How to support clinicians involved as second victims after serious clinical adverse events

Frank Federico
Executive Director: IHI
Supporting clinicians after medical error

The needs of these "second victims" are often ignored

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Clinicians who are unable to cope with their emotions after a medical error or adverse event are suffering in silence. These healthcare providers are often told to take care of the next patient without an opportunity to discuss the details of the event or share how this has affected them personally and professionally. While patients and families are the first victims of such events, we refer to the healthcare providers who are involved as the second victims.1

Second victims may feel guilt, fear, anxiety, or anger and experience social withdrawal, disrupt sleep, and develop alcohol or drug abuse, depression, and insomnia. They tend to doubt their clinical skills, feel as though they have failed the patient, and worry about what their colleagues think. They are embarrassed to request emotional support and feel that the organization has abandoned them. Often, those symptoms are experienced by not only one healthcare provider but a majority of the healthcare team who have either taken care of the patient or were affected by the error because of their role in the organization or their physical proximity to the event. This can affect the provider-patient relationship, and if not managed properly, organizations can face clinical and financial challenges. Over time, second victims may develop signs and symptoms related to post-traumatic stress disorder (PTSD). As a result, these healthcare providers have difficulty forgiving themselves and some may even commit suicide.1

Recent international headlines highlighted the emergence of second victims and the need for support. These range from direct and indirect events, such as that of Kimberly Hiatt, the nurse who committed suicide after a medical error in the US, to more distant events, such as the case of Sunmi Haenssle, the nurse who received a craniocerebral injury after falling from a height at work.2 Addressing the problem of second victims can be sensitive topic given the stigma attached to being involved in a medical error. Over the past decade, system changes in healthcare have focused on disclosure, reporting, and patient safety culture.3 Nonetheless, little attention has been paid to creating systems that help second victims after an unexpected adverse event.

There continues to be limited research in this field. In fact, few studies have examined the prevalence of second victims, with reported rates of 10.4%, 30.8%, and 41.3%.3 Second academic and healthcare institutions in Switzerland, Belgium, Sweden, Italy, the United Kingdom, and the United States have conducted studies into the concept of second victims. Many of these studies focused on dealing with the signs and symptoms of second victims after adverse events.4 Other studies introduced frameworks, models, and roadmaps for how to meet second victims’ needs.5 Although these studies have been useful in understanding the problem of second victims in healthcare, future studies should focus on organizational culture and the willingness of second victims to access support services after an unexpected adverse event. Additional studies should also focus on identifying and mitigating institutional barriers for supporting second victims.

Structured support

When errors happen, second victims may not know who to turn to for guidance. In some instances, informal support offered by colleagues may be helpful. Intensive comments addressed to the second victims or others about the event can negatively affect those involved. Avoiding contact or conversation with the second victim can also cause harm.

To meet these challenges, several institutions have developed formal organizational support programmes that allow healthcare workers to cope with their emotional distress by seeking timely support in a confidential, non-judgmental environment. For instance, the Medically Induced Trauma Support Services (MITSS) in the University of Missouri, Brigham and Women’s Hospital, Boston Children’s Hospital, Kaiser Permanente, and Johns Hopkins Hospital, have developed organizational support programmes for staff. Each of these second victim support programmes has incorporated into its own model aligned with the organization’s response to adverse events. Not only have these institutions embraced the concept of second victims, but they have also...
Objectives

- Understand the concept of second victims
  - “patient story”
- Understand the principles of a preventive and evidence-based support systems
  - Work from Royal College of Physicians of England
- Hear about the Johns Hopkins’ experience
- Start discussion of how we might support activities and peer support groups within our own systems
Supporting “second victims”
A personal perspective

Barry Appleton MA MChir FRCS (Eng) FRCS (Gen Surg)
Consultant Colorectal Surgeon
Health Foundation Quality Improvement Fellow (2013-14)

24 April 2015
My story:
Laying yourself open to survive

- Consultant colorectal surgeon
  - Since 2006
  - Not aware of any “incidents” ’til 2009
- 2009
  - 48 female emergency with colonic dilatation and diarrhoea.
  - Colitis of unknown cause, joint medical / surgical care. Warned might need surgery.
  - Patient absolutely refused to contemplate surgery (stoma related)
  - Improved with antibiotics alone during tests
My story: Laying yourself open to survive

• 2009 contd.
  • Day 4: Vast improvement, plan for discharge for outpatient investigation under medics
  • Day 5: Discovered over night calamitous deterioration. “Surgery” – politely declined.
  • Tried gastroenterologists, specialist nurses – answer still “no”
  • Further deterioration – “yes”
  • Cardiac arrest on way to theatre.
  • Resuscitation attempts ineffective.
  • Saw husband – tried to share the “shock”
  • Post Mortem examination showed perforation
My story:
Laying yourself open to survive

• 2009 contd.
  • Lots of reflection
  • Hugely supportive colleagues
  • Sympathy
  • Not given further opportunity to speak with relatives despite attempts
My story: Laying yourself open to survive

• 2009 contd.
  • Lots of reflection
  • Hugely supportive colleagues
  • Sympathy
  • Not given further opportunity to speak with relatives despite attempts

• Few weeks later referred to GMC
My story: Laying yourself open to survive

- 2009 contd.
  - Lots of reflection
  - Hugely supportive colleagues
  - Sympathy
  - Not given further opportunity to speak with relatives despite attempts

- Few weeks later referred to GMC
  - “Substandard, but not seriously substandard”
My story:
Laying yourself open to survive

• 2011.
  • Career blossoming

• Second disaster
  • 78 man. Complex colorectal case for quality of life proctectomy
  • Detailed, but not well documented, consent
  • Died 3/7 after 9 hour incomplete procedure
My story:
Laying yourself open to survive

- 2011.
  - Career blossoming

- Second disaster
  - 78 man. Complex colorectal case for quality of life proctectomy
  - Detailed, but not well documented, consent
  - Died 3/7 after 9 hour incomplete procedure

- Difficult meeting with partner
My story:
Laying yourself open to survive

• Referred to “Ombudsman” after internal inquiry and coroner’s investigation – open verdict
  • Received a bizarre “expert” report
  • I challenged much of the opinion

• Why?
  • Angry about lack of balance
  • Defensive
  • ? Depressed
  • Confidence damaged – seeking justification
Laying yourself open to survive

- Heard nothing for many months
  - Phone call from CEO
    - “it’s going to be in the press”
    - “recommends you are referred to GMC”
    - “see what I can do to have this removed”
  - “Spoken to Richard – we trust you”
  - “write to Ombudsman yourself”
My story:
Laying yourself open to survive

• Sleepless nights
• Stirred up memories of 2009 death
• Awaited publication of report
My story: Laying yourself open to survive

- Sleepless nights
- Stirred up memories of 2009 death
- Awaited publication of report
- No real idea whether I was “safe”
  - Sought no break from clinical practice
My story: Laying yourself open to survive

- The report
  - Virtually unchanged
  - Permanently nauseated
  - Exhausted, guilty, confused
  - Checked website several times every day
My story: Laying yourself open to survive

- The report
  - Virtually unchanged

- Permanently nauseated
- Exhausted, guilty, confused
- Checked website several times every day

- Absolutely the most hurtful part of the story
My story: Laying yourself open to survive

- The report
  - Virtually unchanged
  - Permanently nauseated
  - Exhausted, guilty, confused
  - Checked website several times every day
- Absolutely the most hurtful part of the story
- Abandoned and lost
My story:
Laying yourself open to survive

• The great paradox
My story:
Laying yourself open to survive

• A good decision
  • Referred myself to the GMC
  • Mainly personal decision
  • Helpful advice from Medical Director
  • Fearful of possibility of another external referral

• Absolute loss of confidence in my ability
  • Talked to my colleagues about case mix
My story:
Laying yourself open to survive

- The final straw
My story: Laying yourself open to survive

- Arrived home
- Envelope on doorstep from GMC
My story: Laying yourself open to survive

• Arrived home
  • Envelope on doorstep from GMC

• Hollow feeling – knew what was coming
My story:
Laying yourself open to survive

- Arrived home
  - Envelope on doorstep from GMC

- Hollow feeling – knew what was coming

- I was wrong
My story: Laying yourself open to survive

• Next day
  • Picked up the phone to withdraw application for QI Fellowship
  • Talked down by my secretary

• “Wait and see”
My story: Laying yourself open to survive

- The tough cases follow you around
  - Paranoia
  - “Everybody out to get you”

- Dichotomy
  - Successful in QI Fellowship application
  - Time off for prolapsed disc
    - Probably saved my career
My story: Laying yourself open to survive

- The tough cases follow you around
  - Paranoia
  - “Everybody out to get you”

- Dichotomy
  - Successful in QI Fellowship application
  - Time off for prolapsed disc
    - Probably saved my career
    - Perhaps saved patients’ lives
Summary

- Second victim is a true phenomenon
- Clinician inside the event cannot see the outside
- Unpredictable effect on emotions and practice
  - defensive, overly risk-averse
  - initially potentially detrimental to patient safety
    – with time and reflection, can reverse
- ? Can happen to anybody
- Process of investigation unpredictable, in my case just as damaging as the emotional fallout of the incident(s)
- Cannot overestimate the benefit of supportive colleagues
Second victims of clinical incidents and errors

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**Clinical Director**
Clinical Effectiveness & Evaluation Unit
*Consultant Geriatrician, Winchester*

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Medical error: the second victim
The doctor who makes the mistake needs help too

When I was a house officer another resident failed to identify the electrocardiographic signs of the pericardial tamponade that would rush the patient to the operating room late that night. The news spread rapidly, the case tried repeatedly before an incredulous jury of peers, who returned a summary judgment of incompetence. I was dismayed by the lack of sympathy and wondered secretly if I could have made the same mistake—and, like the hapless resident, become the second victim of the error.

Strangely, there is no place for mistakes in modern medicine. Society has entrusted physicians with the burden of understanding and dealing with illness. Although it is often said that “doctors are only human,” technological wonders, the apparent precision of laboratory tests, and innovations that present tangible images of illness have in fact created an expectation of perfection. Patients, who have an understandable need to consider their doctors infallible, have colluded with doctors to deny the existence of error. Hospitals react to every error as an anomaly, for which the solution is to ferret out and blame an individual, with a promise that “it will never happen again.” Paradoxically, this approach has diverted attention from the kind of systematic improvements that could decrease errors. Many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster. And, although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims.

Virtually every practitioner knows the sickening realisation of making a bad mistake. You feel singled out and exposed—seized by the instinct to see if anyone has noticed. You agonise about what to do, whether to tell anyone, what to say. Later, the event replays itself over and over in your mind. You question your competence but fear being discovered. You know you should confess, but dread the prospect of potential punishment and of the patient’s anger. You may become overly attentive to the patient or family, lamenting the failure to do so earlier and, if you haven’t told them, wondering if they know.1–3

Sadly, the kind of unconditional sympathy and support that are really needed are rarely forthcoming. While there is a norm of not criticising,4 reassurance from colleagues is often grudging or qualified. One reason may be that learning of the failings of others allows physicians to divest their own past errors among

Wu, Albert. BMJ 18/03/2000
Second victim

- Clinicians involved in errors or adverse events who feel traumatized by their experiences
- They frequently feel personal responsibility for the patient outcome
- They may feel as though they have failed the patient

Scott 2009; Qual & Saf in Healthcare; 18; 325-30
Second victim effects

• Acute stress reactions (days to weeks)
  – Numbness, anxiety, sleep disturbance, grief, detachment, loss of trust, lack of concentration, poor memory

• Longer term effects
  – Shame, guilt, anger, self-doubt, flashbacks, irritability (similar to PTSD?), depression, behavioural change, drug and alcohol abuse etc
Severity of effects related to...

- The severity of the incident
- The characteristics of the patient
- The attitude of clinical colleagues
- The conduct of the enquiry
- Legal proceedings
- The relationship with the patient
Consequences

- Patient safety risks
  - Immediate aftermath
  - Longer term consequences for safety culture, openness, team-working, defensive practice, disruptive behaviour, working relationships etc

- Staff health, welfare, recruitment & retention
Trajectory of recovery (Scott 2009)

Chaos & accident response

Intrusive reflections

Restoring personal integrity

Obtaining emotional first aid

Enduring the inquisition

6. Moving on

Dropping out

Surviving

Thriving

Royal College of Physicians

Setting higher standards
Survey of RCP Fellows & Members 2013*

- 1755 responses
- 37% female
- Mean age 47 years
- All parts of UK
- All medical specialties
- Broadly fits the profile of NHS consultant physicians

*Clinical Medicine Dec 2014
Doctors’ experiences of adverse events in secondary care: the professional and personal impact

Authors: Reema Harrison, Rebecca Lawton and Kevin Stewart

ABSTRACT

We carried out a cross-sectional online survey of fellows and members of the Royal College of Physicians to establish physicians’ experiences of adverse patient safety events and near misses, and the professional and personal impact of these. 1,755 physicians answered at least one question, 1,334 answered every relevant question. Of 1,663 doctors whose patients had an adverse event or near miss, 1,119 (76%) believed this had affected them personally or professionally, 1,077 (66%) reported stress, 975 (63%) anxiety, 846 (60%) sleep disturbance and 888 (56%) lower professional confidence. 1,192 (81%) became anxious about the potential for future errors. Of 1,061 who had used NHS incident-reporting systems, only 315 (20%) were satisfied with this process. 201 (14%) received useful feedback; 267 (19%) saw system changes. 364 (25%) did not report an incident that they should have. Adverse safety events affect physicians, but few formal sources of support are available. Most doctors use incident-reporting systems, but many describe a lack of useful feedback, systems change or local improvement.

KEYWORDS: xxx.

Introduction

In the wake of recent high-profile quality failures, the safety of the NHS is at risk of being compromised in many ways. Despite significant investment in incident-reporting systems, as well as professional and regulatory requirements to support their use, rates of adverse event reporting are low, particularly amongst doctors. Many clinicians are also reluctant to disclose details of adverse events (see Box 1) to patients and their families. Multiple factors are thought to contribute to this, including the psychological effects on clinicians of involvement in adverse patient safety events, a fear by them that their organisation will take a punitive approach to any investigation, and a lack of confidence that systems will change as a result of reporting.

Box 1 Definition of an adverse event and a near miss

An adverse event describes ‘an injury related to medical management, in contrast to complications of disease’ whereas a ‘near miss’ describes a ‘serious error or mishap that has the potential to cause an adverse event but fails to do so because of chance or because it is intercepted’. Negative experience of previous incident investigations may reinforce these concerns.

There is a growing body of evidence to suggest that clinicians who directly or indirectly contribute to the occurrence of an adverse event can experience psychological effects that disrupt their professional and personal lives, as well as their ability to deliver high-quality, safe care. Anxiety, depression, sleep disturbance, fear and worry are consistently reported by those involved in adverse events, as are shame, guilt, loss of self-confidence, and feelings of incompetence and worthlessness. The severity of these effects is related to the degree of harm to the patient and the clinician’s experience of the investigation process; they are more pronounced with more serious incidents.

These effects have adverse consequences for patients, for clinicians and for the wider NHS. Patient safety is at risk in the immediate aftermath of an incident, when a clinician’s ability to manage other patients may be impaired. In days and weeks following an incident, stress, anxiety and sleep disturbance may affect clinical decision making, job performance and collegiate relationships. In the longer term, safety culture and the ability to learn from adverse events is threatened if clinicians are reluctant to report incidents and transparency is suppressed.

In extreme cases, clinicians may consider changing career or leaving the profession.

Most reports of this phenomenon are from the United States, where several programmes have been established to support clinicians who are affected. In this paper, we report the first UK-wide survey of physicians’ experiences of adverse events and near misses, and their perceptions of the organisational mechanisms for supporting staff in these circumstances. Until now we have had no knowledge of doctors’ experiences or needs in the NHS context, and therefore no information on how to address them. Assumptions are drawn from data in other locations. UK studies published to date are small-scale, conducted at either one or two NHS Trusts, and/or have not included a sample of doctors.

This survey of physicians
## Psychological effects of involvement in a safety incident

<table>
<thead>
<tr>
<th>Outcome</th>
<th>%</th>
<th>N</th>
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<tbody>
<tr>
<td>Lower confidence in ability as a doctor</td>
<td>63.2</td>
<td>886</td>
</tr>
<tr>
<td>Difficulty sleeping</td>
<td>59.9</td>
<td>840</td>
</tr>
<tr>
<td>Reduced job satisfaction</td>
<td>48.5</td>
<td>681</td>
</tr>
<tr>
<td>Affected relationships with colleagues</td>
<td>25.5</td>
<td>358</td>
</tr>
<tr>
<td>Damaged professional reputation</td>
<td>20.1</td>
<td>282</td>
</tr>
<tr>
<td>Other personal or professional outcomes</td>
<td>15.8</td>
<td>221</td>
</tr>
<tr>
<td>Anxious about potential for future errors</td>
<td>81.5</td>
<td>1192</td>
</tr>
<tr>
<td>Generally distressed (e.g. depressed, upset, angry)</td>
<td>73.6</td>
<td>1077</td>
</tr>
<tr>
<td>Generally anxious (e.g. nervous, panicky, tense)</td>
<td>68</td>
<td>995</td>
</tr>
<tr>
<td>Negative towards yourself (e.g. shame, guilt, feeling incompetent)</td>
<td>27.3</td>
<td>399</td>
</tr>
<tr>
<td>More confident in your abilities (e.g. effective, efficient, competent)</td>
<td>7.5</td>
<td>110</td>
</tr>
<tr>
<td>Determined to improve (e.g. determined, resourceful, strong)</td>
<td>80.6</td>
<td>1179</td>
</tr>
</tbody>
</table>

8% reported severe feelings of distress
4% reported severe anxiety
Sources of support

- Formal mentor 5.5%
- Family and friends 66%
- Peers 85%

84% had supported a colleague
87% would use a formal mentor if they had one
Incident reporting

- 80% had used NHS incident reporting systems
- 28% were satisfied with the way it had been dealt with
- 25% admitted being involved in an incident which they knew they should have reported, but didn’t
What can we do?

As leaders and professional bodies
As organisations
As individuals
  – The second victim
  – Colleagues
What can we do?

“Abandon blame as a tool and trust the goodwill and good intentions of the staff”
As leaders and professional bodies

• Recognise and publicise the concept, and that….
  – it’s primarily a patient safety issue
  – something can be done
• Promote mentorship for clinicians
• Promote work to understand the best approaches to support within a wider learning culture
• Model expected behaviours
As individuals

Colleagues

– Offer informal support to colleagues who may be potential second victims
– Recognise effects in yourself and seek help early
As organisations

• Build structures into incident responses to;
  – Recognise and mitigate the potential risks to patients after an incident
  – Recognise and support second victims
• Promote and model a (genuinely) open, transparent, non-judgemental reporting culture
Summary

- Second victim effects are common
- They affect clinicians across the spectrum
- This is;
  - Dangerous for patients
  - Harmful for clinicians
  - Bad for the service
- Something can be done to reduce the risks

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Useful references

1. Wu, A. Medical Error; the second victim. BMJ; 2002;320:726-7
Supporting Our Second Victim Colleagues: Implementing RISE at The Johns Hopkins Hospital

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International Forum on Quality and Safety in Healthcare
April 24, 2015
Johns Hopkins Hospital

• 1,075-licensed bed, urban, academic medical center in the state of Maryland, USA

• Medical errors and adverse patient-related events are inevitable
  – reported, investigated and debriefed with staff

• Several events occurred…

• Hospital leadership created second victim taskforce to establish an organizational support program/service for second victims
Our Current Infrastructure

• Patient Safety & Quality Departments
• Risk Management
• Employee Assistance Program
• Chaplain Services
• Occupational Health
• Human Resources
Established Second Victim Support Programs in the Literature

• Limited literature
  – prevalence of second victims: 10.4% - 43.3%
  – studies on concept of second victims:
    • Switzerland, Belgium, Sweden, Italy, the United Kingdom, and the United States
  – descriptions of organizational support programs
  – little documentation of the steps involved in their development
  – limited resources for evaluating the feasibility and effectiveness of these programs
Established Second Victim Support Programs in the Literature

• Medically Induced Trauma Support Services (MITSS)
  – toolkit of resources to help organizations establish second victim programs

• Hospitals and healthcare systems in the United States
  – University of Missouri
  – Brigham and Women’s Hospital
  – Boston Children’s Hospital
  – Kaiser Permanente
Organizational Assessment

- Organizational survey was administered at 2\textsuperscript{nd} Annual Johns Hopkins Patient Safety Summit in June 2010
  - Presentation on second victims by Dr Wu

- Results (n=140):
  - Two-thirds reported experiencing emotional distress following an unanticipated adverse event
  - More than half had reached out for support from a peer or colleague
  - The need for a peer support program to benefit second victims in the Hospital

R.I.S.E.
Resilience In Stressful Events

Providing **confidential, timely peer support** to employees who encounter a stressful, patient related event
Developing the RISE program

Phase 1: Developing the RISE Team

Phase 2: Recruiting and training Peer Responders

Phase 3: Launching RISE pilot in Department of Pediatrics

Phase 4: Launching RISE hospital-wide
Phase 1: Developing the RISE Team

• The RISE Leadership team
• The RISE team:
  – trained Hopkins employees, Peer Responders, who volunteer to support second victims through a dedicated pager 24 hours a day, 7 days a week
• A project charter to include RISE scope of services
RISE Team: Resiliency In Stressful Events

Mission:

“To provide timely support to employees who encounter stressful, patient-related events”

Objectives:

1. Increase awareness of the “second victim” phenomenon
2. Provide multi-disciplinary, one-to-one or group, peer support in a non-judgmental environment
3. Equip managers & employees with healthy coping strategies to promote well-being
4. Reassure & guide employees to continue thriving in their role
What does RISE do?

- Supportive and attentive conversation
- Facilitate resources within the hospital that might be helpful
- Provide 24/7 available support
- One to one or group support
What does RISE NOT do?

- We are not counselors or psychiatrists
- We do not investigate or report back to supervisors
- We do not problem solve
- We do not fix employment problems
Phase 2: Recruiting and Training of Peer Responders

• 40 were invited to participate

• RISE Leadership team met with peer responders to discuss:
  1. Roles and responsibilities: attend training, respond to RISE calls, and participate in monthly Peer Responder meetings
  2. On-Call Schedule
  3. RISE binder: policies and procedures, evaluation tools, and additional resources.
Contacting RISE

Event happens

Second victim pages RISE
Referrals: self, manager, legal/risk management, peer

RISE page received by Peer Responder
Peer Responder meets with second victim

Peer Responder activates debriefing with RISE team to discuss de-identified interaction with second victim
- learning opportunity for RISE team
- support for the Peer Responder
Training Peer Responders

- Psychological First Aid (PFA)
  - used to describe early interventions to address emotional distress
  - goals of PFA are similar to that of physical first aid
    - stabilize, mitigate psychological distress, facilitate recovery, and promote access to additional resource

- Peer Responder meetings
  - Educational sessions: lecture presentations, Role-play, Video excerpts, Handouts, Narratives

- Debriefings
** Psych First Aid**

- Crisis Intervention
- Psychotropic Meds & Psychotherapy

** Physical First Aid**

- Basic Life Support
- Advanced Life Support
- Medicine & Surgery

** Stabilize** psychological and behavioral functioning, **mitigate psychological distress** and dysfunction, **facilitate recovery** and return to adaptive psychological and behavioral functioning, and **promote access to additional resources**
Phase 3: Launching RISE pilot in the Department of Pediatrics

- Launch of *Awareness Campaign*
  - significance of stress after unanticipated events, the second victim problem, peer support, resilience, and stress management
  - 3 one-hour sessions held during all three shifts
Phase 4: Launching RISE hospital-wide

- Kick-off was held at the 4\textsuperscript{th} Annual Johns Hopkins Patient Safety Summit in 2012

- Additional Peer Responders were recruited

- Assessment of Peer Responder perceptions
  - Peer Responders desired additional training to increase competence and confidence levels in responding to second victims

[Manuscript in prep]
Second victim study on perceptions of patient safety leaders in the state of Maryland

- **Objective:** To assess patient safety leaders’ perspectives on the concept of second victims and support programs

- **Overall Results:**
  - 83% response rate (43 patient safety leaders, 38 acute hospitals)
  - All participants believed that they and their executives were aware that the second victim problem exists.
    - There are 6 existing programs in Maryland
  - Gaps in Employee Assistant Programs:
    - timeliness of intervention,
    - EAP staffs’ experience relating to clinical providers
    - physical accessibility
  - There is a need for peer support for both the second victim and for the individuals who provide that support

[Manuscript in prep]
Johns Hopkins Collaboration with the Maryland Patient Safety Center

- Developing program implementation guide and toolkit
- Peer Responder training
How can your organization participate

• Acknowledge the problem of the second victim

• Encourage staff to be involved in system changes and root-cause-analyses to mitigate future errors from happening

• Hold debriefings and offer formal organizational support and coping strategies for individuals

• Develop multidisciplinary second victim support programs that align with existing organizational infrastructure
  – Communicate and collaborate with institutions that have existing or emerging programs
Developmental Stages

- 2010: Self Care
- 2004: Reporting
- 2001: Disclosure
- 2000: Safety

Care for Caregivers
- Learn from Mistakes
- Being Open
- Do No Harm
Acknowledgements

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• Johns Hopkins Second Victim Advisory Board
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References

Wu AW. Medical error: the second victim: the doctor who makes the mistake needs help too. *BMJ* 2000;320:726.

White, AA; Brock D, McCotter P, Hofeldt R; Edrees H; Wu AA; Shannon S; Gallagher TH. (April 2015). Risk Managers’ Descriptions of Programs to Provide Emotional Support for Healthcare Workers after Adverse Events. *Journal of Healthcare Risk Management*.


Additional Slides
## Prevalence of Second Victims

<table>
<thead>
<tr>
<th></th>
<th>Study 1</th>
<th>Study 2</th>
<th>Study 3</th>
</tr>
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<tbody>
<tr>
<td><strong>Prevalence</strong></td>
<td>10.4%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>30%&lt;sup&gt;2&lt;/sup&gt;</td>
<td>43.3%&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Population</strong></td>
<td>otolaryngologists</td>
<td>sample of medical students, physicians, and nurses</td>
<td>physicians, nurses, and pharmacists, and other healthcare professionals</td>
</tr>
<tr>
<td><strong>Feelings/symptoms</strong></td>
<td>described an error they were involved in during the past 6 months</td>
<td>personal problems related to anxiety, depression, and challenges in their ability to provide care during the past 12 months</td>
<td>the error had a moderately severe or severe harmful effect on their personal lives</td>
</tr>
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R.I.S.E.
Resiliency In Stressful Events

Have you experienced:
• a stressful, patient-related event?
• a medical error?
• a distressing patient outcome?

Do you need emotional support?

♦ The RISE Team can help ♦

Our team of trained peer responders provide non-judgmental, confidential, peer-to-peer support

Pager # 410.283.3953