

Recognizing and Supporting Second Victims

What is Second Victim Syndrome?

Second Victims are “healthcare providers who are involved in an unanticipated adverse patient event, medical error and/or a patient related injury and become victimized in the sense that the provider is traumatized by the event.” In a BMJ article published in 2000, Albert Wu, coined the term “second victim” referring to the impact on the healthcare providers involved in a negative patient outcome- especially when there has been an error or the provider feels responsibility for the outcome. These events may cause the provider to feel guilty, fearful, frustrated, anxious, depressed, demoralized and even suicidal

What is the impact of Second Victim Syndrome (SVS)?

Providers can feel personally responsible for the unexpected patient outcomes, feel as though they have failed the patient, second-guess their clinical skills and knowledge base.

Some become burnt out or quit medicine altogether. A survey from the University of Missouri revealed 30% of respondents felt “persistently bad and at least somewhat impaired during the first year after an incident”. Another survey of practicing American and Canadian physicians many suffered from anxiety regarding future errors (61%), loss of confidence (44%), sleep disturbances (42%) and lower job satisfaction (42%). Only 10% of these doctors felt the institutions supported them adequately.

Psychological Symptoms:

Anger/Irritability, Depression, Extreme Sadness, Fear, Feeling numb, flashbacks, frustration, isolation, self-doubt, loss of interest to return to work

Physical Symptoms:

Diarrhea, Difficulty concentrating, eating disturbance, fatigue, headache, muscle tension, nausea/vomiting, rapid breathing, rapid heart rate, sleep disturbance

These feelings and signs/symptoms can last from a few days to weeks to months and even longer.

Studies have shown that traumatized providers can become isolated with little communication and a negative impact at work. SVS is also linked to low morale, increased medical error, impaired job performance, absenteeism and leaving the profession all together.

What can you do to Support Providers with Second Victim Syndrome?

-Awareness and education of Second Victim Syndrome within your Department and Institution can normalize the feelings associated with SVS, and encourage providers to seek help when dealing with SVS.

-Develop a Peer-to-Peer Support system within your Department and/or Institution to ensure providers are receiving ‘emotional first aid’, providing resources for continued support, creating a

culture of no blame mentality, and help clinicians return to pre-event levels of clinical performance.

There is increasing awareness of the desire and benefit of peer support in these situation. A survey by Burlson and colleagues of pediatric healthcare providers indicated that the first choice of support was from “a respected peer to discuss the details of what happened.” Another study from Beth Israel Deaconess also indicated that peers were the “most popular” support source (88%) whereas employee assistance programs was at 29% and mental health professionals were at 48%.

[Click here](#) to learn more about what you can do to increase awareness of Second Victim Syndrome and to help support providers who experience a second victim response to a clinical event. (***embed presentation of SVS***)

SECOND VICTIM TOOLKIT

Does your department/institution have a need for an SVS program?

- Recent studies have shown that there is still a lack of awareness and understanding about Second Victim Syndrome. Most residents (>60% surveyed) have never heard of the term. Studies also describe that first level intervention (simply having a supportive and safe environment where a discussion about the provider's concerns and to debrief the case) help a majority of sufferers (approx 60%). Having a tiered support system in place will help to address the other 40% of providers who may need additional support.

Steps to developing a Second Victim Syndrome, consider implementing a program at either the Departmental level and/or the Institutional level

1. Determine the resources already in place for provider support (Risk Management, Human Resources, EAP, psychiatry, other services available within your department or institution)
2. Create a survey that evaluates the awareness and prevalence of SVS, as well as the current level of support within your department/institution (**[example survey link](#)**)
3. Engage champions and leadership at the departmental level and/or institutional level to help create a task force.
 - Outline a strategic plan (including identifying key players in the department or institution)- Sue Scott's one page checklist (2016): **[click here](#)** for checklist (for risk management, c-suite)
 - Create a team made up of all or most of these departmental representatives:
Clinical (i.e. Emergency Medicine, Surgery, Medicine, Pediatrics) SVS champion(s) (3-5 representatives with interest in SVS), Human Resources representative, C-Suite representative, Nursing Leadership representative, APP leadership representative, Patient Safety and Quality representative, Risk Management representative, Clinical Health Psychologist representative, Employee Assistance Program representative, Chaplain representative
 - **[Click here](#)** for MITSS clinician support toolkit (based on the MITSS organizational assessment tool)

4. Does your Hospital have an established Patient Safety/Quality program in place? If so, identify ways to formalize how medical errors are handled with Risk Management.
5. Develop a formal operation for the program with protocols for activation and for training the peer supporters
Sue Scott Training resources
6. Education of SVS within your department and institution (**Click here for the SVS Powerpoint developed by CORD**)
 - Consider creating a 10-15 slide ppt for programs to use for education
 - Down the road, consider creating 5-10 minute didactic videos
 - Consider compiling real stories of EM docs who have experienced SVS
 - Consider sharing this TED TALK by Brian Goldman “Doctors making mistakes”:https://www.ted.com/talks/brian_goldman_doctors_make_mistakes_can_we_talk_about_tha_t
7. Implementation of a SVS program.
 - Develop your own SVS program within your department/institution.
 - Consider a post implementation survey to determine the impact your program has on your department/institution.

NAMES TO KNOW

- Ø Albert Wu MD,MPH- Johns Hopkin – coined term “second victim”
- Ø Sue Scott RN MSN- University of Missouri- For You Program
- Ø Jo Shapiro, MD-ENT- Brigham and Women’s (medical error/program developer)
- Ø F Van Pelt MD- Anesthesia-Brigham and Women’s (medical error/program developer)
- Ø Linda Kenney- MITSS
- Ø Christopher Jerry/Eric Cropp- The Emily Jerry Story -pharmacist error/child death
- Ø Kim Haitt- nurse who completed a suicide after a medical error
- Ø Sidney Dekker- Australia- professor, speaker and writer on human error and safety including Just Culture and Second Victim

PROGRAMS

Ø Center for Professionalism and Peer Support (CPPS)

Brigham and Women’s Hospital

Jo Shapiro- jshapiro@partners.org (offices at BWHCPPS@partners.org or (617) 525-9797)

Website: http://www.brighamandwomens.org/medical_professionals/career/cpps/PeerSupport.aspx

FAQ’s:

http://www.brighamandwomens.org/Medical_Professionals/career/CPPS/Documents/Peer_Support_Overview_and_FAQ.pdf

Ø Caring for the Caregiver

University of Missouri

Sue Scott

Contact: 573-884-4273

Website:

<http://www.muhealth.org/about/quality-of-care/office-of-clinical-effectiveness/foryou-team/caring-for-caregivers/>

Ø WELLMD Peer Support Program

Stanford

Harise Stein (Program Director)

Website: <http://wellmd.stanford.edu/get-help/peer-support.html>

Contact Numbers: <http://wellmd.stanford.edu/get-help.html> (faculty, resident and student contact numbers)

Ø Resilience in Stressful Events

Johns Hopkins

Albert Wu

Website: <http://safeathopkins.org/resources/johns-hopkins/rise/>

Ø Peer2Peer Support (Resilience Council)

University of Colorado

Jenny Reese

Contact: ResilienceCouncil@ucdenver.edu

Website:

<http://www.ucdenver.edu/academics/colleges/medicalschooll/facultyAffairs/Resilience/Peer-to-Peer/Pages/Peer-to-Peer.aspx>

Ø You Matter

Nationwide Children's (Ohio)

Contact: SecondVictimSupport@NationwideChildrens.org

Website:

<http://www.nationwidechildrens.org/medical-professional-publications/best-outcomes-in-action-you-matter-second-victim-program?contentid=148138>

Ø CandOR (Communication and Optimal Resolution Program)

Medstar Institute for Quality and Safety

Contact: 410 772 6562 (patientsafety@medstar.net)

Phone: (410) 772-6562

Fax: (410) 772-6563

Website: <http://www.medstarhealth.org/quality-and-safety/communication/candor-program/#q={}>

Ø Medically Induced Trauma Support Services

National

Linda Kenney

Contact: Caregivers Support- caregiverse@mitss.org

Healthcare Organization Support healthorg@mitss.org

Toll free- 1-888-36MITSS (2-888-366-4877)

Website:

<http://www.muhealth.org/about/quality-of-care/office-of-clinical-effectiveness/foryou-team/caring-for-caregivers/>

RESOURCES

Ø Sidney Dekker on Second Victim Syndrome (video 6 minutes 16 seconds)

<https://www.youtube.com/watch?v=YeSvCEpg6ew>

Ø Surfing the Healthcare Tsunami: Chris Jerry and Eric Cropp (video 3 minutes 9 seconds)

https://www.youtube.com/watch?time_continue=1&v=MseId9FcVOI

Ø A Hospital Accident: Lessons Learned- A Death, A Conviction and A Healing (Webinar 93 mins)

Sponsor: Texas Medical Institute of Technology (TMIT), a non-profit medical research organization dedicated to driving adoption of clinical solution in patient safety and healthcare performance improvement

Website: http://www.safetyleaders.org/webinars/indexWebinar_June2011.jsp

“Hear directly from the father who lost a child, the pharmacist who went to jail, and the experts who share best practices....Caregivers are still being fired without supportive care, leading to suicides, broken lives and wounded spirits.”

Ø Second Victim Trajectory Table

https://psnet.ahrq.gov/media/perspectives/images/persp102_f01.jpg

“Six stages that described the second victim recovery process: (i) chaos and accident response, (ii) intrusive reflections, (iii) restoring personal integrity, (iv) enduring the inquisition, (v) obtaining emotional first aid, and (vi) moving on. The sixth stage was unique in that it led to one of three potential outcomes: dropping out, surviving, or thriving. The table illustrates the six-stage recovery trajectory as well as stage characteristics and recommended institutional interventional coping strategies.”

Ø Caring for the Caregiver (Workshop)

<https://www.johnshopkinssolutions.com/solution/rise-peer-support-for-caregivers-in-distress/>

“Based on the Johns Hopkins RISE program, Caring for the Caregiver provides guidelines for interested individuals to seek and secure buy-in from their hospital leadership to implement the program in addition to workshops and materials to train peer responders in how to adapt and create a support infrastructure. Participants will also learn how to implement RISE in their institution and receive support once the program is adopted.”

Ø Building A Clinician Support Program: Assessment Worksheet and Planner

http://www.mitsstools.org/uploads/3/7/7/6/3776466/building_a_second_victim_support_programdecember3.pdf

“This working document can be used as a roadmap for implementation of a clinician support program. Using the document will help ensure that action items are completed and in place for clinician support deployment. There are a total of six sections within this worksheet that address necessary support elements needed for a clinician support response team deployment.”

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