Adverse Events and the Second Victim

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Medical error: the second victim

The doctor who makes the mistake needs help too

When I saw a house officer another resident alerted us to the electrocardiographic signs of the pericardial tamponade that was pushing the patient to the operating room late that night. The news spread rapidly, the case file passed swiftly before an incredulous jury of peers, who returned a summary judgment of incompetence I was dismayed by the lack of sympathy and woe-stricken if I could have made the same mistake—and like the house staff, the second victim of the error.

Improvements that could decrease errors Many errors are built into existing routines and devices, such as the misleading physician and patient for disaster. And although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors that are the second victims. Virtually every patient knows the sickening realisation of making a bad mistake. But feel helpless and obscured—deceived by the woe-stricken if one does not have the

Wu AW. BMJ 2000
Definition

• A health care provider involved in an unanticipated adverse patient event and/or medical error who is traumatized by the event

Acute Stress Reaction

• Initial dazed state: tunnel vision, inability to comprehend stimuli, disorientation
• Withdrawal / detachment
• Agitation, hyperactivity
• Anxiety, depression
• Impaired judgment
• Confusion
• Amnesia
• Symptoms appear within minutes of the impact of the stressful event, disappear within 2–3 days
  (Walter Cannon)
Short Term Symptom (Days – Weeks)

- Numbness, Confusion
- Detachment / Depersonalization
- Grief, depression, anxiety
- Withdrawl or agitation, sleep disturbance
- Re-experiencing of the event
- Physical symptoms
- Shame / guilt
- Anger
- Self-doubt

PTSD

- Re-experiencing the original trauma through flashbacks, nightmares
- Avoidance of stimuli associated with the trauma
- Increased arousal: difficulty falling or staying asleep, anger, hypervigilance
- Symptoms lasting > one month
- Cause significant impairment in functioning

Natural History of the Second Victim

(1) Clinician response to initial incident
Josie’s Story

A Mother’s Inspiring Quest to Make Medical Care Safe

SORREL KING

• “Josie died of dehydration and misused narcotics”

Josie died of sepsis and resulting dehydration

Josie’s Story

SAFE PATIENTS, SMART HOSPITALS

How One Mother’s Death Can Help Us Change Health Care From the Inside Out

Peter Pronovost, M.D., M.B.A., and Eric Topol

www.josieking.org
From Closing Ranks to...

...Under the Bus

- Good disclosure but poor follow through
- At expense of the feelings of health care workers?

Doing better but feeling worse

Coup / Contrecoup
Natural History of the Second Victim

(1) Initial response to incident
(2) Peer response
(3) Investigation
(4) Malpractice suit
Multiple Second Victim Traumas

Prevalence

- Prevalence estimates 10-43%
  - Otolaryngologists – 10% (Lander 2006)
  - Health professionals - 30% (Scott 2009)
  - Medication errors – 43% (Wolf 2000)
  - Health professionals – 50% (Edrees 2011)

Burnout Symptoms

- Procrastination
- Chronic fatigue
- Cynicism
- Tardiness
- Anhedonia
- Pessimism
- Diminished future outlook
- Loss of life satisfaction
Participant Characteristics by Percentage (n=140)

Supportive strategies desired within health care organizations (n = 95)

<table>
<thead>
<tr>
<th>Desired support strategy</th>
<th>Percent Agree</th>
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</thead>
<tbody>
<tr>
<td>Personal emotional support</td>
<td>35.5</td>
</tr>
<tr>
<td>Formal emotional support</td>
<td>28.7</td>
</tr>
<tr>
<td>Prompt debriefing, crisis intervention, stress management (indiv or group/team)</td>
<td>74.3</td>
</tr>
<tr>
<td>Access to counseling, psychological, or psychiatric services</td>
<td>35.7</td>
</tr>
<tr>
<td>An opportunity to discuss any ethical concerns you had relating to the event or the processes that were followed subsequently</td>
<td>45.9</td>
</tr>
<tr>
<td>An opportunity to take time out from your clinical duties</td>
<td>32.1</td>
</tr>
<tr>
<td>Supportive guidance/mentoring as you continued with your clinical duties</td>
<td>30.9</td>
</tr>
<tr>
<td>Help to communicate with the patient and/or family</td>
<td>33.3</td>
</tr>
<tr>
<td>Peer and timely information about the processes that are followed after serious adverse events (e.g., peer review preparation of incident reports)</td>
<td>43.6</td>
</tr>
<tr>
<td>Guidance about the roles you were expected to play in the processes that are followed after serious adverse events</td>
<td>24.4</td>
</tr>
<tr>
<td>Help to prepare to participate in the processes that were followed after the serious adverse event</td>
<td>20.2</td>
</tr>
<tr>
<td>Make opportunity to contribute any insights you had into how similar events could be prevented in the future</td>
<td>44.4</td>
</tr>
<tr>
<td>Personal legal advice and support</td>
<td>20.7</td>
</tr>
<tr>
<td>Other</td>
<td>3.3</td>
</tr>
</tbody>
</table>
**Familiarity and experience with second victims (n = 140)**

<table>
<thead>
<tr>
<th>Survey questions (number of responses)</th>
<th>Percentage Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heard the term &quot;second victim&quot; used to describe healthcare workers who have been emotionally affected by an unanticipated clinical event (n = 139)</td>
<td>46%</td>
</tr>
<tr>
<td>Can recall an adverse event in which you were a second victim (n = 139)</td>
<td>60%</td>
</tr>
<tr>
<td>Incident occurred at Johns Hopkins (n = 87)</td>
<td>62%</td>
</tr>
<tr>
<td>Experienced any problems, such as anxiety, depression, or concern about ability to perform the job (n = 83)</td>
<td>66%</td>
</tr>
<tr>
<td>Reached out for support or talk to someone about the incident (n = 85)</td>
<td>69%</td>
</tr>
<tr>
<td>Received support from anyone in health system in which event occurred (n = 83)</td>
<td>52%</td>
</tr>
</tbody>
</table>

**Developmental Stages**

<table>
<thead>
<tr>
<th>Year</th>
<th>Components</th>
</tr>
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<tbody>
<tr>
<td>2000</td>
<td>Safety</td>
</tr>
<tr>
<td>2001</td>
<td>Disclosure</td>
</tr>
<tr>
<td>2004</td>
<td>Reporting</td>
</tr>
<tr>
<td>2010</td>
<td>Self Care</td>
</tr>
</tbody>
</table>

**Care for Caregivers**

- Learn from Mistakes
- Being Open
- Do No Harm

**Components**

- **Awareness** for all
- Training for experts to give peer support
- Policy & Procedures for first responders
- Coordination with existing resources
- Varied interventions
- Resilience
Awareness

Things to Say (and Not to Say) to a Colleague after an Adverse Event

<table>
<thead>
<tr>
<th>Things to say</th>
<th>Things to not say</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>You supportive.</em></td>
<td><em>You're a failure.</em></td>
</tr>
<tr>
<td><em>You tough times.</em></td>
<td><em>You're weak.</em></td>
</tr>
<tr>
<td><em>You're doing this.</em></td>
<td><em>You're not doing this.</em></td>
</tr>
<tr>
<td><em>You just keep going.</em></td>
<td><em>You're not doing well.</em></td>
</tr>
<tr>
<td><em>You did everything you could.</em></td>
<td><em>You need to get over it.</em></td>
</tr>
<tr>
<td><em>You're a good team member.</em></td>
<td><em>You're not a good team member.</em></td>
</tr>
<tr>
<td><em>Didn't you realize what would happen?</em></td>
<td><em>I wasn't expecting that.</em></td>
</tr>
<tr>
<td><em>I wouldn't have done that.</em></td>
<td><em>I was expecting that.</em></td>
</tr>
<tr>
<td><em>You need to get over it.</em></td>
<td><em>You're doing fine.</em></td>
</tr>
</tbody>
</table>

Mental Health / Psychological First Aid

- “The help provided to a person developing a mental health problem or in a mental health crisis. The first aid is given until appropriate professional treatment is received or until the crisis resolves.” (Blain, Hoch & Ryan 1944; Everly 2001; Kitchener, Jorm 2002)
Training
- Reflective Listening
- Assessment of Needs
- Prioritization
- Intervention
- Disposition

Policy
Conway, Federico, Stewart, Campbell
2nd ed 2011

FASAP
The Faculty and Staff Assistance Program
Scott 3-Tiered Model for Second Victim Support

Sue Scott
University Of Missouri

RISE: Continuum of Care and Support
Second Victims Peds Pilot

- Awareness Campaign:
  - “Healing After Errors: Compassion for Clinicians”
  - June 24 (see flyer)
- Focus of the Pilot:
  - Scope of “Second Victim” Incidents
    - Rapid Response Team (but not limited to this)
    - Self Referral
    - Referrals by unit management, colleagues, etc.
  - Second Victim Peer Support
    - Curriculum development for peers
    - Tools for Frontline Providers

Caring for the Caregivers

- Expressive writing (Pennebaker)
- Paradigm
  - Write for 3-5 days, 15-30 min per day
  - Anonymous, no feedback

Comprehensive Strategy for AEs

- Governance and leadership set expectations and culture
- Policies & processes
- Consistent message
- Training and support
- Disclosure to patients
- Caring for caregivers
- Learning from errors
For patients – brochure, stories
For clinicians – staff survey
For organizations - Staff support assessment tool

Linda Kenney

CLINICIAN SUPPORT TOOL KIT FOR HEALTHCARE

<table>
<thead>
<tr>
<th>Core Elements</th>
<th>Things to Consider</th>
</tr>
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<tbody>
<tr>
<td>Informed Culture of Safety</td>
<td></td>
</tr>
<tr>
<td>Staff, physician, and themselves</td>
<td></td>
</tr>
<tr>
<td>Culture,</td>
<td></td>
</tr>
<tr>
<td>Patient Safety</td>
<td></td>
</tr>
<tr>
<td>Patient,</td>
<td></td>
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<tr>
<td>Staff,</td>
<td></td>
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SAFETY PRACTICE B: CARE OF THE CAREGIVER

The Objective
Provide care to the caregivers inherent practice of staff, medical providers, and administrators involved.

The Problem
The harm to patients and families from preventable adverse events resulting from patient, family, or hospital error should never be missed and may result from the form that occurs in our communities. However, since these errors are also critical to patient care, this problem is critical to patient care. Understanding this problem is critical to patient care.

The Solution
The problem is by providing an evidence-based framework for the care of caregivers, which includes:
- Prevention strategies
- Staff education
- Patient involvement
- Hospital protocols

The Expected Outcome
By implementing these strategies, caregivers will be better equipped to provide safe care to patients, reducing the risk of harm and improving patient outcomes.
Re-envisioning the Sentinel Event

Humanistic Investigation

• Begin every investigation with:

“This must be very difficult for you. How are you doing?”

Johns Hopkins
Second Victims Working Group

• Lori Paine, Hanan Edrees, Cheryl Connors, Lolita Carter-Ross; Bob Feroli; Carol Stansbury; Cynda Rushton; Cynthia Duter; Deborah Baker; Deborah Hillard; Deborah Hobson; Doris Thomas-Dow; Ella Ndi; Felipe Torres; Gail Biba; Geetha Jayaram; Janel Sexton; Jeffrey Natterman; Julie Kubiak; Laura Kress; Laurie Saletnik; Lori Paine; Marvin Pittman; Michelle Carlstrom; Michelle Patch; Pamela Paulk; Pat Triplett; Peggy Hood; Reatha Holt; Redonda Miller; Renee Demska; Rhonda Wyskiel; Sharlene Trusty; Sharon Krumm; Shelley Baranowski; Stephen Achuff; Susan Will; Timothy Levens; Tracey Adams; Vanessa Munguia; William Bell
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