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# When Caring Hurts: The Second Victim Phenomenon

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# Objectives

Upon completion of this presentation, participants should be able to

1. Understand the second victim phenomenon.
2. Describe what you can do differently tomorrow to help a colleague who is suffering as a second victim.

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# WARNING

| Rated | |
|---|---|
| **E** | **Professional Rating** |

**This content may contain Emotional Labor!!!!!**

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# An Epidemic?

44,000-98,000 deaths/year in U.S. due to preventable adverse events (Kohn et. al, 2000).

Revised estimates at least 210,000 (and possibly more like 400,000) die in U.S due to preventable harm (James, 2013).

With revised estimates: At least 4 clinicians/patient = 840,000 to 1.6 million clinicians impacted

Kohn, LT, Corrigan, JM, & Donaldson, MS. (2000). *To err is human: building a safer health system.* Washington, D.C.:National Academy of Sciences Press.

James, J.T. (2013). A new, evidence-based estimate of patient harms associated with hospital care. *Journal of Patient Safety, 9(3), 122-128.*

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"Medicine used to be simple, ineffective and relatively safe..... now it is complex, effective, and potentially dangerous"

Sir Cyril Chantler

Lancet 1999; 353:1178-91

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# History of the PROBLEM

Adverse event reviews – individuals at the ‘sharp end’ noted to be experiencing ‘predictable’ behaviors post event

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# Review of the Literature

## Medical error: the second victim

*The doctor who makes the mistake needs help too*

**Albert Wu, MD**

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

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

*"Virtually every practitioner knows the sickening realization of making a bad mistake. You feel singled out and exposed…..You agonize about what to do…… Later, the event replays itself over and over in your mind"*

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

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.

Wu, A. (2000). Medical error: the second victim. The doctor who makes the mistake needs help too. *British Medical Journal*, *320*, 726-727.

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# Commonly Heard Phrases

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# Second Victims Defined…

"*Healthcare team members involved in an unanticipated patient event, a medical error and/or a patient related injury and become victimized in the sense that they are traumatized by the event.*"

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

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# What is a Second Victim?

A Qualitative Research Project is Initiated……

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# Qualitative Research Overview

Participants = 31

Females 58%

Average Years of Experience

- MD 7.7
- RN 15.3
- Other 17.7

Average Time Since Event = 14 months

- Range – 4 weeks to 44 months

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# High Risk Scenarios

- Patient ‘connects’ staff member to family
- Pediatric cases
- Medical errors
- Failure to rescue cases
- First death experience
- Unexpected patient demise

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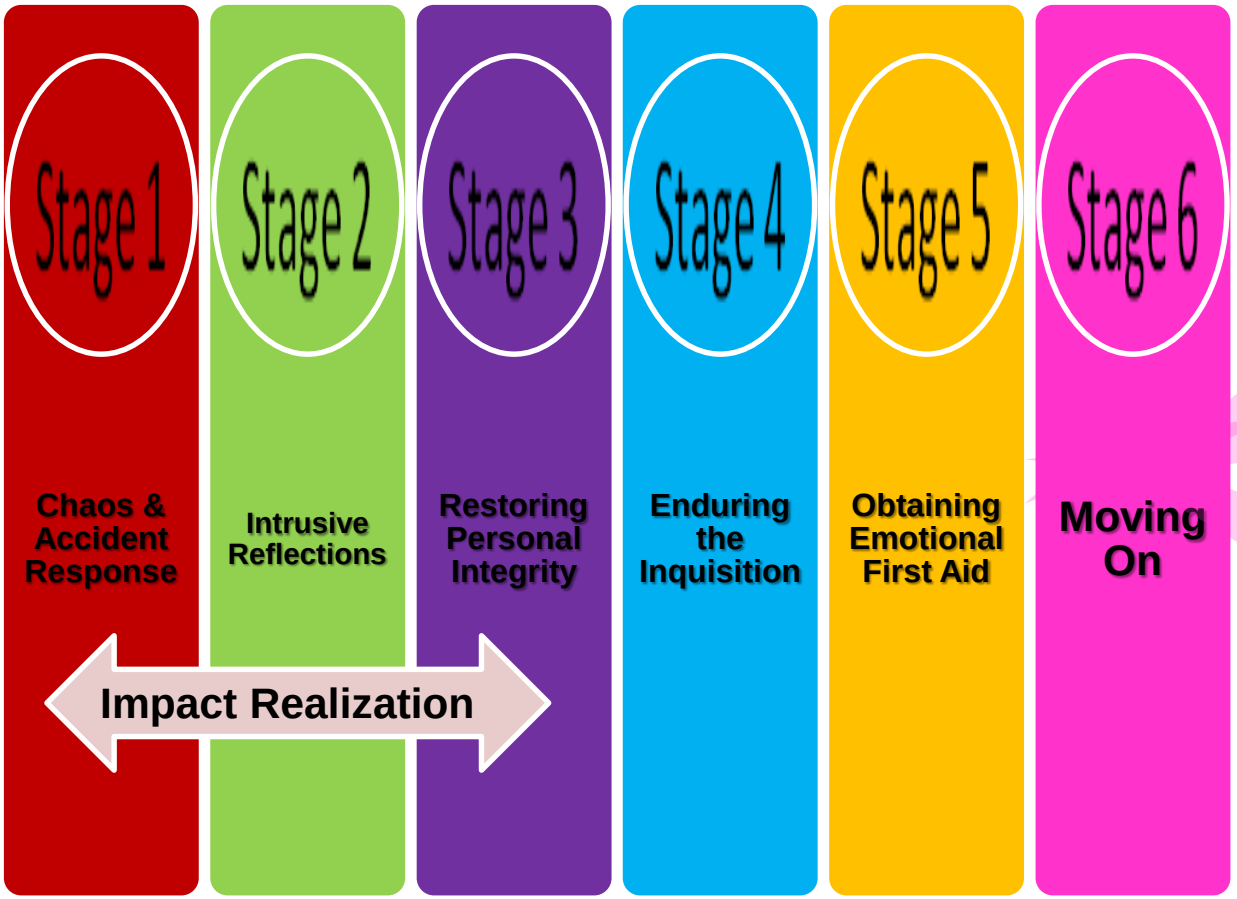
# Stages of Healing: The Second Victim Recovery Trajectory




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

*“ I will never forget this experience……This patient will always be with me – I think about her often…… Because of this, I am a better clinician! ”*

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# What Second Victims Desire…


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# Second Victim Interventions

## Second victims want to feel...

Appreciated
Valued
Respected
Understood

Last but not least….Remain a trusted member of the team!

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# Benefits of Clinician Support

Staff have a way to **get their needs meet** after going through a traumatic event

**Helps reduce the harmful effects of stress**

**Provides some normalization** and helps the individual gett back to their routine after a traumatic event

**Promotes the continuation of productive careers** while building healthy stress management behaviors

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# Challenges to Providing Support

- Stigma to reaching out for help
- High acuity areas have little time to integrate what has happened
- Intense fear of the unknown
- Fear a compromise of collegial relationships because of event
- Fear of future legal woes - HIPAA, Confidentiality Implications

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# Support Basics

- Do not try to fix it…
- Be a good listener!
- Avoid second-guessing performance
- Provide emotional first aid
- Let them know you care……

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# Thoughts About Support

Clinicians have unique support needs.

Health care facilities have unique culture.

Both should be considered when designing a network of support for second victims.

Two types of support

- One on one
- Group

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# Second Victims Need Support

A systematic literature review of second victimization findings:

1) Significant emotional toll on care providers
2) Need for institutional support programs
3) Varied approaches for support

"Unethical not to have a clinician support program as the evidence supported the emotional toll that being a second victim takes on a clinician and then in turn, their patients as well."

Butler, S. (2015). The Just Culture, Second Victimization, and Clinician Support: An Educational/Awareness Campaign. University of Massachusetts-Amherst. Doctor of Nursing Practice Capstone.

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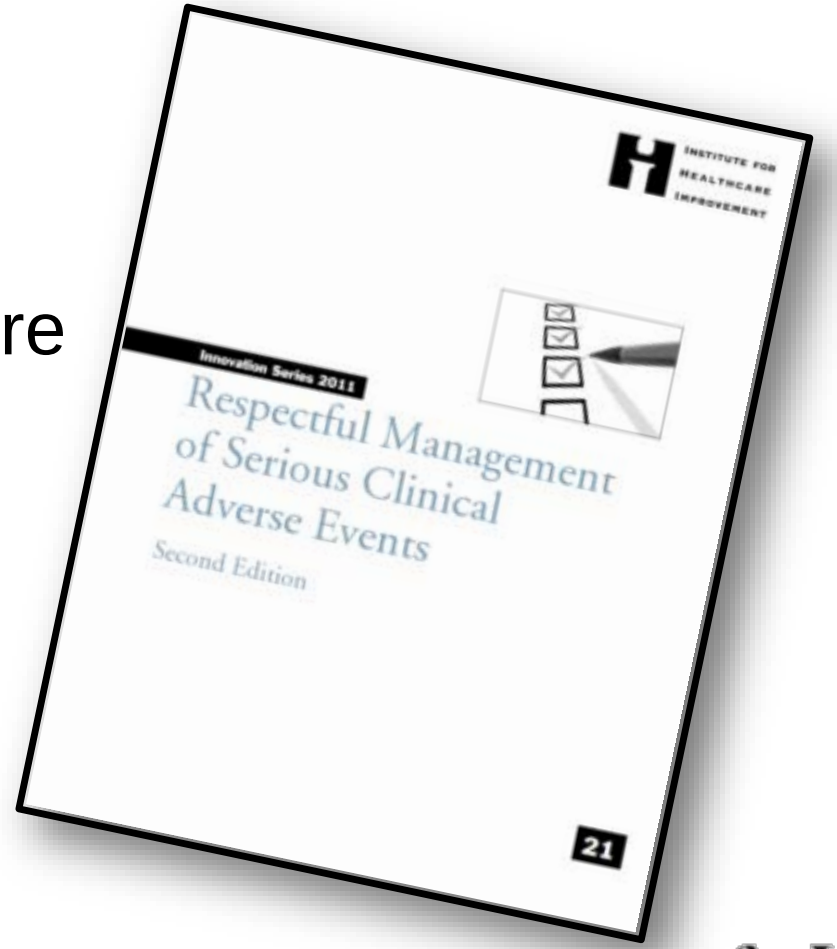
# Guidelines for Clinician Care

Institute for Health Care Improvement




http://www.ihi.org/knowledge/Pages/IHIWhitePapers/RespectfulManagementSeriousClinicalAEsWhitePaper.aspx

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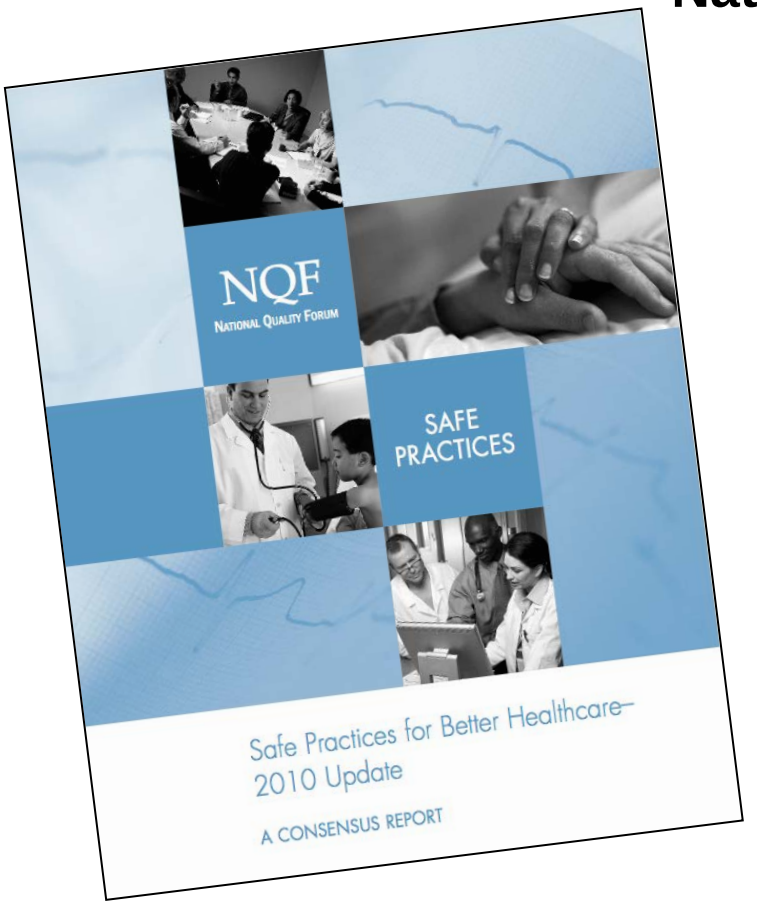
# Guidelines for Clinician Care (continued)




**National Quality Forum – Safe Practice 8: Care for the Caregiver**

*Provide care to the caregivers (clinical providers, staff, and administrators) involved in serious preventable harm to patients, through systems that also foster transparency and performance improvement that may reduce future harmful events.*

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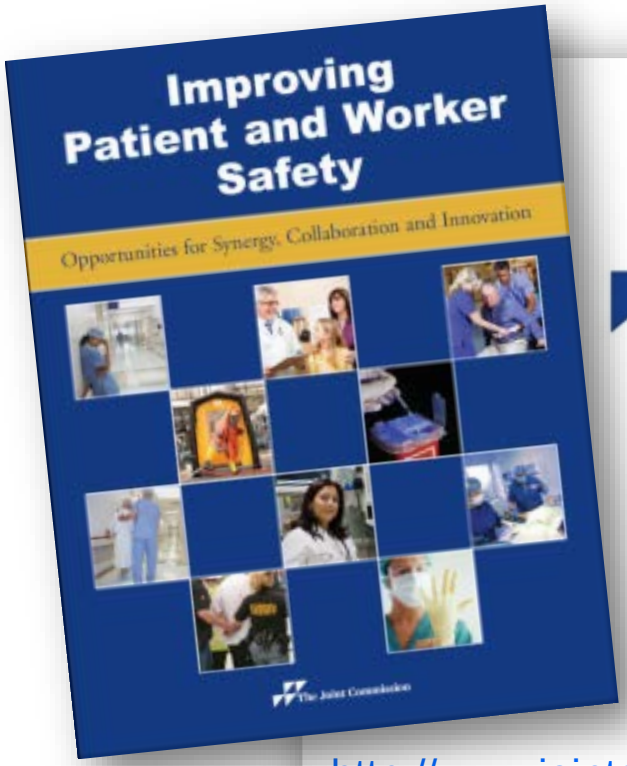
# Guidelines – Regulatory Insights




The Joint Commission

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The leaders make support systems available for staff who have been involved in an adverse of sentinel event.

http://www.jointcommission.org/improving_Patient_Worker_Safety/

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# The forYOU Team is Formed

Addresses research findings
Peer to peer support model
Referral systems coordinated to facilitate prompt care
Two Types of Supportive Intervention
- One-On-One
- Group Debriefings

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# forYOU Team Objectives….

- **Minimize the human toll** when unanticipated adverse events occur.
- **Provide a 'safe zone'** for faculty and staff to receive support to mitigate the impact of an adverse event.
- an internal rapid response infrastructure of **'emotional first aid'** for clinicians and personnel following an adverse event.

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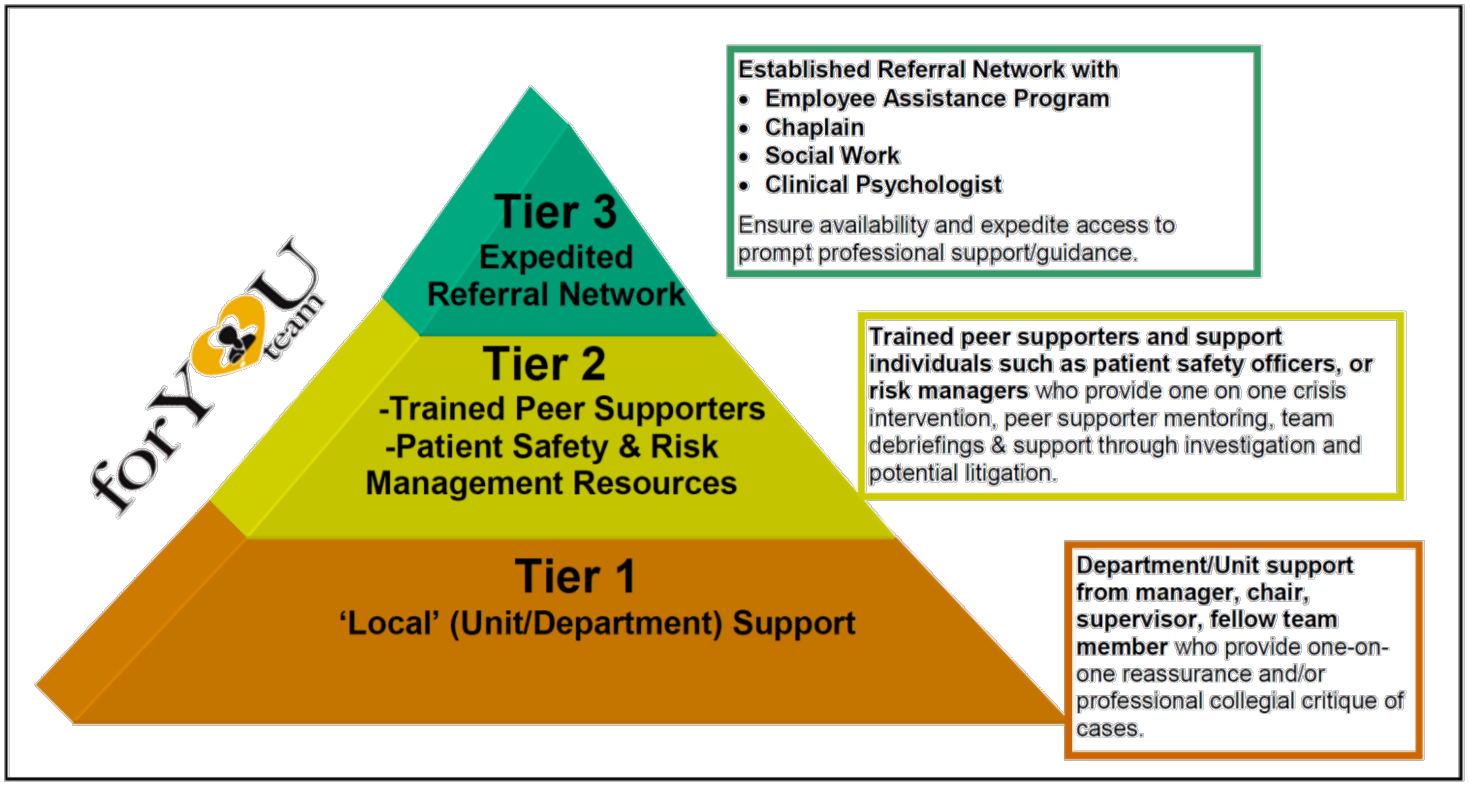
# Support Strategies Interventions

**The Scott Three-Tiered Interventional Model of Second Victim Support**

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# Lessons Learned….

- Not all clinicians respond the same - everyone is unique
- Watch for isolation
- Many hidden ‘pearls’ within health care systems – Tier 3 inventory
- Cast a big net - look for ‘hidden’ staff
- Consider building surveillance into existing practices (i.e. huddles, post code critique, disaster drills, etc.)
- Team briefings help to build team resilience and enhanced teamwork

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# A Point to Ponder…..


Wu, A.W., Shapiro, J., Reema, H., Scott, S.D., Connors, C., Kenney, L. and Vanhaecht, K. (2017). The impact of adverse events on clinicians: What's in a name? *Journal of Patient Safety.* DOI: 10.1097/PTS.0000000000000256.

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# The Aftermath of No Support

Traumatized Clinician

Isolation

Limited Communication

Negative Impact on Teamwork

Low Morale

Impaired Job Performance

Negative Personal and Professional Impact

Prolonged Clinician Suffering

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# What Can You Do Differently Tomorrow?

- Understand the concept of Second Victims
- Talk about the Second Victim concept and spread the word – Awareness is the first intervention!
- Determine a way that you can make an individual difference.
- If you have a ‘personal story’ about your experience as a second victim, share it with a colleague in need.
- ‘Be there’!

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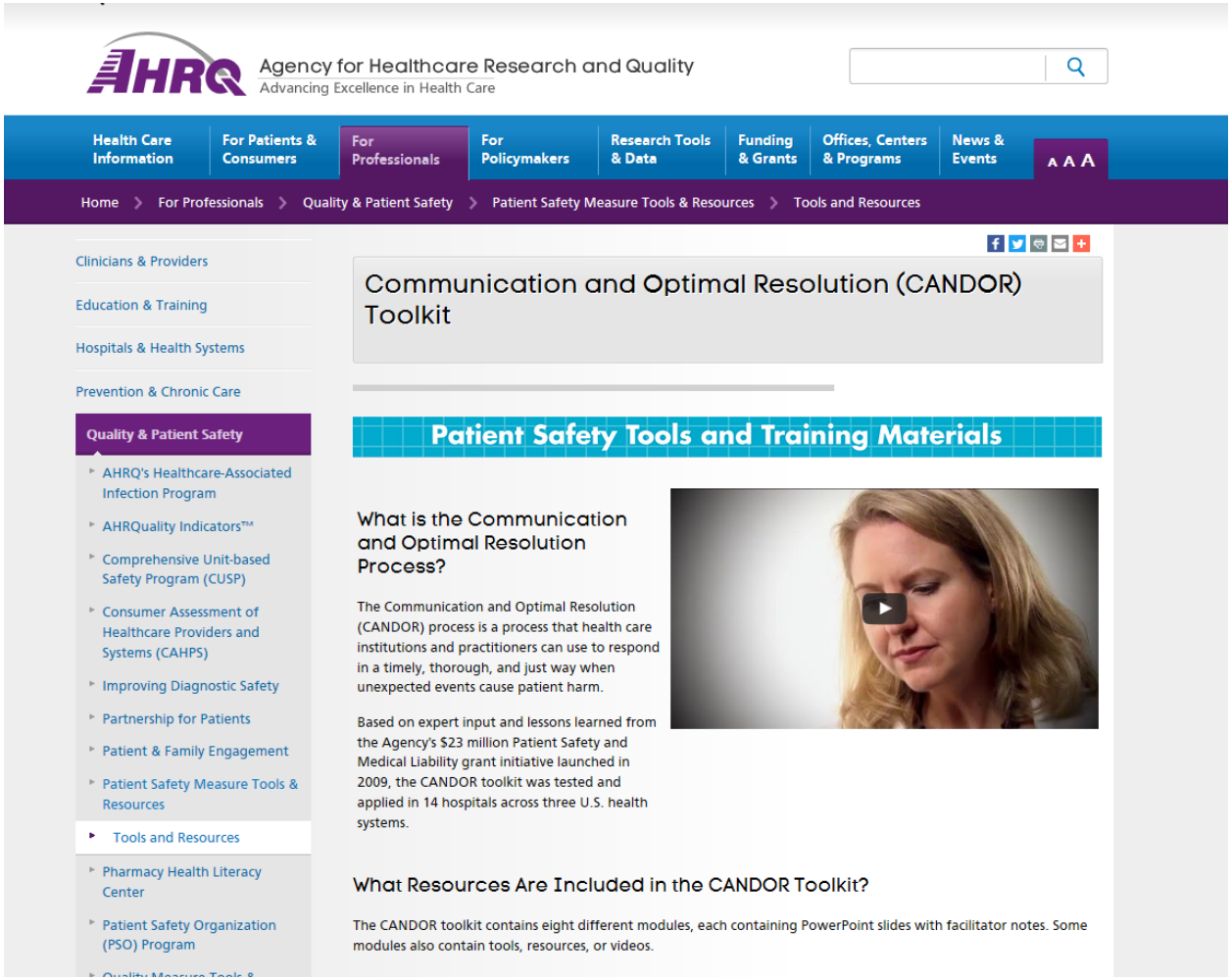
# AHRQ – CANDOR Tool




http://www.ahrq/gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor

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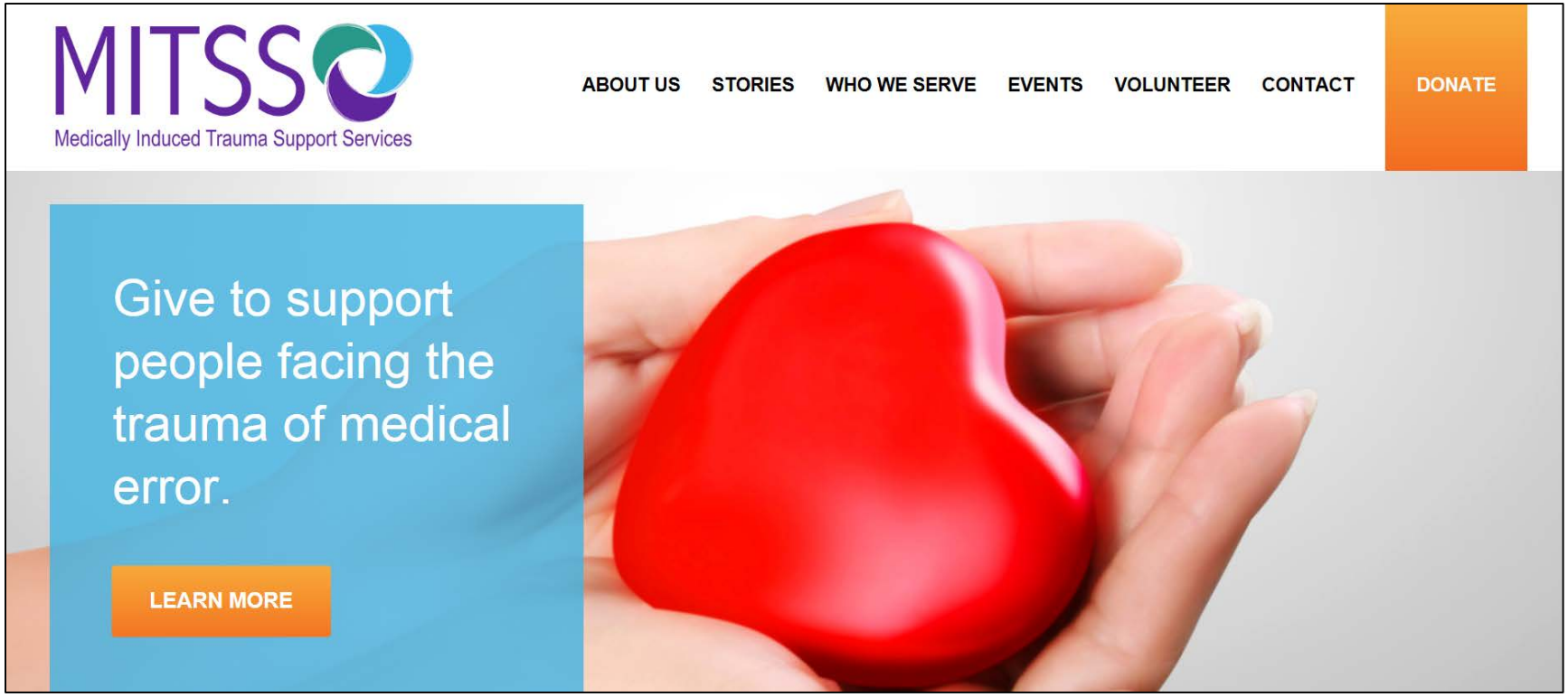
# www.mitss.org

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# Questions…

***"The longer we dwell on our misfortunes, the greater is their power to harm us."*** **Voltaire**

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www.muhealth.org/foryou

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