**Second Victim Phenomenon/Care for the Caregiver**

Information for healthcare workers about the second victim phenomenon with quick access to resources for support.

In 1996, an infant was killed when penicillin G benzathine was incorrectly administered intravenously instead of intra-muscularly. Three nurses were indicted for criminally negligent homicide. After the jury delivered the verdict for the third nurse, which was an acquittal, it gave the following recommendation: “*We must look beyond blame and focus on the multiple, underlying system failures that shape individual behavior and create the conditions under which medication errors occur*.”1

The term second victim is less than 20 years old and today is met with some controversy. Many healthcare professionals are reluctant to use the term while others may be unfamiliar with its concept.2,3 The term “second victim” is used commonly in literature about medication errors and while we are utilizing the term here, it is in no way meant to overshadow the experience of the patients and their families as the victims of medication errors.

This information is intended to provide the following:

* Education to healthcare providers about the second victim phenomenon
* Resources for facilities looking to improve their organizational structure to support healthcare staff through programs such as peer to peer
* Resources for individuals seeking professional support

1. Definitions

| Term | Definition |
| --- | --- |
| Second Victim Phenomenon | * “A healthcare provider involved in an unanticipated adverse patient event, medical error, and/or patient related injury who becomes victimized in the sense that the provider is traumatized by the event” 4,5 * “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.”5 * Providers considered are “any individual who provides patient services” (physicians, nurses, pharmacists, and other members of the healthcare team susceptible to error and vulnerable to its consequences such as allied health clinicians, support personnel, students, and volunteers).4,5,6 |
| Care for the Caregiver Programs | * A program that provides support for the caregiver after they are involved in an unanticipated adverse event, medical error, and/or patient related injury. This support can be provided at a local level (unit/department), an organizational level with trained individuals, or at a referral network level.7 |
| Peer Support Programs | * A program involving colleagues or co-workers as equals giving each other support and connection on a reciprocal basis. A peer is able to offer this support by virtue of relevant and/or similar work experience to the one seeking support. |
| Adverse Event | * An injury that was caused by medical management (rather than the underlying disease) and that prolonged the hospitalization, produced a disability at the time of discharge, or both.8 * An injury resulting from a medical intervention.9 * An untoward, undesirable, and usually unanticipated event, such as death of a patient, an employee, or a visitor in a health care organization. Incidents such as patient falls or improper administration of medications are also considered adverse events even if there is no permanent effect on the patient.10 * An event or omission arising during clinical care and causing physical or psychological injury to a patient.11 * An injury that was caused by medical management and that results in measurable disability.12 |
| Near Miss | * Patient safety incident that does not reach the patient and does not cause harm3 |
| Latent Failure1,13 | * Weaknesses in the structure of an organization. * Errors in the design, organization, training, or maintenance of systems that lead to operator errors and whose effects typically lie dormant in the system for lengthy periods of time |
| Active Failure | * Errors caused by individuals such as nurses, pharmacists and physicians in direct contact with the vulnerable weaknesses in the structure of an organization.1 |
| Inattentional blindness13 | * The phenomenon of not being able to see things that are actually there. This can be a result of having no internal frame of reference to perceive the unseen objects, or it can be the result of the mental focus or attention that causes mental distractions. The phenomenon is due to how our minds see and process information. Also known as perceptual blindness. |

1. **Background/ Statistics/Perspective**

In the year 2000, when Albert Wu coined the term “second victim,” he stated that physicians will always make mistakes and the deciding factor will be how we choose to handle these mistakes. He noted honesty would serve not only patient’s safety but also physician welfare.6 Second victims are the healthcare professionals involved in unforeseen adverse events that feel traumatized by the event.4,5 These professionals can experience stress-related psychological and physical reactions.14 Manifestations include sadness, fear, anger and shame and can include fear of returning to work, loss of confidence, depression, nervousness, guilt, worry, remorse and anguish.14 While health care facilities have systems in place to report and review adverse events, and many conferences discuss events, it is only to examine the medical facts and not the feelings of those involved.6 In a self-reported survey, a systematic random sample of nurses, pharmacists and physicians reported that 40.8% felt that a patient care error left a harmful effect on their personal lives.4,6 Healthcare professionals experiencing a negative emotional response following an event has been estimated to be 30% in the US and 43% in Canada.3 Many surveys and studies have been conducted in various healthcare populations over the last two decades and give us insight to the frequency, impact and lasting effects these errors have on healthcare professionals as well as the barriers we must face to address the second victim phenomenon.

|  |  |
| --- | --- |
| **Year Published** | **Survey Reported** |
| 2007 | Over 3000 physicians reported that 61% had anxiety about future errors, 44% had loss of confidence, 42% had sleeping difficulties, 42% had reduced job satisfaction and 13% felt harm to their reputation following medical errors.15 |
| 2009 | Patient Safety Culture Survey at UMHC found almost 1 in 7 of staff (175/1160) reported they had experienced a patient safety event within the last year that caused personal problems such as anxiety, depression, or concerns about the ability to perform one’s job. An overwhelming 68% of these reported they did not received institutional support to assist with this stress.16 |
| 2015 | Community hospital survey (650 bed adult and pedi facility with a level 1 trauma center) had 120 respondents and over 60% disclosed that they felt fear of retribution in reporting a PSE (patient safety event).17 |
| 2015 | A survey conducted in Spain to assess second and third victim support or crisis management in health organizations and primary care offices. The study concluded the majority of health organizations have reporting systems, but lack subsequent systemic analysis of reported events in comparison to primary care settings that highlight failures in both reporting and assessments of adverse events. It was reported most organizations did not have a crisis plan in place for serious events for third victim protection.18 |
| 2017 | A questionnaire assessing the perceived need for organizational support for second victims in acute care hospitals in Maryland from the perspectives of patient safety representatives showed over 80% of respondents stated that the second victim problem was relevant. Barriers noted to starting a second victim program included funding, stigma, trust and concerns about confidentiality, lack of interest of staff, and unclear of best practice.19 |
| A cross-sectional online survey in the NICU compared responses of three groups (no event, observation of event, involvement in event) in relation to anxiety, depression, professional quality of life and coworker support. Higher levels of anxiety and secondary traumatic stress were reported in those who observed or were involved in an error or adverse event. Coworker support may mitigate negative outcomes such as increased emotional distress and effects on their professional life.20 |

|  |  |
| --- | --- |
| **Year Published** | **Study Reported** |
| 20104.5 | Thirty percent of 5000 respondents (physicians, nurses, and medical students) reported personal problems as a result of a clinical patient safety event in the past year. Fifteen percent contemplated leaving their profession. |
| 2016 | Study conducted with nursing staff at one hospital to assess the impact a patient safety culture can have on second victim related distress using the Agency for HealthCare Research and Quality (AHRQ) Hospital Survey on Patient Culture (HCOPSC) and the Second Victim Experience and Support Tool (SVEST). The study concluded that having a non-punitive patient safety culture can increase the support for health care workers involved in a patient safety event potentially reducing or preventing distress associated with these events. The study supports that a punitive safety culture may contribute to self-reported second victim distress potentially caused by a lack of organizational support.21 |
| 2017 | A cohort of academic surgeons in Boston described their experiences with intraoperative adverse events and the emotional impact these events had on them. The responses of over 125 surgeons provided alarming insight into the distress faced by many of our colleagues when things go wrong in their OR. Over 90% of respondents reported experiencing an intraoperative adverse event, most commonly within the last year.22 |
| 2017 | Study to develop and access an online awareness and information program targeting healthcare professionals in direct contact with patients (both hospital and primary care). The MISE (Mitigating Impact in Second Victims) Program is preventative in nature and allows easy online access to knowledge which allows users to correct their own approach. MISE was well received among healthcare professionals. Specific Objectives of MISE include the following:3   * + Facilitate information and training about second victims (for a large number of healthcare professionals at low cost)   + Describe emotional reactions and common behavior after being involved in an adverse event   + Describe correct and incorrect actions of how to act after an adverse event in order to respect the rights of patients and support second victims   + Act in the area of primary care, expanding the extent of studies primarily done in hospital setting |
| 2019 | One study in surgical trainees and nine case series or cross-sectional studies in surgeons the UK or North America were reviewed (>8500 participants). Four themes were identified in how surgeons were affected emotionally after complications and included the following:23   1. Adverse emotional consequences of complications (anxiety, guilt, sadness, shame) 2. Coping mechanisms used (discussion with colleagues, exercise, creative outlets, substance abuse) 3. Institutional support mechanisms and barriers to support 4. Consequences in clinical practice (changes in practice, RCA, introduction of protocols)   Study concluded that further efforts are needed for effective support. |

* 1. HIGH-RISK SCENARIOS (from Emotional First Aid for Second Victims and From for You Team website-University of Missouri) <https://www.muhealth.org/about-us/quality-care-patient-safety/office-of-clinical-effectiveness/foryou>

There are several types of clinical events that can evoke a second victim response. Examples of high-risk situations that may induce a stress response include:

* + - 1. Patient who “connects” to a health care professional’s own family
      2. Unanticipated clinical event involving a pediatric patient
      3. Unexpected patient death
      4. Preventable harm to patient
      5. Multiple patients with bad outcomes within a short period of time within one clinical area
      6. Long-term care relationship with patient death
      7. Clinician experiencing his or her first patient death
      8. Failure to detect patient deterioration in timely manner
      9. Death in a young adult patient
      10. Notification of pending litigation plans
      11. Community high-profile patient or event
      12. Health care professional who experienced needle stick exposure with high-risk patient
      13. Death of a staff member or spouse of a staff member

**Effects on Second Victims:**

The medical literature does not clearly establish the proportion of health care professionals who are affected by the second victim phenomenon, nor is the long-term impact on the careers of health care professionals well delineated.5 Effects on second victims can range from insomnia to suicidal thoughts and effects can extend not only to their professional lives but also their personal lives.14 Some practitioners suffer a medical equivalent to PTSD and they fear being labeled incompetent, losing their employment and litigation.14 These victims struggle with processing their feelings of fear, sadness, guilt and shame. In 2014, ISMP advised there was a need for the development of second victim support plans with formal infrastructures.14 The disclosure of adverse events to patients forces health care workers to confront and accept responsibility for errors which can increase distress but reporting of these events is paramount. Data published in 2013 estimated between 210,000 and 440,000 preventable deaths occur annually in the US and are related to adverse events.24,25 Rafter and colleagues estimated 4-17% of international hospital admissions are associated with adverse events.24,26. A systematic and comprehensive approach in handling these events includes providing clinician support as well as awareness and consideration.27

**Lack of Support**

In 2010, Scott and colleagues noted the lack of literature available on how to formalize access to support or address the unique need of second victims.5 Multiple cases collected throughout the years reflect there is a lack of support in general within the healthcare industry. In 2014, ISMP reported the lack of support mechanisms to address the severe side effects often felt in second victims of fatal errors.14 In 2016, Burlison and colleagues used the Second Victim Experience and Support Tool to show a relationship between second victim distress and both absenteeism and turn over intentions. They concluded that organizational support mediated the turnover and absenteeism trends.28 Issues with organizational support identified by other researchers include inadequate safety culture, a punitive approach to adverse events and barriers to access institutional support.24 The importance of a supportive organizational climate seems vital in supporting the needs of second victims.24 Several programs have been implemented at facilities due to the realization of how devastating these events can be for the healthcare providers involved.

1. Six stages of Second Victim Recovery5,16

Stage 1: Chaos and accident response

Stage 2: Intrusive reflections

Stage 3: Restoring personal integrity

Stage 4: Enduring the inquisition

Stage 5: Obtaining emotional first aid

Stage 6: Moving on (either by dropping out, surviving, or thriving)

The Five Rights of Second Victims14

* + - 1. Treatment that is just.
      2. Respect
      3. Understanding and compassion
      4. Supportive care
      5. Transparency and opportunity to contribute

1. Resources/ Example Programs

Professionals are often met with uncertainty once an adverse event occurs. They do not know what to do and they question the support of not only their colleagues but also their institution.3 Without programs to help with healing, professionals often turn to dysfunctional ways protect themselves.6

* Desired Resources for victims - data suggests underutilization4
  + 1. Internal resources – preferred internal vs external support per Scott study
       1. Formal employee support
       2. Pastoral care, chaplains
       3. Social Work
       4. Employee assistance
       5. Private counseling
* Beta Heart Care for the Caregiver Toolkit: Information on development and implementation of a program.
  + <https://www.betahg.com/beta-heart-care-for-the-caregiver/>

| **Table 1. Established Resources for Support** | | | | |
| --- | --- | --- | --- | --- |
| **Title of Program** | **Implementation Date** | **Description** | **Details** | **Link** |
| Nationwide Children’s Hospital You Matter Program | November 2013 | Second Victim Peer Support Program | Individual and group support is provided for staff of Nationwide Children’s Hospital 24 hours a day through peers from all disciplines. | <https://www.nationwidechildrens.org/careers/you-matter-program> |
| Caring for the Caregiver: Implementing RISE (Resilience in Stressful Events)  Johns Hopkins Medicine and the Maryland Patient Safety Center | 2011 | Modeled after the RISE (Resilience in Stressful Events) program at Johns Hopkins Medicine this training program teaches you how to set up a healthcare specific, organization wide peer-to-peer support program. A multi-disciplinary team of volunteers will be trained to respond and support a colleague dealing with work and/or patient related stressors from a variety of sources (i.e. medical error, unanticipated patient loss, workplace violence, burnout, etc.). | Lead by Johns Hopkins peer-support experts, this 2-day workshop trains institutional leadership, the identified peer responder team, and those responsible for future internal trainings and sustainment of the program. The workshop includes:   * Strategies for leadership buy-in and to navigate operational challenges * Guidance on recruiting and retaining peer responders * Skill-building activities * Strategies for rolling out and sustaining *Caring for the Caregiver*   Workshop participants will also receive all the necessary materials to support the program, access to an online portal for training videos, publications, communications, templates, etc.  Furthermore, participating organizations are included in the nationwide network of “CFC/RISE Partners” for shared learning opportunities and networking | <https://www.johnshopkinssolutions.com/solution/rise-peer-support-for-caregivers-in-distress/>  <http://www.marylandpatientsafety.org/Caregiver.aspx> |
| Brigham and Women’s Peer to Peer Support Program | 2008 | Outreach to any member of the healthcare team involved in emotionally stressful events such as: adverse events, errors, difficult patient interactions, or being named in a lawsuit. | 24/7 support provided by trained clinician peer supporters from various disciplines who are not mental health practitioners. | <https://www.brighamandwomens.org/about-bwh/omcoss/peer-support-program> |
| UNC Health Care Emotional Support and Mental Health Resources | 2017 | The UNC Well-Being Program has several resources designed to provide emotional support and promote mental health.  This program is for employees throughout the UNC Health Care System. | A confidential warm support helpline staffed by licensed mental health professionals to provide supportive listening, access to resources, or a direct referral for therapy  Virtual Support Groups led by Department of Psychiatry faculty addressing a constellation of issues related to self care and coping for individuals and their families  Virtual Educational Webinars led by Department of Psychiatry faculty providing group-based sessions that include an overview of coping skills and strategies, as well as a clinician-led discussion  Stress First Aid Training designed to help provide compassionate assistance and increase coping longevity, prevent the progression of stress reactions, and bridge affected individuals to more formal treatment when that is required  Taking Care of Our Own addresses burnout syndrome and other mental health concerns in attending and resident physicians  Peer Support Program that offers one on one support from trained colleagues after adverse patient events including physical and verbal assaults from patients and visitors | [https://www.unchealthcare.org/wellbeing/toolkit/toolkit-overview/mental-healthemotional-support-resources-for-co-workers-and-prov/](https://urldefense.com/v3/__https:/www.unchealthcare.org/wellbeing/toolkit/toolkit-overview/mental-healthemotional-support-resources-for-co-workers-and-prov/__;!!PfbeBCCAmug!1bn5sZjpvTmfGH1gdI0r30Rg9o2xHRb5kIzEW251ANP3oZTZcYnhj7sQA6_LZJQkhA$)  [https://www.med.unc.edu/psych/wellness-initiatives/peer-support-program/](https://urldefense.com/v3/__https:/www.med.unc.edu/psych/wellness-initiatives/peer-support-program/__;!!PfbeBCCAmug!1bn5sZjpvTmfGH1gdI0r30Rg9o2xHRb5kIzEW251ANP3oZTZcYnhj7sQA6_OHVFMBg$) |
| ISMP | Since 1975 | Educational/Professional resource | ISMP offers various tools and resources on their site. | https://www.ismp.org/ |

Figure 1. Six Key Components in Initiating a Second Victim Program29

References:

1. Smetzer JL, Cohen MR. Lesson from the Denver Medication Error/Criminal Negligence Case: Look Beyond Blaming Individuals. *Hospital Pharmacy* 1998;33(6):640-657.
2. Tumelty ME. The Second Victim: A Contested Term? *J Patient Saf*. 2018;00:1-6.
3. Mira JJ, Carrillo I, Guilabert M, et al. The Second Victim Phenomenon After a Clinical Error: The Design and Evaluation of a Website to Reduce Caregivers' Emotional Responses After a Clinical Error. *J Med Internet Res*. 2017;19(6):e203. Published 2017 Jun 8. doi:10.2196/jmir.7840
4. Krzan KD, Merandi J, Morvay S, Mirtallo J. Implementation of a “second victim” program in a pediatric hospital. *Am J Health-Syst Pharm.* 2015;72:563-7.
5. Scott SC, Hirschinger LE, Cox KR, et al. Caring for our own: deploying a system-wide second victim rapid response team. *Jt Comm J Qual Patient Saf*. 2010;36:233-40.
6. Wu A. Medical error: the second victim. The doctor who makes mistakes needs help too. *BMJ*. 2000;320:726-7.
7. Care for the Caregiver Program Implementation Guide. Content last reviewed February 2017. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/module6-guide.html>
8. Brennan TA, Leape LL, Laird NM, Hebert L, Localio AR, Lawthers AG, et al. Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study I. *N Engl J Med* 1991;324:370-6.
9. Kohn LT, Corrigan JM, Donaldson MS. To Err Is Human: Building a Safer Health System. Washington, DC: National Academy Press. 1999. # 0-309-06837-1.
10. Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Glossary of terms. Oakbrook Terrace, Calif: Joint Commission on Accreditation of Healthcare Organizations. 2001.
11. National Health Service (NHS). Department of Health: An organization with a memory. Report of an expert group on learning from adverse events in the NHS. London: The Stationery Office. 2000.
12. Quality Interagency Coordination (QuIC) Task Force. Doing what counts for patient safety: Federal actions to reduce medical errors and their impact. Washington, DC: Quality Interagency Coordination Task Force. 2000. # 1-58763-000-1
13. Smetzer J, Baker C, Byrne FD, Cohen MR. Shaping Systems for Better Behavioral Choices: Lessons Learned from a Fatal Medication Error. *Jt Comm J Qual Patient Saf.* 2010;36(4):152-163.
14. Grissinger M. Too Many Abandon the “Second Victims” of Medical Errors. *P&T.* 2014; 39(9):591-592.
15. 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;33:467-476.
16. Scott SD, Hirschinger LE, Cox KR,et al. The natural history of recovery for the healthcare provider “second victim” after adverse patient events *BMJ Quality & Safety.* 2009;18:325-330.
17. 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. *J Patient Saf*. 2015 Jun;11(2):73-8.
18. Mira JJ, Lorenzo S, Carrillo I, et al. Interventions in health organizations to reduce the impact of adverse events in second and third victims. *BMC Health Services Research*. 2015;15:34.
19. Edrees HH, Morlock L, Wu AW. Do hospitals support second victims? Collective insights from patient safety leaders in Maryland. *Jt Comm J Qual Patient Saf*. 2017 Sep;43(9):471-483.
20. Winning AM, Merandi JM, Lewe D, et al. The emotional impact of errors or adverse events on healthcare providers in the NICU: The protective role of coworker support. *J Adv Nurs*. 2017;00:1-9.
21. Quillivan R, Burlison J, Browne E, et al Patient Safety Culture and the Second Victim Phenomenon: Connecting Culture to Staff Distress in Nurses. *Jt Comm J Qual Patient Saf*. 2016 August;42(8):377–386.
22. Han K, Bohnen JD, Peponis T, et al. The surgeon as the second victim? Results of the Boston Intraoperative Adverse Events Surgeons’ Attitude (BISA) Study. *J Am Coll Surg*. 2017;224:1048–1056.
23. Srinivasa S, Gurney J, Koea J. Potential Consequences of Patient Complications for Surgeon Well-being: A Systematic Review. *JAMA Surg.* Published online March 27, 2019. doi:10.1001/jamasurg.2018.5640
24. Chan ST, Khong PCB, Wang W. Psychological responses, coping, and supporting needs of healthcare professionals as second victims. *International Nursing Review.* 2017;64:242–262.
25. James JT. A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care. *Journal of Patient Safety*. 2013;9(3):122–128.
26. Rafter N, Hickey A, et al. Adverse events in healthcare: learning from mistakes. QJM: An International Journal of Medicine. 2015; 108(4):273–277.
27. Wu AW, Boyle DJ, Wallace G, Mazor KM. Disclosure of adverse events in the United States and Canada: an update, and a proposed framework for improvement. *J Public Health Res*. 2013;2(3):e32.
28. Burlison JD, Quillivan RR, Scott SD, et al. The Effects of the Second Victim Phenomenon on Work-Related Outcomes: Connecting Self-Reported Caregiver Distress to Turnover Intentions and Absenteeism. *J Patient Saf*. 2016; 00(00):1-6.
29. Merandi J, Liao N, Lewe D, et al. Deployment of a Second Victim Peer Support Program: A Replication Study. Pediatr Qual Saf. 2017;2:e031; doi. 10.1097/pq9.0000000000000031. eCollection 2017 Jul-Aug.