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## The “Second Victim”

Institutions are Doubling Down  
to Support Staff



Combating  
Workplace  
Violence

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# The Second Victim”

Medical error and adverse events may cause trauma for the physician as well as the patient. Many institutions are doubling down on efforts to support their staff.

By Delia O'Hara

**“SECOND VICTIM”** syndrome emerged 20 years ago, when researchers realized that caregivers who inadvertently harm patients, the first victims, often suffer grievous emotional fallout themselves. More recently, it has become clear that error is not the only cause of trauma for caregivers.

A stillbirth, a patient who loses a long battle with cancer, a surgical team unable to save a young gunshot victim—these tragedies take their toll, too, and can lead to depression, burnout, post-traumatic stress disorder, and even thoughts of suicide.

“At first, we had a laser focus on medical errors, but those are the minority”—only about 15%, says Susan Scott, PhD, RN, director of professional nursing practice at University of Missouri Health Care, who has been researching the second victim phenomenon for 13 years. More than half of traumatized clinicians at UMHC were devastated by an adverse event they didn't cause—or an accumulation of them—of the type that happen in hospitals every day.

One emergency room doctor was stricken, after an accident, to find himself caring for two badly injured pre-schoolers who were the same age as his own two children, Scott recalls. And half the respondents in one survey she conducted were supervisors, medical directors, nursing leaders or attending physicians who took responsibility in their own minds for adverse events that occurred on their watch. Half of that subset of survey

**LEFT: Timothy McDonald, MD, is a pediatric anesthesiologist, a consultant and a lawyer. RIGHT: Susan Scott, PhD, RN, is the director of professional nursing practice at the University of Missouri Health Care.**



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respondents left their jobs as a result, she says.

### A High-Risk Profession

Nearly half of all healthcare providers will find themselves in the “second victim” position some time, and unless they get help, the experience can cause real damage to the individuals and their careers. In an age when about half of all doctors acknowledge that they have experienced at least one of the signs of burnout—emotional exhaustion, loss of empathy for patients and reduced effectiveness—many institutions are doubling down on efforts to support physicians and other caregivers.

“I think there is a dawning awareness that health care is a high-risk profession,” says Albert Wu, MD, MPH, professor of health policy and management at the Johns Hopkins School of Public Health. Dr. Wu coined the term “second victim” in a 2000 editorial for the *British Medical Journal*, one year after the National Academy of Medicine (formerly the Institute of Medicine) released its watershed report, *To Err Is Human*, which catalogued for the first time the magnitude of preventable medical errors occurring in the American medical system. “When patients do badly, the people who take care of them will always suffer.”

The first impulse may be to recede into the wall of silence medicine has historically thrown up around adverse events, for a number of reasons, Dr. Wu says—shame, not knowing what to say, and “by no means least, fear of litigation.”

### Stages of Response to Medical Error

Scott and her colleagues have described an “intense and multilayered” experience providers enter into, stages that for physicians who have made a medical error include ruminating over how the mistake might have been averted; worrying about its impact on future employment, reputation and standing with co-workers; and “enduring the inquisition” into the event. The last stage Scott has

identified is “moving on,” which can diverge into three paths:

- Dropping out—of the job, the practice, perhaps even the profession.
- Surviving, but not resolving the experience in a wholly satisfactory way.
- Thriving, learning from the event, taking work to a new level.

Margaret Plews-Ogan, MD, a physician, associate professor and researcher at the University of Virginia Health System in Charlottesville, has explored that last path, thriving. Her team found in two studies, in 2013 and 2016, that many physicians who have made a grievous medical error have actually become better doctors in the aftermath. They may learn new skills—perhaps how to work better as part of a team—or they may learn to speak up more forcefully for what they know is right. Eventually, they create for themselves “a new narrative of what it means to be a good doctor,” Dr. Plews-Ogan says.

Two important early steps in that journey to “wisdom,” Dr. Plews-Ogan’s team found, are acceptance—owning that a bad thing has happened that can’t be fixed—and “stepping in,” the opposite of avoidance, a stance in which transparency becomes crucial, not only to the patient and the institution, but also to the practitioner who has made the mistake—disclosure, apology, “deeply learning about what has happened,” Dr. Plews-Ogan says.

“Adversity can be a powerful force in helping people change for the better,” she says. As to that term, “second victim,” Dr. Plews-Ogan says, “I don’t use it. I think the word, victim, sets people off on a path that can be difficult to overcome.”

### Legalistic Approach v. Transparency

Others are uncomfortable with the term as well, including some patients and families who have



**LEFT: Margaret Plews-Ogan, MD, is a physician and an associate professor and researcher at the University of Virginia Health System in Charlottesville. RIGHT: Ana Pujols McKee, MD, is the executive vice president and chief medical officer of the Joint Commission.**



suffered as a result of medical error. Dr. Wu says he stands by it, and it remains in use.

Timothy McDonald, MD, a pediatric anesthesiologist and consultant, says that while concern for providers who suffer trauma on the job has grown apace in the past 20 years, support can be short-circuited if leaders defer to their institutions' lawyers. Dr. McDonald, himself a lawyer as well as a physician, says a legalistic, "delay, deny, defend" approach is incompatible with the desired outcome of "discovery, learning and improvement."

In the 2000s, Dr. McDonald was chief risk officer at the University of Illinois at Chicago Medical Center when that institution began to explore best practices in patient safety. Dr. McDonald was part of the team that developed an influential system of response to medical error that advocated for transparency—full disclosure to the patient or family, an apology, rapid remedy if appropriate, and

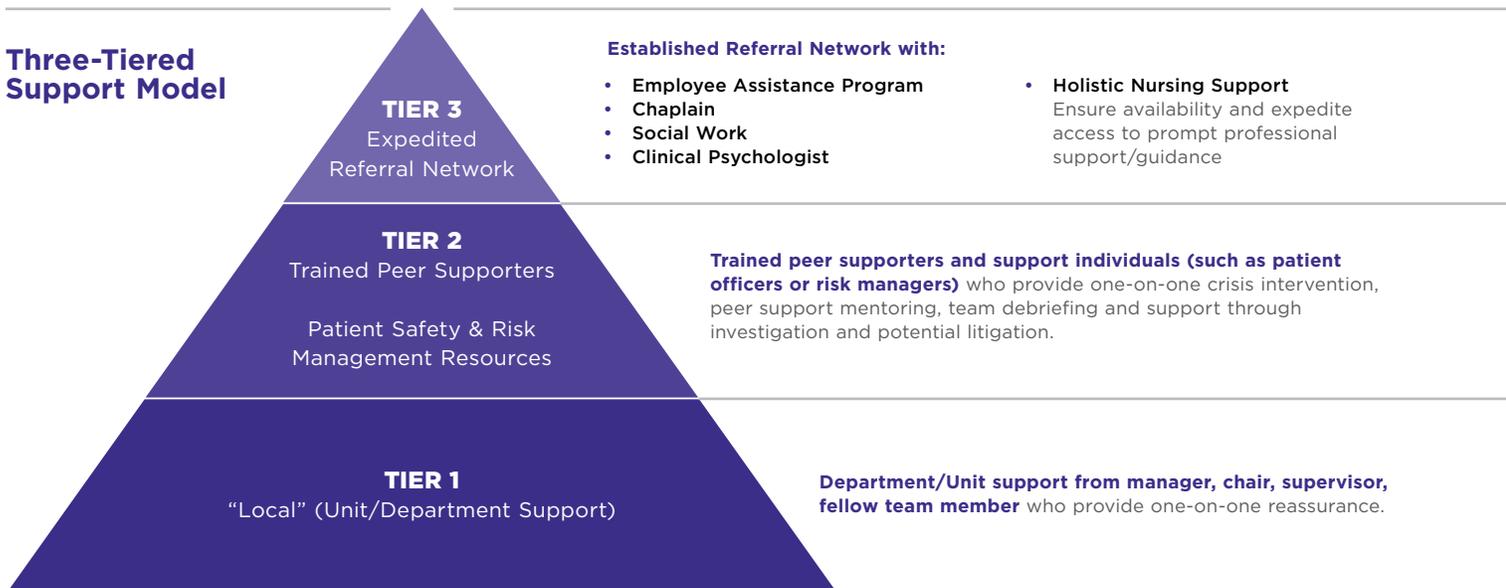
addressing systemic faults that contributed to the error.

Peers play a crucial role in supporting the second victim, but a strong patient safety culture is an essential foundation, and positive institutional leadership is key, says Ana Pujols McKee, MD, executive vice president and chief medical officer of The Joint Commission, an independent nonprofit organization that upholds standards of quality and safety in healthcare through accreditation and certification. "If leadership is not on board, then peers are going to be limited in what they can do," she says.

**"When patients do badly, the people who take care of them will always suffer."**

### Three-Tiered Support Model

Scott's team at UMHC developed and tested a peer-support model fully fledged in 2009 and now used around the world, a three-tiered model of escalating support. At each step, practitioners



**LEFT: Albert Wu, MD, MPH, is a professor of health policy and management at the Johns Hopkins School of Public Health. RIGHT: Amber Pincavage, MD, is an associate professor of medicine at the University of Chicago Medical Center.**



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are able to share their feelings and recollections without fear of repercussions, Scott says.

In the first phase, practitioners receive immediate “emotional first aid” from trained peers or supervisors in their unit. Intervention at this level is sufficient for about 60% of workers who have experienced an adverse event. At the second tier, the forYOU team, as it’s called at UMHC, is deployed to provide one-on-one peer support to the affected providers who require more care. If a team goes through an adverse event, that group is brought together with trained peers to “debrief” about the event. A third phase is activated if the first two are not sufficient, and the individual is given access to the services of a psychologist or other counseling professional. This is typically required for 10% of affected workers, Scott says.

Since 2011, Johns Hopkins has had a similar peer support program, Resilience in Stressful Events (RISE), three dozen trained peer volunteer healthcare workers who are on call 24/7, and who make themselves available to fellow providers within half an hour after stressful patient-related events throughout the 1,000-bed complex, Dr. Wu says. Johns Hopkins has exported the program that trains those peer supporters, called Caring for the Caregiver, to other hospitals in Maryland, and it may go nationwide, a recognition that the problem is widespread.

But Dr. Wu says that especially in the beginning, staff members did not take advantage of the program after adverse events. “No one called. We were all dressed up with nowhere to go,” he recalls. Then, “we took a number of measures to increase awareness among the staff, and now, in our busiest typical week, we may get 10 calls; the average might be three or four.” In a disaster scenario, “we may get 20 people at once, in a group,” he says.

Scott has found that some distressed providers fear their colleagues see asking for help as a sign of weakness. “Health care personnel do not make

very good helppees,” she says. “We’ve found that a small minority will actually reach out.”

At the second tier of Scott’s support system, if need be, trained peers will proactively contact affected workers, because her research has shown that connecting individuals with immediate support is critical to their healing. In addition, many practitioners say they have appreciated having a chance later to contribute to constructive changes in the system and the institution.

### **Change at Medical Education Level**

Amber Pincavage, MD, associate professor of medicine at the University of Chicago Medical Center, trains medical students and residents, and is working to change the reticent medical culture at the level of medical education. She is developing programs to give young physicians skills they’ll need to respond to adverse events, to “let go” after medical errors, and to support colleagues in difficult times. She is also working on a curriculum to build resilience, the ability to adapt well to challenges.

Dr. Pincavage, who herself trained at UCM, and the chief residents of two cohorts of UCM interns, Michelle Martinchek, MD, and Amber Bird, MD, did two studies that showed that their programs can make talking about adverse events easier for interns, and give team leaders new skills for addressing challenging situations. Participants said they wanted to continue to meet, preferably in a setting away from the hospital.

Says Dr. Pincavage, “My goal is to help us as a community support each other, to create a space where we can help each other through these challenges we all face and, ultimately, provide better patient care.”

*Delia O’Hara is an award-winning writer and journalist, and a former features reporter for the Chicago Sun-Times. [C](#)*