Second Victim

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This is to acknowledge that Vivek Patel, M.D. has disclosed that he does not have any financial interests or other relationships with commercial concerns related directly or indirectly to this program. Dr. Patel will not be discussing off-label uses in his presentation.

Vivek Patel is an assistant professor of internal medicine in the Division of Hospital Medicine. He is interested in inpatient medicine, physician wellness, patient safety, high value care, and education. The purpose of the presentation is to raise awareness of the Second Victim phenomenon among health care providers, identify those at risk, and discuss potential responses.

Second Victim

Second victims are practitioners who are involved in an event where someone is killed, injured, or put in harm's way. Importantly, the practitioner feels responsible for causing the event, mismanaging the event, or not preventing the event (1). The focus during these events is appropriately on the first victim who is usually a patient. However, the effect on providers can be significant including a loss of confidence, intrusive thoughts, personal feelings of failure, and anxiety which may lead to more errors, defensive practice, or leaving healthcare as a career(2, 7,9,10).

Providers, nurses, and ancillary staff are at risk to become second victims although providers and nurses are the most likely. Literature suggests that most practitioners will be involved in at least one adverse event in their careers that causes severe personal distress. Of providers at Parkland Memorial Hospital consisting of members of the medical staff, residents, fellows, and advance practice providers approximately 40% reported being involved in an event that caused intense stress or additional anxiety while over 20% said they of a peer who left their position due to the inability to cope after an event based on the 2017 AHRQ Culture of Safety Survey.

Second victims often will experience panic, anxiety, sleep disturbances, intrusive thoughts, guilt, and intense self-doubt which can contribute to burnout, decreased quality of life, and decreased empathy. Depressive symptoms and even suicidal thoughts are more common in second victims. Medical errors appear to be more likely as well and patients who have an adverse event as a result of a provider who is a second victim are known as third victims.

Scott Eggener, a urologist at the University of Chicago, wrote an article published in the New York Times titled "Murderer in the Mirror" in which he describes his own journey after his patient dies during surgery. In it he describes his initial reaction, and the discussion with his patient's family. Focusing on the loss, he goes over all that the patient will miss like holding a grandchild or telling his wife goodbye. The self-doubt feels unbearable despite attempted reassurance from colleagues.

> My mind has rarely experienced such topical focus, intensity and obsession. If I don't think about him 24/7, am I dishonoring his life? I want to call the family. I want to let them know how I am feeling. I want to share in their grief. Is that the right thing to do? Should I call? Should I wait? So many questions and so few answers. This goes on waking hour after waking hour, sleepless night after sleepless night.
>
> I continue to mourn, I continue to analyze, I continue to reflect. It does not go away. But a new feeling comes forth: carrying on. I tell myself to ask for help, if needed. I can get through this. I know I can. This cannot cripple me.

At the end of the article he reflects on his failure and goes back to lessons he learned from baseball and his father about learning from mistakes. Getting back into the operating room is what he and his team expect.

The figure below by Scheiss et al illustrates a model of the second victim experience based on a metasynthesis of qualitative studies of second victim syndrome.

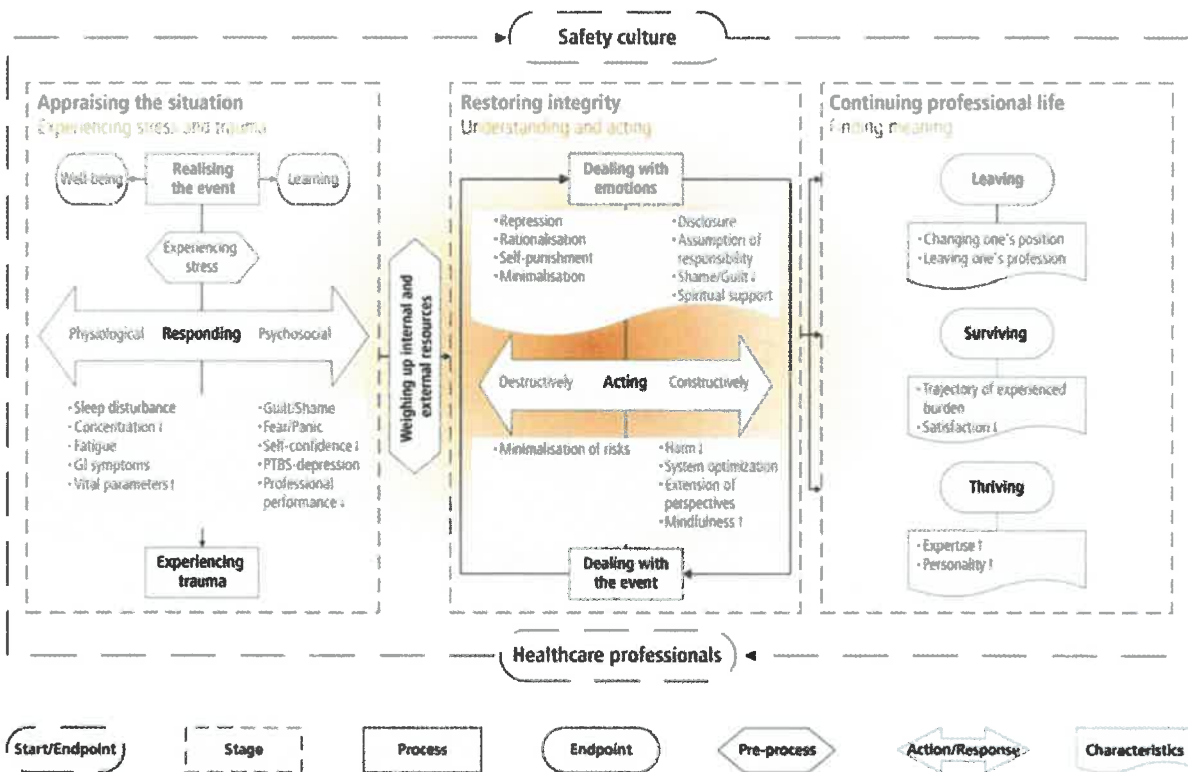

Figure 3. Transactional second victim experience Scheiss et al. A Transactional "Second-Victim" Model—Experiences of Affected Healthcare Professionals in Acute-Somatic Inpatient Settings: A Qualitative Metasynthesis, J Patient Safety 2018;00: 00–00. This figure follows the emotional and psychosocial response. Note how constructive or destructive actions when dealing with emotions and the event pertain to professional life.

After an adverse event ideally second victims will receive personal and institutional support. If not supported the second victim can adopt maladaptive behaviors such as repression or self-punishment. When that occurs, the outcome is often a feeling of merely surviving with decreased job satisfaction. Leaving the career altogether remains an all too often occurrence.

Denham delineated the rights of the second victim which are treatment that is just, respect, understanding and compassion, supportive care, transparency, and the opportunity to contribute to learning.

In response to the needs of healthcare providers programs have been developed to provide support to second victims. Medically Induced Trauma Support Services offers peer support to clinicians, patients, and families as well as training for implementation of their peer support program. The forYOU program at the University of Missouri has a three-tiered support structure consisting of local support from a manager or team member followed by trained peer supporters with professional support at the top.

The Cleveland Clinic has "Code Lavenders" which can be called after stressful events. A team of holistic nurses and chaplains arrive to engage affected staff in manual therapies such as massage, expressive arts like drawing or journaling, and mind body tools including meditation or acupressure.

Resilience in Stressful Events (RISE) was developed at Johns Hopkins in part by Albert Wu who first used the term Second Victims for healthcare providers dealing with the fallout from an adverse event. RISE is currently being implemented at Parkland and will be called Supporting Parkland Staff (SPARKS). Like MITSS and forYOU RISE is based on trained peer supporters who are always available for members of the healthcare team.

Almost all providers and nurses at some point in their career will be involved in an event where a patient is harmed. The subsequent cascade of grief, guilt, and doubt can lead to future errors, depressive symptoms, burnout, and loss of employees. The peer review process in and of itself may compound the aforementioned symptoms. It is imperative we consider the impact of the work we do on our colleagues especially when there are adverse events by offering support and empathy. This may take the form of peer support, professional counseling, or a respite from clinical duties.

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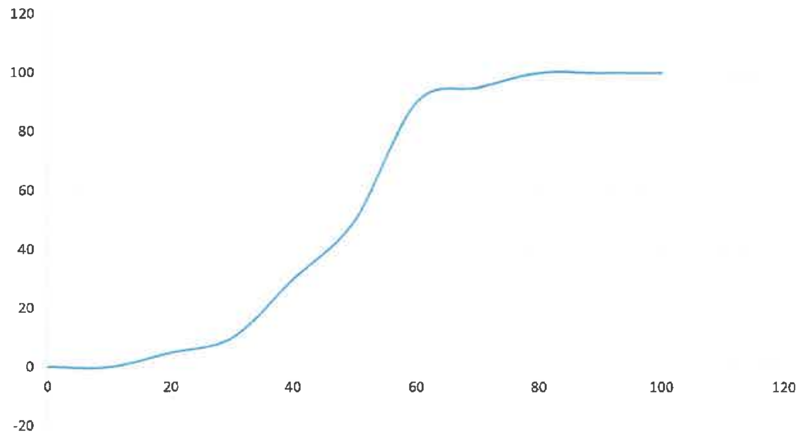
Life Expectancy as Function of Distance from a Bear



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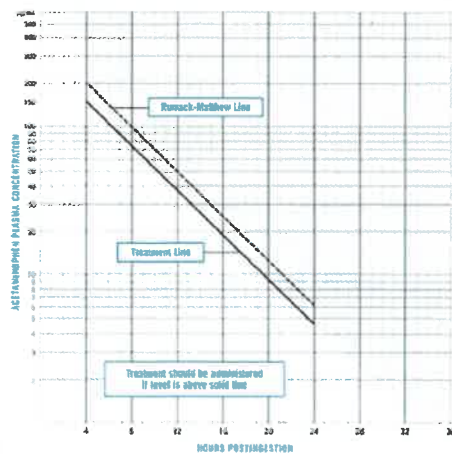
Single Acute Acetaminophen Overdose Nomogram



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Definition

Second victims are healthcare providers who are involved in an unanticipated adverse patient event, in a medical error and/or a patient related injury and become victimized in the sense that the provider is traumatized by the event. Frequently, these individuals feel personally responsible for the patient outcome. Many feel as though they have failed the patient, second guessing their clinical skills and knowledge base.

Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for the healthcare provider "second victim" after adverse patient events. Qual Saf Health Care 2009;18:325–30.

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Shortcomings

- Unanticipated does not mean unaffected
  - Young mother with metastatic cancer
  - Trauma victims
  - End of life care

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Empathy is a Double Edged Sword

Frequently it is our ability to put ourselves in the patient's or their loved one's position that can lead to very strong emotional reactions

-quote Mayo resident study on empathy

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Prevalence

Table 7: Main-2nd Victim & Engagement Action Planning*
*Statistically significant @ $p<0.05$

Question	NEG	Neutral	POS
In the last year, I was involved in an event which caused intense stress or additional anxiety in my role			
MD	37.4%	20.2%	42.4%
R/F	32.1%	25.2%	42.7%
I would feel comfortable/safe seeking support from the organization after an event which caused intense stress or additional anxiety			
MD	19.9%	29.7%	50.4%
R/F	19.8%	26.2%	54.0%
I am satisfied with Parkland's response to staff needs after an event that caused intense stress or additional anxiety			
MD	20.0%	38.8%	40.3%
R/F	13.5%	44.7%	41.8%
I know a peer or colleague that has left their position in the last year due to their inability to cope after an event which caused intense stress or additional anxiety			
MD	51.6%	22.5%	25.9%
R/F	53.0%	26.8%	20.8%
Question	**NEG**	**Moderately True**	**POS**
I was involved in creating the action items for my workgroup for the Employee Engagement Objective: "my work unit works well together" *			
MD	59.1%	21.4%	19.6%
R/F	58.1%	26.0%	15.9%

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The Second Victim

Kimberly Hiatt

"Nurse's suicide highlights twin tragedies of medical error"

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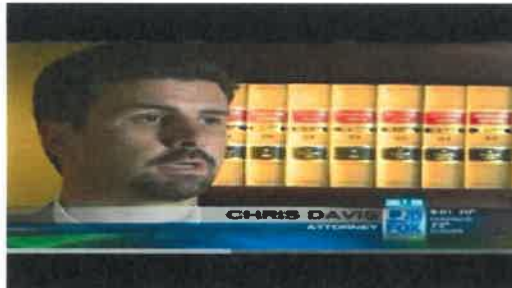
How was this reported?



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What Happens?

- Accident Response

Swift, Taylor. "Shake it off" 1989 by Taylor Swift. 2014, Produced by Max Martin and Shellback

- Suboptimal care delivered after a stressful event
- Linked to burnout and burnout associated with errors
- Decreased patient satisfaction

Martin TW, Roy RC. Cause for pause after a perioperative catastrophe: one, two, or three victims? Anesth Analg 2012;114:485–7.
Williams ES, Manwell LB, Konrad TR, Linzer M.
The relationship of organizational culture, stress, satisfaction, and burnout with physician-reported error and suboptimal patient care: results from the MEMO study. Health Care Manage Rev 2007;32:203–12.
Shanafelt TD, Bradley KA, Wipf JE, Back AL. Burnout and self-reported patient care in an internal medicine residency program. Ann Intern Med 2002;136:358–67.
Shanafelt TD, Balch CM, Bechamps G, et al. Burnout and medical errors among American surgeons. Ann Surg 2010;251:995–1000.

Intrusive Reflections

- The perception of having made a major medical error in the previous 3 months was associated with a 3-fold increased risk of SI, with 16.2% of surgeons who reported a recent major error experiencing SI compared with 5.4% of surgeons not reporting an error ($P < .001$)

Shanafelt TD, Balch CM, Dyrbye L, et al. Special Report Suicidal Ideation Among American Surgeons. Arch Surg. 2011;146(1):54–62. doi:10.1001/archsurg.2010.292

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Table 1 Range of signs and symptoms described by second victims.

Physical symptoms	n (%)	Psychosocial Symptoms	n (%)
Extreme fatigue	16 (52)	Frustration	24 (77)
Sleep disturbances	14 (45)	Decreased job satisfaction	22 (71)
Rapid heart rate	13 (42)	Anger	21 (68)
Increased blood pressure	13 (42)	Extreme sadness	21 (68)
Muscle tension	12 (39)	Difficulty concentrating	20 (65)
Rapid breathing	11 (35)	Flashbacks	20 (65)
		Loss of confidence	20 (65)
		Grief	20 (65)
		Remorse	19 (61)
		Depression	17 (55)
		Repetitive/intrusive memories	16 (52)
		Self-doubt	16 (52)
		Return to work anxiety	15 (48)
		Second guessing career	12 (39)
		Fear of reputation damage	12 (39)
		Excessive excitability	11 (35)
		Avoidance of patient care	10 (32)

Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for thehealthcare provider "second victim" after adverse patient events. Qual Saf Health Care 2009;18:325–30.

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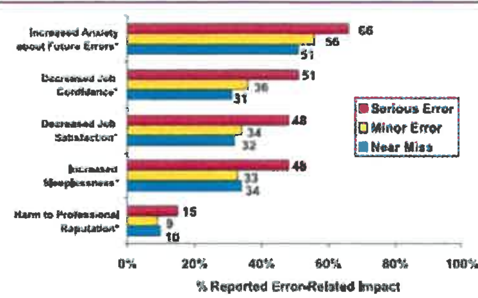

Waterman AD, Garbutt J, Hazel E, et al. The emotional impact of medical errors on practicing physicians in the United States and Canada. Jt Comm J Qual Patient Saf 2007;33:467–76.

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- Restoring Personal Integrity
  - –Seeking support and validation
  - –Do people trust me?
  - –Don't want to hear it through the grapevine

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- Managing Investigation
  - –Talking to the boss
  - –Peer Review
  - –Root Cause Analysis

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- Seek Emotional Support
  - –Colleagues, family, friends
  - –Ongoing process

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- Moving On
  - –Surviving vs Thriving
- Moving Out
  - –Changing careers
- Just Moving
  - –New Job

Goal

Treatment that is just,

Respect,

Understanding and compassion,

Supportive care, and

Transparency

and the opportunity to contribute to learning.

TRUST: The 5 Rights of the Second Victim Denham, Charles R. MD Journal of Patient Safety: June 2007 - Volume 3 - Issue 2 - p 107-119

"A majority of nearly 200 000 respondents to the Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture believed that their organization responds to clinician error in a punitive and non-supportive way."

Code Lavender at the Cleveland Clinic

- Called by hospital staff (usually nurses or doctors) after a stressful event
- Team is made up of holistic nurses and chaplains
  - **Manual Therapies** – reflexive brushing, light massage, reflexology
  - **Energy–based Tools** – Reiki, Healing Touch™
  - **Expressive Arts** – playing recorded music, singing, self-driven art, journaling, story telling
  - **Mind–Body Tools** – guided imagery, meditation, movement and breathing exercises, acupressure, holistic coaching

https://consultqd.clevelandclinic.org/code-lavender-offering-emotional-support-holistic-rapid-response/

"There was mention that social workers would be available to speak with us on an upcoming day. I thought, "Seriously? What are they going to say? 'This must be hard for you'?" I didn't need that. I needed a colleague who understood obstetric anesthesia to say one of two things to me after hearing everything: either a) you could have done X differently – so that I could learn from a mistake I had made – if it existed, or b) there is NOTHING you could have done differently."

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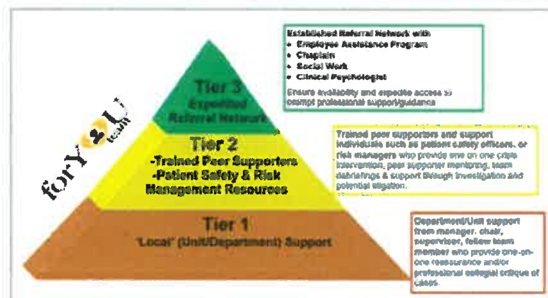
Missouri Loves Company

The Scott Three-Tiered Interventional Model of Second Victim Support



https://www.muhealth.org/sites/default/files/Scotts_Three_Tier_Support.pdf

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Peer Support

Hallmarks of the peer support team model

- Credibility of peers
- Immediate availability
- Voluntary access
- Confidential
- Emotional "first aid" (not therapy!)
- Facilitated access to next level of support (eg, Employee Assistance Program)

van Pelt F. Peer support: healthcare professionals supporting each other after adverse medical events. Qual Saf Health Care 2008;17:249–52.

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Johns Hopkins

- Resilience in Stressful Events -emotional peer support structure, supports second victims who were emotionally impacted by a stressful patient-related event or unanticipated adverse event. This RISE team is composed of a multidisciplinary peer responder team who has volunteered to support second victims when an unanticipated patient-related event occurs. Support from RISE is available to "second victims" or health care providers having difficulty coping with their emotions after patients' adverse events and who subsequently have difficulty coping with their emotions.
- Available for purchase

http://www.safeathopkins.org/resources/johns-hopkins/rise/index.html

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Brigham and Women's

- Peer support programs - trained clinician peer supporters will reach out to you if you are involved in any critical event such as an adverse event or being named in a lawsuit. In addition, they are available at any time if you are feeling distress from any cause. This is not therapy. **It is for the support and collegiality that comes from talking to someone who has "been there."**

https://www.brighamandwomens.org/medical-professionals/center-for-professionalism-and-peer-support/peer-support

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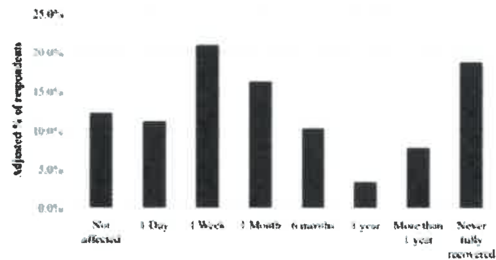
How long does it take?

Time to Emotional Recovery after Index Case



Gazoni FM, Amato PE, Malik ZM, Durieux ME. The impact of perioperative catastrophes on anesthesiologists: results of a national survey. Anesth Analg 2012;114:596–603.

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Institutional Support

- UT Southwestern Employee Assistance Program

FIGURE. Phases of Critical Incident Stress Debriefing

1. Introduction: CISD team members introduce themselves and describe the process, guidelines, and ground rules.
2. Facts: extremely brief overviews of the facts are requested to facilitate discussion.
3. Thoughts: participants are asked to recount their initial cognitive reaction to the event.
4. Reactions: participants discuss their feelings and the worst aspect of the experience for them.
5. Symptoms: participants discuss the day-to-day impact of the event and their cognitive, physical, emotional, and behavioral symptoms.
6. Teaching: explanations of the participants' reactions are discussed, along with topics pertinent to their concerns. Other stress management information is also provided.
7. Re-entry: participants ask questions, discussions are summarized, and final explanations, information, actions, and guidance are offered.

CISD indicates critical incident stress debriefing.

Harrison PhD, Reema; Wu MD, Albert Critical Incident Stress Debriefing After Adverse Patient Safety Events
Am J Manag Care. 2017;23(5):310-312

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Recommendations

- Inform faculty of available resources
- Formalize peer supporting process to ensure someone is always available
- Reach out and refer providers who are at risk
  - Average of 4 PROC cases per month
  - Average of 5 Hospitalist Peer Review Cases per month

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