

Patient Safety Tip of the Week

August 9, 2016 More on the Second Victim

Back in the early 1990's as we began dealing with investigations on serious events we recognized that those healthcare workers involved in serious events, either directly or indirectly, often had difficulty coping in the aftermath of such events. Albert Wu, M.D., is generally recognized as coining the term "second victim" to describe such individuals and their plight ([Wu 2000](#)). But while we recognized the issue of the second victim in those early days of patient safety, we didn't really know how to best help them. We often simply made available to them professional assistance (employee assistance programs or psychological counselling). Over the years, helping the "second victim" has evolved considerably and such referral for professional help is not a good firstline strategy and may even be counterproductive.

In our December 17, 2013 Patient Safety Tip of the Week "[The Second Victim](#)" we described some of the excellent work done in developing "second victim" programs by Wu and colleagues at Johns Hopkins and by Susan Scott and colleagues at the University of Missouri. Scott et al. ([Scott 2009](#)) interviewed 31 second victims (10 physicians, 11 nurses, 10 other) involved in serious events and identified 6 stages that constitute the **natural history of second victims**. They found that, regardless of the gender or profession or years of experience of the healthcare worker, the second victim phenomenon is a life-altering experience with long-term impact. Both psychological symptoms and physical symptoms were common in second victims. Intensity varied and was often influenced by factors such as the relationship the provider had with the patient or family or the age of the patient being similar to that of a provider's family member. External stimuli (eg. same location, similar name, similar diagnosis) often triggered thoughts about the incident. But they found that "second victims" typically went through the following **6 stages**:

1. Chaos and accident response
2. Intrusive reflections
3. Restoring personal integrity
4. Enduring the "inquisition"
5. Obtaining emotional first aid
6. Moving on

See our December 17, 2013 Patient Safety Tip of the Week "[The Second Victim](#)" or the original study by Scott and colleagues ([Scott 2009](#)) for details about those 6 stages. Their work has since been further expanded. The March/April 2015 issue of Patient Safety & Quality Healthcare has an article on the "second victim" that every healthcare organization needs to read. That article ([Hirschinger 2015](#)) summarizes lessons learned over 5 years of the University of Missouri program providing clinician support in such

cases. The program they built has 3 tiers. The first tier is immediate “emotional first aid” from colleagues and/or supervisors. In the second tier, trained peers monitor the colleagues for “second victim responses” and provide support in both one-on-one sessions (“caring moments”) and group debriefings. The third tier is access to professional services beyond the capabilities of the trained peers. The system relies heavily on the use of trained peers who have volunteered to participate. The paper nicely describes what they look for, how they use services, team design, safety culture development, and lessons learned (both from peers and insights from the “second victims” themselves). It discusses how real-time support is used and how to identify when interventions are necessary (because many “second victims” do not actively seek support).

There have been multiple other publications related to the “second victim” in the past two years. Two new “second victim” programs have recently launched in Maryland ([Pitts 2015](#)). These actually resulted from the work done by Albert Wu, M.D., who is generally recognized as coining the term “second victim” ([Wu 2000](#)) and was developed by the Maryland Patient Safety Center and Johns Hopkins’ Armstrong Institute for Patient Safety and Quality. The program has rolled out at Greater Baltimore Medical Center and will soon be launched at the University of Maryland Medical Center. Each facility assembles a team of about two dozen peer responders (physicians, nurses, administrators and others) who get comprehensive training using case studies and videos. They brainstorm possible scenarios and act out scenarios. Effective listening is the most critical skill for team members.

In our December 17, 2013 Patient Safety Tip of the Week “[The Second Victim](#)” we discussed many of the symptoms experienced by healthcare workers following a serious incident in which they were involved. One recent study from Belgium reveals the personal and professional tolls taken on second victims ([Van Gerven 2016](#)). The study looked at responses from a sample of almost 6000 physicians and nurses at Belgium acute and psychiatric hospitals. 9% of participants reported having been personally involved in a patient safety incident in the preceding 6 months. Compared to those who had not been involved in an incident, those who were involved in an incident (the “second victims”) were found to be at a greater risk of burnout, more prone to problematic medication use and to greater work-home interference, and to more turnover intentions. Moreover, they found that incidents resulting in harm to a patient predicted problematic medication use, risk of burnout, and work-home interference. There were some differences between physicians and nurses. Patient safety incidents were more likely to be related to problematic medication use in physicians and more excess alcohol consumption in nurses. And the relationship between actual patient harm and work-home interference and turnover intentions was stronger in respondents from psychiatric hospitals. The authors note that the occurrence of these personal and professional adverse consequences following a patient safety incident might put these physicians and nurses at risk for future patient safety incidents as well, highlighting the importance of implementing programs to help “second victims”.

Another recent study compared emotions and coping mechanisms between the UK and US ([Harrison 2015](#)). Though the authors had suspected differences such as the litigation climate might impact these, they found little evidence of such a difference. Interestingly, they also found little difference between emotional responses and severity of the incident. Overall, a third of respondents reported that either their work performance or personal life suffered at least moderately following an incident. As expected, negative emotional responses were more common than positive ones. While many had strained relationships with colleagues, 56% actually valued their relationships with colleagues more following the incident. And the vast majority (84%) noted they paid more attention to safety issues following the incident. As in many other studies, differences between physicians and nurses were noted. Nurses had more of the following emotions: upset, worried, distressed, scared, and nervous. Coping strategies included **“approach” strategies** (eg. discussing the error with colleagues or superiors) and **“reappraisal” and learning from mistakes**. Just over half of the respondents were aware of organizational support services and 49% expressed willingness to access them. However, many noted feelings of shame and fears over confidentiality as barriers to using such services. Importantly, many expressed that support from a trusted existing resource (such as a peer) was preferable to a formal service.

Perception of the level of institutional support available after a patient safety event was also an important issue in another recent study. Joesten and colleagues surveyed healthcare workers at a large community teaching hospital ([Joesten 2015](#)), using one of several tools available from [MITSS \(Medically Induced Trauma Support Services\)](#), a non-profit organization whose mission is to support healing and restore hope to patients, families, and clinicians impacted by medical errors and adverse medical events. Of a convenience sample of 365 individuals, 73% answered that they had been directly involved in a patient safety event within the past 3 years. However, over half of those did not answer any of the items on the survey, leaving 120 evaluable surveys. Most of the respondents were female nurses, practicing a median 16 years. Symptoms of the “second victim” phenomenon were present in many respondents. But, notably, a significant proportion of respondents were unaware of services available to them (including guidance from a disclosure support team member, personal legal advice and support, opportunity to take time out from clinical duties, and access to counseling). Those that were aware of available services generally found them to be useful. Interestingly, 64% of respondents agreed they experienced support from their clinical colleagues but only 38% noted support from managers or chairmen. Also notable was that 60% disagreed that they could report a patient safety event without fear of retribution. This study highlights two things. First, it’s not enough to just have services available. You need to make everyone aware of the program and its usefulness. Second, it again emphasizes how “culture” trumps everything else. In a culture where fear of retribution is widespread, it is difficult to implement even programs designed to help the frontline healthcare worker.

In an editorial, Edrees and Federico ([Edrees 2015](#)) note that although these and other studies have been useful in further understanding the problem of second victims in healthcare, future studies should focus on organizational culture and the willingness of second victims to access support services after an unanticipated adverse event. They also

call for studies that focus on identifying and mitigating institutional barriers for supporting second victims.

Most studies on the “second victim” have chronicled the negative symptoms and experiences a healthcare worker suffers after a serious event. But a recent study ([Plews-Ogan 2016](#)) looked at factors associated not just with “coping” after a medical error but with growing and achieving positive outcomes. The authors interviewed 61 physicians who had made a serious medical error. The study was likely biased towards those who had positive outcomes since they were recruited via advertisement and word of mouth. Nevertheless, the findings offer significant insight into factors that help such physicians have positive outcomes. They identified eight themes reflecting what helped physician “wisdom exemplars” cope positively:

- talking about it
- disclosure and apology
- forgiveness
- a moral context
- dealing with imperfection
- learning/becoming an expert
- preventing recurrences/improving teamwork
- helping others/teaching

Talking about it is a strategy always noted in studies about second victims. However, the interesting insight from this study was that it was crucial that the person they talked to did **not downplay the seriousness** of the error. They note that there is a “tendency of well-intentioned colleagues to minimize, dissolve, deny or attempt to solve the error, which they did not find helpful.” They noted they needed to share both the medical aspects of the error and the emotional ones. They also found that in talking others often shared their own mistakes, letting the physician understand they were not alone.

We’ve discussed **disclosure and apology** in multiple columns (see full list below). Physicians who had positive outcomes were more likely to have disclosed the error to patients or their families and apologized. This helped patients and families understand the physician cared. There was even one instance where the disclosure and apology was met with anger by the patient but the physician went back a second time to apologize and the patient said “I know you care about me...I forgive you”.

Foregiveness from the patient/family was often the result of disclosure and apology but some noted it was also a struggle to forgive themselves without lowering their standards or “letting themselves off the hook”. Several noted how the **moral context** (eg. spirituality or professionalism) helped them to do the right thing, citing how discussions with mentors or even a medical student helped them do the right thing.

Dealing with imperfection was a key theme but those with positive outcomes realized they could be “**imperfect but good**” physicians.

The last three themes are related. Those with positive outcomes often strived to learn about and **become experts** about the knowledge or technical deficiencies involved. They also participated in figuring out what happened and fixing it, **preventing similar events**, and **teaching others** about it.

The study has important implications for organizations. We need to train physicians to provide peer support in the proper way, serving as “an ear” that listens and does not try to minimize the seriousness of the event(s). Also noted was that many of the responding physicians noted they had never been trained on how to do disclosure and apology so we need to do a better job of preparing physicians for that. And changing our culture to recognize we are not perfect needs to start in medical school and extend throughout our careers.

As we have evolved in patient safety toward full disclosure and apology when adverse events occur (see our many columns on disclosure and apology listed below) there has been a lag in preparing clinicians to participate in such activity. Carolyn Clancy, in an editorial on how we should approach second victims ([Clancy 2012](#)), noted how the evolving practice of disclosure and apology might be a means of alleviating the emotional trauma of both the first and second victims of patient safety events. A recent study of how surgeons address adverse clinical events with their patients and/or patient families is most telling ([Elwy 2016](#)). Elwy and colleagues surveyed surgeons in the Veterans Affairs medical system about their experiences in disclosing adverse events. Most of the respondents to the survey used 5 of 8 recommended disclosure items:

- why the event happened (92%)
- expressed regret for what happened (87%)
- expressed concern for the patient’s welfare (95%)
- disclosed the adverse event within 24 hours (97%)
- discussed steps taken to treat any subsequent problems (98%)

But use of the other 3 recommended disclosure items was less frequent:

- apologized to patients (55%)
- discussed whether the event was preventable (55%)
- discussed how recurrences could be prevented (32%)

They found that surgeons who reported they were less likely to discuss preventability of the adverse event, those who stated the event was very or extremely serious, or who reported difficult communication experiences were more negatively affected by disclosure than others. Those surgeons with more negative attitudes about disclosure at baseline reported more anxiety about patients’ surgical outcomes or events following disclosure. The study clearly highlights the need for training for disclosure and apology and development of skillsets to use for such. Logically, it might be anticipated that development of those skills might reduce the negative experiences with disclosure and apology on the part of surgeons and perhaps be a first step in aiding the “second victims”, too.

In all our years in both clinical medicine and patient safety we've always found that personal stories are much more compelling than any study. We noted several such personal stories in our December 17, 2013 Patient Safety Tip of the Week "[The Second Victim](#)". But we can't do it any better than the **story by Sarah Kliff in Vox** earlier this year ([Kliff 2016](#)). She tells the tragic story of Kim Hiatt, an experienced and compassionate nurse who struggled after a medical error and ultimately took her own life. This emphasizes the plight of the second victim and how our systems often fail to identify the needs of the second victim and provide the right kinds of support to our colleagues and coworkers in their greatest time of need. We can't just sit back and wait for them to ask for help. We need proactive programs in place that anticipate the stages a "second victim" will go through and be there at the right time for them with the skills needed to help them cope and not only mitigate the negative effects but also grow and achieve positive outcomes. It takes a strong organizational commitment to develop programs like those in Maryland and Missouri but some day each one of us could be a "second victim" and need such a program.

Some of our prior columns on Disclosure & Apology:

July 24, 2007	"Serious Incident Response Checklist"
June 16, 2009	"Disclosing Errors That Affect Multiple Patients"
June 22, 2010	"Disclosure and Apology: How to Do It"
September 2010	"Followup to Our Disclosure and Apology Tip of the Week"
November 2010	"IHI: Respectful Management of Serious Clinical Adverse Events"
April 2012	"Error Disclosure by Surgeons"
June 2012	"Oregon Adverse Event Disclosure Guide"
December 17, 2013	"The Second Victim"
July 14, 2015	"NPSF's RCA2 Guidelines"
June 2016	"Disclosure and Apology: The CANDOR Toolkit"

Other very valuable resources on disclosure and apology:

- IHI's "Respectful Management of Serious Clinical Adverse Events" ([Conway 2010](#))
- The Canadian Disclosure Guidelines ([Canadian Patient Safety Institute 2008](#))
- The Harvard Disclosure Guidelines ([Massachusetts Coalition for the Prevention of Medical Errors 2006](#))
- The ACPE Toolkit ([American College of Physician Executives](#))
- Oregon Patient Safety Commission [Oregon Adverse Event Disclosure Guide](#).

References:

Wu AW. Medical error: the second victim. The doctor who makes the mistake needs help too. *BMJ* 2000; 320: 726–727

http://www.bmj.com/content/320/7237/726?ijkey=455554e5354d21b654c631effb8fdc215e040cf0&keytype2=tf_ipsecsha

Scott SD, Hirschinger LE, Cox KR, et al. The natural history of recovery for the healthcare provider “second victim” after adverse patient events. *Qual Saf Health Care* 2009; 18(5): 325-330

<http://qualitysafety.bmj.com/content/18/5/325.full?sid=495da4c7-557e-45ec-a01e-54538e9ebc1f>

Hirschinger LE, Scott SD, Hahn-Cover K. Clinician Support: Five Years of Lessons Learned. *Patient Safety & Quality Healthcare* 2015; March/April 2015. Published 03 April 2015

<http://psqh.com/march-april-2015/clinician-support-five-years-of-lessons-learned>

Pitts J. Program helps caregivers under stress after errors. *The Baltimore Sun* 2015; June 21, 2015

<http://www.baltimoresun.com/health/maryland-health/bs-hs-caring-for-caregivers-20150621-story.html#page=1>

Van Gerven E, Vander Elst T, Vandenbroeck S, et al. Increased risk of burnout for physicians and nurses involved in a patient safety incident. *Med Care* 2016; [Epub ahead of print] May 20, 2016

http://journals.lww.com/lww-medicalcare/Abstract/publishahead/Increased_Risk_of_Burnout_for_Physicians_and.98900.aspx

Harrison R, Lawton R, Perlo J, et al. Emotion and Coping in the Aftermath of Medical Error: A Cross-Country Exploration. *Journal of Patient Safety* 2015; 11(1): 28-35

http://journals.lww.com/journalpatientsafety/Abstract/2015/03000/Emotion_and_Coping_in_the_Aftermath_of_Medical.5.aspx

Joesten L, Cipparrone N, Okuno-Jones S, DuBose ER. Assessing the Perceived Level of Institutional Support for the Second Victim after a Patient Safety Event. *Journal of Patient Safety* 2015; 11(2): 73-78

http://journals.lww.com/journalpatientsafety/Abstract/2015/06000/Assessing_the_Perceived_Level_of_Institutional.2.aspx

MITSS (Medically Induced Trauma Support Services)

<http://www.mitsstools.org/index.html>

Edrees H, Federico F. Supporting clinicians after medical error. (Editorial). BMJ 2015; 350: h1982 (Published 15 April 2015)
<http://www.bmj.com/content/350/bmj.h1982>

Plews-Ogan M, May N, Owens J, et al. Wisdom in Medicine: What Helps Physicians After a Medical Error? Acad Med 2016; 91(2): 233-241
http://journals.lww.com/academicmedicine/Fulltext/2016/02000/Wisdom_in_Medicine_What_Helps_Physicians_After_a.29.aspx

Clancy CM. Alleviating “Second Victim” Syndrome: How We Should Handle Patient Harm. Journal of Nursing Care Quality 2012; 27(1): 1-5, January/March 2012
http://journals.lww.com/jncjournal/Fulltext/2012/01000/Alleviating_Second_Victim_Syndrome_How_We.1.aspx

Elwy R, Itani KMF, Bokhour BG, et al. Surgeons’ Disclosures of Clinical Adverse Events. JAMA Surg 2016; Published online July 20, 2016
<http://archsurg.jamanetwork.com/article.aspx?articleid=2534133>

Kliff S. Fatal mistakes. Doctors and nurses make thousands of deadly errors every year. They are reprimanded. Do they also deserve support? Vox 2016; March 15, 2016
<http://www.vox.com/2016/3/15/11157552/medical-errors-stories-mistakes>

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