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AHRQ Commentary

This commentary on patient safety in nursing practice comes from the Agency for Healthcare Research and Quality.

Alleviating "Second Victim" Syndrome

How We Should Handle Patient Harm

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MOST EXPERIENCED NURSES, physicians, and other clinicians have been associated, in some way, with health care-associated harm. Adverse events in health care occur far too often. A recent study[1] by the Office of Inspector General, US Department of Health and Human Services, determined that about 1 in 7 Medicare fee-for-service patients experienced a serious adverse event, and that an additional 1 in 7 experienced a less serious adverse event (Table). On the basis of our best estimates of the incidence of adverse events, it is reasonable to assume that the majority of experienced clinicians have been near one. And yet, at that moment that an event occurs, the clinician closest to it feels alone. How does one feel after patient harm occurs? Responsible? Guilty? Inadequate? Defensive? Angry?

Nurses involved in an adverse event could seek consolation by reminding themselves that the number of patients who benefit far exceeds the number of patients injured as a result of their care. Or they could blame the system, knowing that complex clinical conditions, poorly designed processes, and inadequate communication patterns often are the root causes for patient harm in health care.[2] But the assignment of blame or the search for solace does not change the essential fact that harmful events can be devastating—and not just to patients whom they strike. Adverse events also can do great and lasting damage to the clinicians who are associated with them. This does not in any way diminish the severity of harm to the patients. Patients are always the first victims of an adverse event, and it is our job in the health care system to protect patients from harm. Yet while patients are the principal victims, they are not the sole victims.

Physicians, nurses, and other clinicians who are connected to these events often feel somehow responsible. Emotional trauma is frequent. Patient safety expert Albert Wu, MD, MPH, has coined a term for such clinicians: "second victims." According to Dr Wu, the burden that health care providers feel after a patient is harmed, manifesting in anxiety, depression, and shame, weighs so heavily on the providers that they themselves are wounded by the event.

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Table. Adverse Events Identified Among Sample Medicare Beneficiaries by Clinical Category (n = 128)

Types of Adverse Events	n (%)
Related to	
Medication (eg, excessive bleeding, delirium, or change in mental status)	40 (31)
Patient care (eg, intravenous volume overload, aspiration)	36 (28)
Surgery or other procedures (eg, excessive bleeding, severe hypotension)	33 (26)
Infection (eg, urinary tract infection, vascular catheter-associated infection)	19 (15)

Data from the US Department of Health and Human Services, Office of Inspector General analysis of hospital stays for 780 Medicare beneficiaries in October 2008.[1]

The tragic case of Kimberly Hiatt is illustrative. Ms Hiatt was a nurse in the cardiac intensive care unit at Seattle Children's Hospital who last September mistakenly overdosed an 8-month-old patient with calcium chloride. The patient died. Ms Hiatt, a nurse with 24 years' experience, immediately reported the event to colleagues. She suffered professionally from the experience (although the details surrounding that remain in dispute) and faced an investigation. Six months after the event, Ms Hiatt committed suicide.[3]

Clearly, Ms Hiatt was a second victim. This term can be described as a "health care provider who [is] involved in an unanticipated adverse patient event, in a medical error and/or a patient related injury and become[s] victimized in the sense that the provider is traumatized by the event."[4] Typically, second victims feel personally responsible for the patient outcome, as if they have failed the patient, second-guessing their clinical skills and knowledge base.

In a groundbreaking article in the *British Medical Journal*, Dr Wu describes the onset of second-victim syndrome:

> Virtually every practitioner knows the sickening realization of making a bad mistake. You feel singled out and exposed—seized by the instinct to see if anyone has noticed. You agonize 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 have not told them, wondering if they know.[5]

THE SYSTEMIC NATURE OF PATIENT SAFETY EVENTS

What is striking about this description is its universality. Health care-associated injuries are events associated with the process or structure of care, rather than with a patient's underlying physiological, environmental, or disease-related conditions. The term "patient safety events" is often used to describe events that cause or have the potential to cause harm.[6]

We have been working hard to enhance our systems to make harm less frequent. For years, patient safety advocates have promoted a culture of safety that focuses on the role of systems and de-emphasizes blame. Many health care institutions are implementing reporting systems so that both patient safety events, including near misses, can be reported in an anonymous, safe environment, with the goal of encouraging reporting and learning from these events or near misses *before* injury occurs.

Systematic reporting is critical to improving patient safety. The creation of Patient Safety Organizations (PSOs), established by the Patient Safety and Quality Improvement Act of 2005 to collect voluntarily reported patient safety events, was an important step, because PSOs give us a system to learn from these events without fear of legal discovery.[7] To ensure that patient safety events reported to PSOs can be collected in a standardized fashion and analyzed in a meaningful way, the Agency for Healthcare Research and

Quality has coordinated the development of common definitions and reporting formats called the Common Formats (www.pso.ahrq.gov/formats/commonfmt.htm). These descriptions allow providers to collect and submit information on patient safety events and unsafe conditions in an apples-to-apples fashion.

Thus, the "name, blame, and shame" approach to dealing with patient safety events is becoming less accepted and, thankfully, less prevalent. However, it is not gone. Health care providers continue to struggle to balance the systems approach to patient safety with the need to correct individual behavior when necessary.[8] Many clinicians still regard patient safety events as a personal failing rather than the result of a systemic defect, which poses challenges in fostering a patient safety culture.[9]

There are in fact 2 ways that a health care worker can become a second victim: the internalized judgment that amounts to a self-inflicted emotional wound, and the review and judgment of an oversight body (such as a nursing board) that reinforces those internalized self-criticisms.[10] Oversight bodies are integral entities to ensuring a safe and effective health care system; however, under certain circumstances, some clinicians who are associated with a patient safety event may feel themselves singled out by such bodies.

FROM ONE VICTIM TO ANOTHER: THE IMPORTANCE OF DISCLOSURE

Second victimhood, much like patient safety events, is much more common than we might recognize. Researchers at the University of Missouri Health Center found that almost 1 in 7 staff members reported in an internal patient safety culture survey that they had experienced a patient safety event within the past year that caused personal problems such as anxiety, depression, or concerns about the ability to perform one's job; more than two-thirds of these clinicians reported they did not receive institutional support.[11]

To learn more about these second victims, researchers conducted a series of qualitative interviews with potential subjects. More than one-third of the interview subjects were registered nurses. Researchers identified a 6-step clinician recovery process: (1) chaos and accident response, (2) intrusive reflections, (3) restoring personal integrity, (4) enduring the inquisition, (5) obtaining emotional "first aid," and (6) moving on.[12] How does one move on? Researchers classified 3 ways: dropping out (ie, leaving health care altogether); surviving (ie, emotionally burying the incident); or thriving (ie, learning from the incident to become a better clinician).[11] Whether clinicians can reach stages 5 and 6 in the recovery process—and whether they thrive rather than drop out—often depends on the culture of the institution. Health care institutions that have successfully instilled a patient safety culture may help their clinicians; those that have not might unintentionally harm them.

A true test of a patient safety culture comes immediately after an event occurs. An initial reaction among clinicians may be to try to hide it—which is precisely the wrong thing to do. Instead, it is important to disclose it immediately. Many clinicians will find this counterintuitive. The prospect of talking with patients about patient safety events strikes fear in the clinicians' heart. Our culture favors being open with patients, but our legal system unfortunately does not. This makes the prospect of disclosure daunting. As a result, patients and families often learn little about tragic events.[13,14] But many progressive thinkers today are advancing disclosure and even an immediate, protocol-enabled apology as a means of alleviating the emotional trauma of both the first and second victims of patient safety events."[15-17]

Much as the occurrence of adverse events is a systems issue, disclosure also must be a systems issue. One model has shown some success. Since 2001, the University of Michigan Health System has fully disclosed and offered compensation to patients for health care-associated harm.[18] This protocol-driven

policy ensures that the right people are having the right conversation with victims of patient safety events; a 2006 survey of faculty physicians showed near universal approval of the approach,[19] indicating the protocol's popularity with frontline clinicians.

The Michigan model has been duplicated at other large systems, including the University of Illinois at Chicago, which adapted the approach when developing a program now being expanded throughout the region through Agency for Healthcare Research and Quality funding.[20] This is a positive development, because absent a protocol, an apology or disclosure may be at best clumsy and at worst an invitation to litigation that could only exacerbate the problem. Leadership within health systems is required to ensure that when an event does occur, somebody knows what to do and how to do it.

Health care workers are supposed to be strong. We strive to provide the highest quality, safest care for our patients, not be a burden on the system. Our culture is one of caring, but also of heroism, which often does not tolerate the idea of victimhood. Thus, merely to acknowledge that we can become second victims of a patient safety event is a difficult concept for many of us and may have contributed to our reluctance to acknowledge the phenomenon. Yet we will never completely address the physical and psychological toll of health care-associated harm unless we confront and seek to better understand it.

The best way to avoid second-victimhood is obviously to avoid patient harm in the first place. But, to borrow the cliché, to err truly is human. The health care field is working hard to refashion systems to avoid the commission of errors that lead to harm. Until we achieve a harm-free health care system, however, we need to acknowledge that there are better ways to handle harm when it does occur. This will mitigate the damage both to the victim and to the second victim.

REFERENCES

1. US Department of Health and Human Services, Office of Inspector General. Adverse events in hospitals: national incidence among medicare beneficiaries. OEI-06-09-00090. http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf. Published November 2010. Accessed August 12, 2011.
2. Kumar S. *Fatal Care: Survive in the U.S. Health System*. Minneapolis, MN: IGI Press; 2008.
3. Aleccia J. *Nurse's Suicide Highlights Twin Tragedies of Medical Errors*. MSNBC.com Web site. http://www.msnbc.msn.com/id/43529641/ns/health-health_care/. Accessed June 27, 2011.
4. Scott SD, Hirschinger LE, Cox KR, et al. The natural history of recovery for the health care provider "second victim" after adverse patient events. *Qual Saf Health Care*. 2009;18(5):325-330.
5. Wu AW. Medical error: the second victim. The doctor who makes the mistake needs help too. *BMJ*. 2000;320(7237):726-727.
6. Battles JB, Lilford RJ. Organizing patient safety research to identify risks and hazards. *Qual Saf Health Care*. 2003;12(suppl 2):ii2-ii7.
7. Agency for Healthcare Research and Quality. *Advancing Patient Safety: A Decade of Evidence, Design, and Implementation*. Rockville, MD: Agency for Healthcare Research and Quality; 2009. AHRQ Publication No. 09(10)-0084. www.ahrq.gov/qual/advptsafety.htm.
8. Casarett D, Helms C. Systems errors versus physicians' errors: finding the balance in medical education. *Acad Med*. 1999;74(1):19-22.
9. Collins ME, Block SD, Arnold RM, et al. On the prospects for a blame-free medical culture. *Soc Sci Med*. 2009;69(9):1287-1290.
10. Wachter R. *In Conversation with... Albert Wu, MD, MPH*. Rockville, MD: AHRQ, WebM&M Perspectives on Safety; 2011.
11. Scott SD. *The Second Victim Phenomenon: A Harsh Reality of Health Care Professions*. Rockville, MD: AHRQ, WebM&M Perspectives on Safety; 2011.
12. Scott SD, Hirschinger LE, Cox KR, et al. The natural history of recovery for the health care provider "second victim" after adverse patient events. *Qual Saf Health Care*. 2009;18(5):325-330.
13. Gallagher TH. *Duty to Disclose Someone Else's Error?* Rockville, MD: AHRQ, WebM&M Cases & Commentaries; 2011.

14. Gallagher TH. A 62-year-old woman with skin cancer who experienced wrong-site surgery: review of medical error. *JAMA*. 2009;302(6):669-677.
15. Bismark MM. The power of apology. *N Z Med J*. 2009;122(1304):96-106.
16. Woods MS, Star JI. *Healing Words: The Power of Apology in Medicine*. Oak Park, IL: Doctors In Touch; 2004.
17. Berlinger N. *After Harm: Medical Error and the Ethics of Forgiveness*. Baltimore, MD: The Johns Hopkins University Press; 2005.
18. Kachalia A, Kaufman SR, Boothman R, et al. Liability claims and costs before and after implementation of a medical error disclosure program. *Ann Intern Med*. 2010;153(4):213-221.
19. Welti MK. *Disclosure of Medical Adverse Events: A Study of the University of Michigan Health System Model*. Massachusetts Bar Association Section Review, vol 9, no 1. www.massbar.org/publications/section-review/2007/v9-n1/disclosure-of-medical-adverse-events-a-study-of-the-university-of-michigan-health-system-model.
20. McDonald TB, Helmchen LA, Smith KM, et al. Responding to patient safety incidents: the "seven pillars." *Qual Saf Health Care*. 2010;19:1-4. doi: 10.1136/qshc.2008.031633.

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