Second Victim: What is it and What Can Be Done?

Lynne M. Smith, M.D.
Chair
Department of Pediatrics
Harbor-UCLA Medical Center
Professor of Pediatrics
David Geffen School of Medicine at UCLA
Conflicts

- I have no financial or other interests which pose a conflict.
Disclosure

Data: Primarily Qualitative
When Things Go Wrong

The Surgeon as Second Victim

Jordan D. Bohnen, MD, MBA,* Keith D. Lillemoe, MD,* Elizabeth A. Mort, MD, MPH,†
and Haytham M. A. Kaafarani, MD, MPH‡

Keywords: intraoperative adverse event (iAE), medical error, peer support program, second victim

(Ann Surg 2019;269:808–809)

In a recent study, we asked a cohort of academic surgeons in Boston to describe their experiences with intraoperative adverse events and the emotional impact these events had on them.² The responses of over 125 surgeons provide alarming insight into the distress faced by many of our colleagues when things go wrong in
<table>
<thead>
<tr>
<th>Key Component</th>
<th>Helpful Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership</td>
<td>Departmental and Institutional QA endorsement</td>
</tr>
<tr>
<td></td>
<td>Faculty program leader</td>
</tr>
<tr>
<td>Core Working Group</td>
<td>Identify faculty champions</td>
</tr>
<tr>
<td></td>
<td>Identify trainee champions</td>
</tr>
<tr>
<td>Identification of Peer Supporters</td>
<td>Voting by peers</td>
</tr>
<tr>
<td></td>
<td>1 or 2 in each PGY or division</td>
</tr>
<tr>
<td>Training</td>
<td>Expert-guided training session</td>
</tr>
<tr>
<td></td>
<td>Written and online resources</td>
</tr>
<tr>
<td>Database</td>
<td>Secure database for record-keeping</td>
</tr>
<tr>
<td></td>
<td>(deidentified as needed)</td>
</tr>
<tr>
<td>Protection</td>
<td>Obtain QA peer-review protection (ie, like M&amp;M conferences)</td>
</tr>
<tr>
<td>Outreach Algorithm</td>
<td>Peers identify colleagues after challenging case</td>
</tr>
<tr>
<td></td>
<td>Outreach email sent by Program leader to affected individuals. Includes offer to speak with peer supporter and list of additional resources</td>
</tr>
<tr>
<td></td>
<td>Assignment of resident and faculty peer supporters to affected individuals</td>
</tr>
<tr>
<td></td>
<td>Peer supporter and affected colleague schedule informal meeting/call at their convenience</td>
</tr>
</tbody>
</table>

M&M indicates Morbidity and Mortality; QA, Quality Assurance.

*Nb. Programs are advised to tailor specific elements to their local context and needs.*
The Scott Three-Tiered Interventional Model of Second Victim Support

Tier 3: Expedited 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
- 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.

Tier 1: ‘Local’ (Unit/Department) Support
- Department/Unit support from manager, chair, supervisor, fellow team member who provide one-on-one reassurance and/or professional collegial critique of cases.

Abandon the term “second victim”

An appeal from families and patients harmed by medical errors

Melissa D Clarkson assistant professor¹, Helen Haskell president², Carole Hemmelgarn patient advocate³, Patty J Skolnik president⁴

¹Division of Biomedical Informatics, University of Kentucky, Lexington, KY, USA; ²Mothers Against Medical Error, Columbia, South Carolina, USA; ³Highlands Ranch, CO, USA; ⁴Citizens for Patient Safety, Centennial, CO, USA

BMJ 2019;364:l1233 doi: 10.1136/bmj.l1233 (Published 27 March 2019)
Objectives

1) To understand the concept and importance of second victim
2) To recognize risk factors for the development of second victim
3) Interventions for second victim
   Individual
   Institutional
Objectives

1) To understand the concept and importance of second victim
2) To recognize risk factors for the development of second victim
3) Interventions for second victim
   Individual
   Institutional
Definition

“Second victims are health care providers who are involved in an:

- unanticipated adverse patient event
- a medical error, and/or
- a patient related injury

and become victimized in the sense that the provider is traumatized by the event.”

CASE
Real World Example  Kimberly Hiatt
Kimberly Hiatt

• Served as a critical care nurse at a prestigious children’s hospital for over 20 years

• Administered 10 times the dose of Calcium Chloride (1400 mg instead of 140 mg) to an 8 month old in the Cardiac Critical Care Unit
Kimberly Hiatt

- She immediately reported it verbally to her colleagues as well as in the hospital electronic reporting system.
"I messed up. I’ve been giving CaCl (Calcium Chloride) for years. I was talking to someone while drawing it up. Miscalculated in my head the correct mls according to the mg/ml. First med error in 25 years of working here. I am simply sick about it. Will be more careful in the future."
Before the end of her shift she was escorted out of the building
Kimberly Hiatt

Placed on administrative leave and then fired

State prosecutors considered manslaughter charges

She fought hard to keep her state nursing license
State Nursing Board

- $3,000 fine and 80 hours of didactics
- Four years of probation where supervisor report was required every 90 days
- Job applications and inquiries produced no leads for a new nursing position
“She was basically a healer. She told me she lost everything.”

April 3, 2011
“She was in such anguish, she ran out of coping skills.”

April 3, 2011
First Victim—The Patient and Her Family
Investigation records noted this was her first medication error.

Second Victim—The Health Care Professional
What is a Second Victim?

"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”

To Err is Human
Healthcare is a high risk profession

- Institute of Medicine Report

- At least 44,000 and possibly as high as 98,000 die in the US annually due to medical errors
And it’s worse than we thought

Each year, at least 210,000 patients and possibly more than 400,000 die related to preventable harm in hospitals.

4 clinicians/patient = 840,000 to 1.6 million clinicians impacted

DANGER SIGNS

Safety events owing to EHR and other health IT issues have been steadily rising. Even so, experts say cases are widely underreported.

SAFETY-RELATED INCIDENTS LINKED TO EHR OR OTHER IT

SOURCE: QUANTROS
Electronic Medical Record

“\textbf{In America, we have 11 minutes to see a patient and….you’re not going to be empathetic, make eye contact enter about 100 pieces of data and never commit malpractice. It’s not possible!”}

\textit{John Halamka CIO of Beth Israel Deaconess Medical Center who served on EMR standards committee for George W Bush and Barack Obama}

\textit{Death by a thousand clicks Fortune April 2019}
How many clicks in a 10 hour shift in the ED?

- a) 800
- b) 1400
- c) 2100
- d) 2700
Brief Report

4000 Clicks: a productivity analysis of electronic medical records in a community hospital ED

Robert G. Hill Jr., MD, Lynn Marie Sears, MBA *, Scott W. Melanson, MD

Emergency Department, St Luke’s University Health Network, Allentown, PA 18104

ABSTRACT

Objective: We evaluate physician productivity using electronic medical records in a community hospital emergency department.

Methods: Physician time usage per hour was observed and tabulated in the categories of direct patient contact, data and order entry, interaction with colleagues, and review of test results and old records.

Results: The mean percentage of time spent on data entry was 43% (95% confidence interval, 39%-47%). The mean percentage of time spent in direct contact with patients was 28%. The pooled weighted average time allocations were 44% on data entry, 28% in direct patient care, 12% reviewing test results and records, 13% in discussion with colleagues, and 3% on other activities. Tabulation was made of the number of mouse clicks necessary for several common emergency department charting functions and for selected patient encounters. Total mouse clicks approach 4000 during a busy 10-hour shift.

Conclusion: Emergency department physicians spend significantly more time entering data into electronic medical records than on any other activity, including direct patient care. Improved efficiency in data entry would allow emergency physicians to devote more time to patient care, thus increasing hospital revenue.

© 2013 Elsevier Inc. All rights reserved.
Reporting Systems

The Emotional Impact of Medical Errors on Practicing Physicians in the United States and Canada

Amy D. Waterman, Ph.D.
Jane Garbutt, M.B., Ch.B.
Erik Hazel, Ph.D.
William Claiborne Dunagan, M.D.
Wendy Levinson, M.D.
Victoria J. Fraser, M.D.
Thomas H. Gallagher, M.D.
Impact

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

- Increased Anxiety about Future Errors*: 66%
- Decreased Job Confidence*: 51%
- Decreased Job Satisfaction*: 48%
- Increased Sleeplessness*: 48%
- Harm to Professional Reputation*: 15%

*Serious Error, Minor Error, Near Miss

% Reported Error-Related Impact

Figure 3  Emotions and reactions experienced by respondents who self-reported making a mistake. Respondents could select multiple outcomes.
Surgeons

- 125 surgeons at Mass General
- 90% reported experiencing an intraoperative adverse event
- Nearly 100% reported strong feelings of anxiety, guilt, sadness, shame and/or embarrassment

Bohnen JD et al. When things go wrong The surgeon as Second Victim *Annals of Surgery* 269 (5) 808-809, May 2019
• “We all hide our grief, suffer in silence. The pain can be close to debilitating”

Bohen JD et al. When things go wrong The surgeon as Second Victim  Annals of Surgery 269 (5) 808-809, May 2019
Objectives

1) To understand the concept and importance of second victim

2) To recognize risk factors for the development of second victim

3) Interventions for second victim
   - Individual
   - Institutional
Risk Situations for Second Victim

- Preventable harm to patient/medical errors
- Community high-profile patient or event
- Notification of pending litigation
Risks for being adversely affected

- **Infrequency of self disclosure about mistakes to colleagues, family and friends leading to isolation**
  - “Good doctors do not make mistakes”
    - (The Emotional Fallout from the Culture of Blame and Shame  JAMA Pediatrics 171:12, p 1141 2017.)
Risks for being adversely affected

- Infrequency of self disclosure about mistakes to colleagues, family and friends leading to isolation

- Lack of emotional support
Risk

Lack of emotional support

The Swiss cheese model of accident causation illustrates that, although many layers of defense lie between hazards and accidents, there are flaws in each layer that, if aligned, can allow the accident to occur.
Inquiries

• Debriefings after the event
• Root Cause Analysis
• M&M Divisional/Department
• Litigation preparation
Risks for being adversely affected

- Infrequency of self disclosure about mistakes to colleagues, family and friends leading to isolation

- Lack of emotional support

- If the health care institution or an area within the facility that has a culture of
  - Blame
  - Shame
Risks for being adversely affected

“We see the horror of our own mistakes, yet, we are given no permission to deal with their enormous emotional impact....the medical profession simply has no place for its mistakes”

Hilfiker D Facing our mistakes. NEJM 1984;310(2) 118-22
The role of talking (and keeping silent) in physician coping with medical error: A qualitative study

Natalie May *, Margaret Plews-Ogan

Department of Medicine, Division of General Medicine, Geriatrics and Palliative Care, University of Virginia Health System, Charlottesville, USA
Unhelpful Conversations

Family or colleagues downplay the event or only say things in an attempt to make the individual feel better.
What Can Be Done?

Just Culture regarding medical errors

“Systems should be in place to offer emotional support to the clinician, even (or perhaps especially) in the case of clear negligent error.”

Pratt SD and Jachna BR. Care of the clinician after an adverse event. International Journal of Obstetric Anesthesia, Volume 24, Issue 1, 54 - 63
Objectives

1) To understand the concept and importance of second victim
2) To recognize risk factors for the development of second victim
4) Interventions for second victim
   Individual
   Institutional
Stages of Healing: The Second Victim Recovery Trajectory

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

Challenges to providing support

• SILENCE!
The role of talking (and keeping silent) in physician coping with medical error: A qualitative study

Natalie May *, Margaret Plews-Ogan

Department of Medicine, Division of General Medicine, Geriatrics and Palliative Care, University of Virginia Health System, Charlottesville, USA
Silence (self imposed)

“I was too ashamed to tell any of my colleagues....if I tell them, they’re not going to trust me to cover their patients and they’re not going to think I’m smart anymore”
Silence (colleagues)

• “I think my friends and the chief residents cared at the moment, but...there is the sense that “Okay, now pull it together...””
Silence (leadership)

• ".. The chairman, the guy who’d recruited me to come there, never said a word to me....Sure, don’t talk about the case, but wouldn’t it have been nice to have heard....‘we think a lot of you and we’ve got your back’..."
Challenges to providing support

- SILENCE!
- Fear of making a mistake with a colleague
Unhelpful conversations

- “I took the resident aside and said, ‘I don’t know if I am suited to medicine or not’ and my resident said, ‘Yeah, you’re right. Maybe you are not’.”
First Tier – ‘Local’ support

Colleagues/Peers

- “Be there” for your co-worker and listen
- Don’t ask about specific details of the event…. Instead, focus on how your colleague is feeling.
Second Victim anxieties

• Patient
  – Is the patient/family okay?

• Me
  – Will I be fired?
  – Will I be sued?
  – Will I lose my license?

• Peers
  – What will my colleagues think?
  – Will I ever be trusted again?

• Next Steps
  – What happens next?
Peer Support Statements

- You've just been through a lot
- This sounds really hard, I am so sorry
- I am so glad you could share this with me
- I don't know what to say, yet I am really glad you told me
- I want you to know that YOU ARE NOT ALONE.
Challenges to providing support

• SILENCE!

• Fear of making a mistake with a colleague

• Risk Management Concerns
Risk Management Tips

Find a quiet, private place for encounter

Make efforts to focus encounter on providing emotional support

Second victims may share concerns about liability/litigation with you.

Do not review the medical record!
First Tier – ‘Local’ support

Leaders

• Connect with clinical staff involved

• Notify staff of next steps – keep them informed

• Check on them regularly
Helping Healers Heal (H3)

Tier 3
Advanced Referral Network

Tier 2
Trained Peer Supporters

Tier 1
Local (Unit/Department) Support
H3 Founders

Drs. Eric Wei and Tobi Fishel
Peers supporting Peers

One on one support

Team Debriefings
Second Tier Interventional Strategy

- **One on one peer support**
- **Team Debriefings**
Team Debriefings

This is not the same as the debriefings for post-resuscitation events (NRP) debriefings.

- What went well?
- What could improve?
- Summarize important points learned
Tier 2: Group debrief

Homogenous group

3-12 people

- Sit in a private place, in a circle
- Have tissues available in the center of the circle
- Main facilitator introduces the group debrief and H3 team (usually two peer facilitators)
Processing event with team

- “I think the turning point for me was really when 2 of my colleagues and I each shared our story....I didn’t share just a story; I shared the feelings.......all the regret and loss....That was so important, because I was still carrying around so much shame and guilt.”

Harbor-UCLA Second Victim

• One-on-One colleague support
• Social Work and Psychiatry group debriefs available to all staff 24/7

• Emotional First Aid not Therapy
Third Tier Interventional Strategy

Expedited Referral to Experts: Clinical Psychologists, Chaplains, Employee Assistance Program (EAP), Social Workers, Holistic Nurse or Personal Counselor.

NOT DISCOVERABLE!
Fig. 1. Supports reported as required and useful by Second Victims.
Challenges to providing support

• SILENCE!

• Fear of making a mistake with a colleague

• Risk Management Concerns

• Stigma associated with reaching out for help
The mission of the H³ Program is to increase awareness of second victim syndrome, destigmatize suffering and seeking help, and provide support to staff through 1:1 peer support, group debriefs, and mental health specialists.
What can you do?

- Educate colleagues about second victim
- Remove the stigma of reaching out for help
What can you do?

- Be supportive of colleagues after a high risk event
  - “YOU ARE NOT ALONE!”

- Share your story with a colleague (if you have one)
Lynne M. Smith, M.D.
Chair
Department of Pediatrics
Harbor-UCLA Medical Center
lysmith@dhs.lacounty.gov