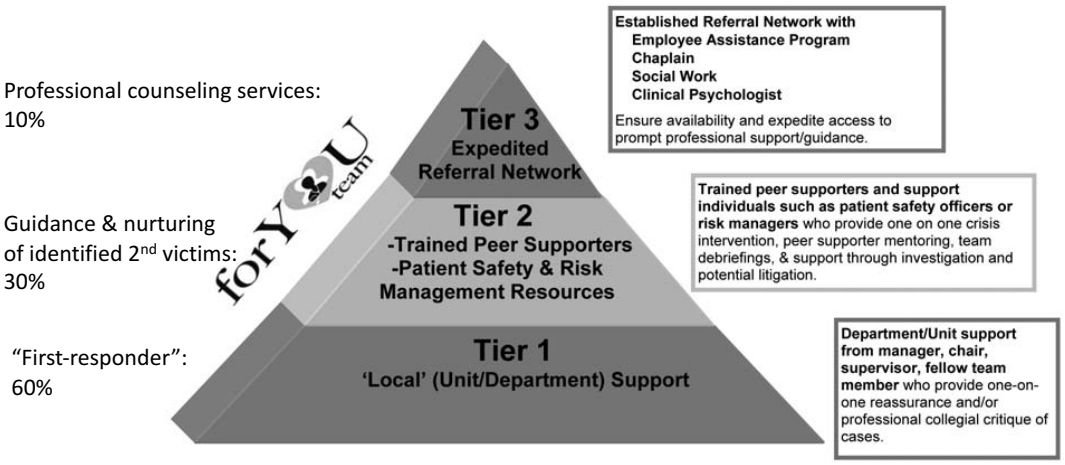

Figure 4. *The Scott Three-Tiered Interventional Model of support consists of three tiers, with the nature of support escalating from Tier 1 through Tier 3.*

Scott, S.D., Hirschinger, L.E., Cox, K.R., McCoig, M., Hahn-Cover, K., Epperly, K.M., Philipps, E.C., & Hall, L.W. (2010). Caring for our own: deploying a systemwide second victim rapid response team. *Joint Commission Journal on Quality and Patient Safety*, 36(5), 233-240.

Exercise: design second victim "program"

1. **Background:**
   - Industry
   - Organization
   - Any legislative/regulatory concerns
   - For whom?
2. **Needs assessment:**
   - Assess organizational readiness
   - Use of standardized/previously validated tool
   - Other data sources:
     - Direct observation
     - Incident report(s)
     - patient complaints
     - M&M rounds
     - Alerts/notifications
     - Published literature (e.g. case report, series, etc.)
     - Everyone is talking about THAT case….
3. **Taking stock of available resources:**
   - what do you have/utilize?
4. **Identify barriers & enablers**
5. **Engage stakeholder and enlist buy-in & support**
   - Elevator speech
6. **Program design & development**
7. **What else do you need/want that you do not have?**
   Timeline for implementation?
8. **Program evaluation:**
   - feasible? effective? & sustainable?

Many thanks for participating!

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