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PATIENT SAFETY NETWORK

Second Victims: Support for Clinicians Involved in Errors and Adverse Events

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Background

Multiple studies have shown that involvement in medical errors and adverse events can take a significant toll on clinicians. It is estimated that one in seven patients is affected by adverse events, and that as many as half of all clinicians will be involved in a serious adverse event at least once during their career. When a medical error or patient harm occurs, the first priority is to attend to the patient and family members. However, Seys and colleagues and the Institute for Healthcare Improvement have identified three levels at which damage from errors and adverse events occur: the patient, clinicians, and health care organizations. This primer addresses clinician responses to involvement in errors and adverse events, along with support that can be put in place to respond when such involvement occurs.

Common Responses to Involvement in Errors and Adverse Events

Some degree of emotional distress is likely when a clinician is involved in any error or adverse event, regardless of severity. In a survey of more than 3000 physicians in the United States and Canada, 92% reported previous involvement in events ranging from near misses to serious errors, and 81% reported some degree of job-related stress linked to the event. Responses to error and adverse events are individualized: the severity of any error(s), degree of perceived responsibility, and the outcome for the patient seem to be predictive of the degree of distress clinicians experience after an adverse event. Some clinicians are affected profoundly and with potentially lasting consequences. This distress is known as the "second victim" phenomenon, a term coined by Albert Wu in 2000.

Scott and colleagues define second victims as health care providers who are involved in an unanticipated adverse event, medical error, or patient injury and "become victimized in the sense that the provider is traumatized by the event." Across studies, clinicians involved in these events report feelings of responsibility for the patient outcome, shame, anger, failure, depression, inadequacy, and loss of confidence; some report symptoms of post-traumatic stress disorder. One systematic review found that

women were more likely to experience emotional distress, feelings of guilt and inadequacy, and loss of reputation following an adverse event compared to men in similar circumstances.

A qualitative descriptive study with 31 clinicians described 6 stages of recovery after an incident (Table). The authors speculate that the intensity of the experience and the responsiveness of the organization affect how clinicians ultimately "move on."

Table. Stages of Recovery for Second Victims

Stage of Recovery	Summary
Chaos and Accident Response	Clinician experiences internal and external turmoil and may be in a state of shock in the midst of trying to both determine what happened and manage a patient who may be unstable or in crisis. Clinician is distracted and self-reflected, needs others to take over.
Intrusive Reflections	Clinician experiences feelings of inadequacy, self-doubt, and loss of confidence. Clinician engages in continuous re-evaluation of the situation through "haunted re-enactments."
Restoring Personal Integrity	Clinician seeks support from trusted persons, but may not know where to turn and may be fearful of how others will react. Unsupportive responses from colleagues can impair recovery, as they may intensify self-doubt and make it difficult for the clinician to move forward.
Enduring the Inquisition	Clinician braces for the institutional investigation, wonders about the impact on their job, licensure, and the potential for litigation. Clinician may be reluctant to disclose information for fear of violating privacy regulations.
Obtaining Emotional First Aid	Clinician feels uncertain about who is safe to confide in due to privacy concerns and not wanting to expose loved ones to pain. In the study, most clinicians felt unsupported or under-supported, partly due to ambiguity around whom to approach and what can be discussed.

Stage of Recovery	Summary
Moving On	Clinicians feel internal and external pressure to "move on," and in the study had three forms of doing so: • **Dropping out:** changing their role, moving to a different practice setting, or leaving their profession • **Surviving:** "doing okay" after acknowledging mistake, but having a hard time forgiving self, finds it "impossible to let go" • **Thriving:** making something good come out of the event

Source: Scott SD, et al. Qual Saf Health Care. 2009;18:325-330.

Providing Support to Clinicians After an Error or Adverse Event

A survey of 898 clinicians at the University of Missouri found that clinicians wanted a unit- or department-based support system that could relieve them of immediate patient care duties for a brief period; provide one-on-one peer support, professional review, and collegial feedback, as well as access to patient safety experts and risk managers; and offer crisis support and external referral when needed. The University of Missouri Health Care system developed a three-tiered support program deployed by an interprofessional rapid response team.

The first tier of support consists of unit- or department-based event recognition and support by colleagues and local leaders who have received basic response training. Approximately 60% of involved clinicians will have their needs met through this tier. The second tier involves trained peer support persons embedded in high-risk clinical units to monitor colleagues for second victim responses and provide immediate intervention with one-on-one support, trigger debriefings, and access to other organizational resources such as patient safety or risk management leaders. This tier is expected to meet the needs of 30% of identified second victims. The needs of about 10% of affected clinicians are addressed at the third tier, through facilitated access to professional counseling.

Current Context

Creating an environment where clinicians feel safe disclosing their involvement in errors and adverse events is important for patients, families, clinicians, and organizations. The basics of disclosing errors to patients are covered in another Patient Safety Primer. Other important reasons to disclose involvement include enhanced clinician recovery and organizational learning, as discussed in an AHRQ commentary. A study examining provision of support for second victims in hospitals in Maryland found such services to be limited despite recognition by Patient Safety Officers of the need to support clinicians involved in errors and adverse events. The science behind interventions for second victims is in its infancy. However, several resources are available to help organizations prepare to respond. The Institute for Healthcare Improvement

has a whitepaper on respectful management of serious adverse events.