Second Victim Syndrome

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Disclosures

No financial disclosures
No conflict of interests
Not an expert
Objectives

1) Define the second victim syndrome

2) Describe the stages of second victim syndrome and the physical, cognitive and emotional changes second victims experience

3) Develop strategies to identify and support second victims within our institutions
Let’s Look Back

Facing Our Mistakes
David Hilfiker, M.D.

Medical error: the second victim

1980s
2000
2000s

TO ERR IS HUMAN
BUILDING A SAFER HEALTH SYSTEM
“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”
Second Victim Syndrome

“Health care team members who are involved in an unanticipated patient event, which might involve harm, become victimized in the sense that they are traumatized by the event.”
Stage 1: Chaos & 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

Impact Realization

Thriving
Surviving
Dropping Out

“Dropping out and Starting Over”

Majority (70%) related to permanent harm or death of patient

Half (50%) were direct care providers

One third (33%) reported significant decrease in joy and meaning of work

Changing roles primarily driven by

1) Inadequate social support
2) Effects of emotional labor

Prevalence

10.4 %  
Lander et. al 2006  
n = 210 ENTs

30 %  
Scott et. al 2006  
n = 898 nurses, residents, attendings

43.3%  
Wolf et. al 2000  
n = 402 health care professionals
High Risk Clinical Situations

- Patient reminds staff member of their own family or loved ones
- Pediatric cases
- Medical errors
- Failure to rescue cases
- First death experience
- Long term patient
- Unexpected patient demise
- Multiple patients with bad outcomes
- Community high profile patient

Hirschinger 2015
High Risk Clinical Areas
The Emotional Impact of Medical Errors on Practicing Physicians in the United States and Canada

N = 3100 Physicians
Impact of Errors on Physicians’ Life Domains by Level of Error Severity*

<table>
<thead>
<tr>
<th>Impact</th>
<th>Serious Error</th>
<th>Minor Error</th>
<th>Near Miss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased Anxiety about Future Errors*</td>
<td>66</td>
<td>56</td>
<td>51</td>
</tr>
<tr>
<td>Decreased Job Confidence*</td>
<td>51</td>
<td>31</td>
<td>36</td>
</tr>
<tr>
<td>Decreased Job Satisfaction*</td>
<td>48</td>
<td>34</td>
<td>32</td>
</tr>
<tr>
<td>Increased Sleeplessness*</td>
<td>48</td>
<td>33</td>
<td>34</td>
</tr>
<tr>
<td>Harm to Professional Reputation*</td>
<td>15</td>
<td>9</td>
<td>10</td>
</tr>
</tbody>
</table>

Figure 1. Physicians’ lives were more likely to be affected as error severity increased. *Chi-square tests; p < .001 level.
<table>
<thead>
<tr>
<th>Physical symptoms</th>
<th>n (%)</th>
<th>Psychosocial symptoms</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extreme fatigue</td>
<td>16 (52)</td>
<td>Frustration</td>
<td>24 (77)</td>
</tr>
<tr>
<td>Sleep disturbances</td>
<td>14 (45)</td>
<td>Decreased job satisfaction</td>
<td>22 (71)</td>
</tr>
<tr>
<td>Rapid heart rate</td>
<td>13 (42)</td>
<td>Anger</td>
<td>21 (68)</td>
</tr>
<tr>
<td>Increased blood pressure</td>
<td>13 (42)</td>
<td>Extreme sadness</td>
<td>21 (68)</td>
</tr>
<tr>
<td>Muscle tension</td>
<td>12 (39)</td>
<td>Difficulty concentrating</td>
<td>20 (65)</td>
</tr>
<tr>
<td>Rapid breathing</td>
<td>11 (35)</td>
<td>Flashbacks</td>
<td>20 (65)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Loss of confidence</td>
<td>20 (65)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Grief</td>
<td>20 (65)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Remorse</td>
<td>19 (61)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Depression</td>
<td>17 (55)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Repetitive/intrusive memories</td>
<td>16 (52)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-doubt</td>
<td>16 (52)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Return to work anxiety</td>
<td>15 (48)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Second guessing career</td>
<td>12 (39)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fear of reputation damage</td>
<td>12 (39)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Excessive excitability</td>
<td>11 (35)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Avoidance of patient care area</td>
<td>10 (32)</td>
</tr>
</tbody>
</table>
Results

90% physicians did not feel the hospital adequately supported them

82% reported they would be interested in counseling
## Concerns of the Second Victim

<table>
<thead>
<tr>
<th>Patient</th>
<th>Self</th>
</tr>
</thead>
</table>
| Is the patient/family okay?  
What have they been told?  
How did they respond? | Will I be fired?  
Will I be sued?  
Will I lose my license? |

<table>
<thead>
<tr>
<th>Peers</th>
<th>Next Steps</th>
</tr>
</thead>
</table>
| What will my colleagues think?  
Will I ever be trusted again?  
Will I still be a respected member of team? | What happens next?  
Who will be contacting me to discuss the case?  
If a lawsuit does happen, when will I know?  
How will I hear about it? |
Symptoms of the Second Victim

- Extreme fatigue
- Sleep disturbances
- Rapid heart rate
- Increased blood pressure
- Muscle tension
- Rapid breathing

- Frustration
- Decreased job satisfaction
- Difficulty concentrating
- Flashbacks
- Loss of confidence
- Grief/remorse

Scott 2010
Physicians’ Needs in Coping with Emotional Stressors: The Case for Peer Support

Yue-Yung Hu, MD, MPH\textsuperscript{1,2}, Megan L. Fix, MD\textsuperscript{3}, Nathanael D. Hevelone, MPH\textsuperscript{1}, Stuart R. Lipsitz, ScD\textsuperscript{1}, Caprice C. Greenberg, MD, MPH\textsuperscript{1}, Joel S. Weissman, PhD\textsuperscript{4}, and Jo Shapiro, MD\textsuperscript{5}

### Survey Respondent Characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Training</td>
<td></td>
</tr>
<tr>
<td>Resident</td>
<td>69 (64)</td>
</tr>
<tr>
<td>PGY 1</td>
<td>13 (12)</td>
</tr>
<tr>
<td>PGY 2</td>
<td>22 (20)</td>
</tr>
<tr>
<td>PGY 3</td>
<td>16 (15)</td>
</tr>
<tr>
<td>PGY 4</td>
<td>14 (13)</td>
</tr>
<tr>
<td>PGY 5+</td>
<td>4 (4)</td>
</tr>
<tr>
<td>Fellow</td>
<td>4 (4)</td>
</tr>
<tr>
<td>Attending</td>
<td>35 (32)</td>
</tr>
<tr>
<td>Department</td>
<td></td>
</tr>
<tr>
<td>Anesthesia</td>
<td>46 (43)</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>23 (21)</td>
</tr>
<tr>
<td>Surgery</td>
<td>39 (36)</td>
</tr>
</tbody>
</table>

![Graph showing % likely to seek support](image)
Results

“What would you seek help?”

- Legal situations (72%)
- Medical Errors (67%)
- Adverse patient events (63%)

“What are barriers to seeking help?”

Lack of time, concerns of confidentiality, negative impact on career, documentation on records, stigma of mental health care, difficulty accessing services, unwanted interventions
Health Care Professionals as Second Victims after Adverse Events: A Systematic Review

Deborah Seys¹, Albert W. Wu², Eva Van Gerven¹, Arthur Vleugels¹, Martin Eeuwema³, Massimiliano Panella⁴, Susan D. Scott⁵, James Conway⁶, Walter Sermeus¹, and Kris Vanhaeckt¹
Coping Strategies

Problem- Focused

Emotion- Focused
Defensive Changes

- Keep error to themselves
- Avoid similar patients
- Feel less confident, get more worried, less trusting
- Avoidance behavior
- Order more tests

Constructive Changes

- Ask colleagues what they would have done
- Seek more advice, pay attention to detail
- Read more carefully, change practice to reduce errors
- Keep better documentation, do more observations on patient, confirm data personally
- Follow procedures more closely
- Increase self care
Suffering in silence: a qualitative study of second victims of adverse events

Susanne Ullström, Magna Andreen Sachs, Johan Hansson, John Øvretveit, Mats Brommels

The characteristics of the informants
The occupational distribution of the 21 informants was as follows: physicians (n=10), registered nurses (n=9) and allied healthcare professionals (n=2). Sixteen of the participants were women and five were men. The length of time in practice ranged from 5 to 30 years. The largest group (n=9) had worked for 21–30 years, the second largest group (n=7) for 11–20 years, and the smallest group (n=5) for 5–10 years. Eighteen of the 21 informants were still employed by the hospital at the time of the interviews.
Findings

1) Most informants experienced emotional distress following the adverse events

“I kept coming back to that day.”

“I felt terribly ashamed that I had made a mistake”

2) Extent of the impact on the healthcare professional was related to the organisation’s response to the event

3) Most critical need was to talk with others about what had happened
Institutional Support
Tier 3
Expeditied Referral Network
- Established Referral Network with
  - Employee Assistance Program
  - Chaplain
  - Social Work
  - Clinical Psychologist
  - Ensure availability and expedite access to prompt professional support/guidance.

Tier 2
- Trained Peer Supporters
- Patient Safety & Risk Management Resources

Tier 1
‘Local’ (Unit/Department) Support

Trained peer supporters and support individuals such as patient safety officers, or risk managers who provide one-on-one crisis intervention, peer supporter mentoring, team debriefings & support through investigation and potential litigation.

Department/Unit support from manager, chair, supervisor, fellow team member who provide one-on-one reassurance and/or professional collegial critique of cases.
Stanford Physician Peer Support Program

Resilience Program
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

RISE: Peer Support for Caregivers in Distress
Resilience in Stressful Events

Physicians caring about each other

Johns Hopkins Medicine

Caring 4 you
Penn Medicine
What about in other fields?
**Psychological debriefing:** Single-session individual psychological intervention that involves reworking, reliving or recollection of the trauma and subsequent emotional reactions.¹

**Critical incident stress debriefing:** Used in the 1980s to describe a small-group-based multicomponent program for crisis intervention designed for emergency service workers (secondary trauma victims).²

**Critical incident stress management:** Introduced in the 1990s to refer to the “overarching umbrella program/system” as well as group-based psychological debriefing to remediate the impact of traumatic incidents.²
Psychological debriefing for preventing post traumatic stress disorder (PTSD)

Authors' conclusions:

There is no evidence that single session individual psychological debriefing is a useful treatment for the prevention of post traumatic stress disorder after traumatic incidents. Compulsory debriefing of victims of trauma should cease. A more appropriate response could involve a 'screen and treat' model (NICE 2005).
An ER doctor steps outside after losing a 19-year old patient. (Posted by a close friend and coworker on Facebook; We are both EMTs)
Doctors share their personal stories of grief after this heartbreaking image goes viral

'Patients will come and go - we will save a lot of them, but some we cannot save.'

Photo Of Doctor Grieving Over Lost Patient Is Worth A Thousand Words

Chris Jancelewicz
The Huffington Post Canada
Hypothetically had a pt in vtach with bp in the 80s, but completely awake/alert/with it. Gave 1mg versed, but didn't help much. He obviously felt the shock, but symptoms resolved after he converted. In hindsight realized I should have maybe done etomidate? What about ketamine? Trying to be more prepared for next time. I realize it is technically Emergent and at the end of the day you don't have to do anything…but if I have a few extra seconds to give a med and be humane, why not?
First time in 11 years doing this I’ve been certain a human trafficking victim just walked out of the ER with her pimp and there wasn’t a damn thing I could do about it. Spoke to her alone, called the hotline multiple times only to get elevator music, spoke to our psych social worker, and had police come talk to her. She totally changed her mood and affect when this guy showed up. She wouldn’t leave his side and refused to let us kick him out. So frustrated.

Bess Stillman: But now she knows there's help available to her. so if the day comes when she realizes she can get it, you planted the seed.

Nicholas Dyc: Man I hope so. This guy was so passive aggressive towards her so I really hope he's not assaulting her right now.
“Health care workers who get wrapped up in error and injury, as almost all someday will, get seriously hurt too. And if we’re really healers, then we have a job of healing them too. That’s part of the job. It’s not an elective issue, it’s an ethical issue.”
References

1. Makary MA, Daniel M. Medical error—the third leading cause of death in the US. BMJ. 2016;353:i2139.
Thank you

Dr. Zack Meisel
Jenn Barger
Karen Anderson
Dr. David Jang
Dr. Ben Abella
Jack Welsh, RN
John McCormack
Penn EM Residency