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Abstract

Adverse and traumatic events happen regularly in healthcare settings, and often they create a clinician "second victim" who struggles with feelings of guilt, isolation, doubt, and incompetence. Research has shown that clinicians desire support in the wake of such adverse events, but that factors such as stigma, culture of perfection, and lack of an available structured peer program limit the support that might be offered. Healthcare institutions contract with EAP (employee assistance program) agencies to provide counseling for employees, but it is more likely that a second victim will seek out or welcome help first from a peer who shares their discipline, expertise and environment. This article explores the second victim phenomenon in healthcare, the desire and need for peer support programs for clinicians, and best practices and ideas for piloting such a program.

Keywords

second victim, peer support, resilience, moral suffering

Conflict of Interest Statement

This author has no financial or ethical conflicts of interest regarding the content of this article.

Cover Page Footnote

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Adverse and traumatic events happen regularly in healthcare settings, and often they create a clinician "second victim" who struggles with feelings of guilt, isolation, doubt, and incompetence. Research has shown that clinicians desire support in the wake of such adverse events, but that factors such as stigma, culture of perfection, and lack of an available structured peer program limit the support that might be offered. Healthcare institutions contract with EAP (employee assistance program) agencies to provide counseling for employees, but it is more likely that a second victim will seek out or welcome help first from a peer who shares their discipline, expertise and environment. This article explores the second victim phenomenon in healthcare, the desire and need for peer support programs for clinicians, and best practices and ideas for piloting such a program.

Keywords: Second victim, Peer support, Resilience, Moral suffering

Modern healthcare institutions project an image of innovation, expertise and mastery over human problems. Hospitals display awards on billboards and feature the newest technology on their online advertisements. Medication, science and technology leaps in recent decades give the impression to those in need of care that their illnesses will be diagnosed correctly, treated expertly, and managed without a misstep. Often this is the case, and it is certainly the intent of most healthcare practitioners.

However, errors and accidents do occur. Between 3 and 16% of inpatient surgical procedures encounter major complications, adverse events and errors that sometimes lead to disability or death.[1] A nurse with tired eyes inadvertently scans past a note with crucial information. An anesthesiologist on-call makes a miscalculation during the induction phase of anesthesia. A nurse practitioner's order for medication does not get communicated on time. Most errors or accidents do not affect the patient and can be rectified soon after. At times, though, an error or oversight in a healthcare setting leads to grievous harm. In these instances, there is an obvious first victim: the patient. The second victim is the healthcare provider who feels responsible.

1. Defining the second victim

Second victims are healthcare practitioners who become traumatized by an unanticipated adverse event, medical error or instance that causes patient harm.[2] Even in near-miss situations or cases where the patient does not die or become seriously affected, a clinician can become a second victim: "The incident does not in fact have to kill or injure anyone - the strong possibility is often enough to engender symptoms of second victimhood."[3] Following an event, a second victim's quality of life and job satisfaction can diminish due to extreme feelings of guilt, shame, and incompetence.[4] Although it is human nature to feel guilty and remorseful about making a mistake, there are added factors at play in the healthcare setting: 1) mistakes and oversights can kill, and 2) it is not easy to talk to anyone, let alone a professional colleague, about making a mistake that did or could have killed someone.

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The standards for clinicians are high. In her book on moral suffering in healthcare, Dr Cynda Rushton writes "In clinical environments, primacy is often placed on expertise and mastery, on 'heroic' intervention and competence. Stakes are high, pressures and expectations can be great."[5] In healthcare culture and clinical training, fallibility is a concept that is rarely discussed, let alone normalized.[3] Even though adverse events occur in hospitals on a regular basis (a large international review found 4−17% inpatient charts reflected at least one), from an institutional point of view they are anomalies and potential embarrassments.[6] Hospitals invest capital into eliminating errors, paying for regular surveys from national regulatory organizations such as the Joint Commission and operating robust quality departments. Second victims might be the subject of a fault-finding investigation and even litigation, but often their emotional well-being and resilience go unattended. Clinicians whose achievements are oft-touted by their hospital are left to founder on their own after a mistake, wringing their hands and trying to soldier on in the shadow of their assumed perfection. The emotional fallout from the adverse event, if left unaddressed, may affect not only the individual but patients, colleagues and the institution as well.[7]

2. Desire for support among clinicians

Before discussing how to support second victims, it is important to ask: do second victims *want* support? At Mayo Clinic in Minnesota in 2016, 68% of anesthesiologists reported experiencing an adverse event that caused serious guilt, professional self-doubt, depression and sleeplessness. Of these, almost all of them (229 of 240) reported that they did not feel supported in the aftermath of the adverse event.[8] A 2007 survey of more than 3000 physicians in the US and Canada found that in times of distress following an error, most felt their emotions went unaddressed.[2] A survey of clinical staff at Johns Hopkins Hospital in Baltimore in 2010 discovered that two-thirds of those surveyed has experienced an unanticipated adverse event, and the majority of these had informally reached out to a peer for support.[9] Another research team reported similar findings in 2017 after surveying surgeons at three major US hospitals (126 respondents), the majority of whom relied on a colleague for support after an adverse event.[10]

From these examples and the many more that could be cited, it is clear that clinicians want emotional support in the wake of unanticipated traumatic events or mistakes. Many healthcare systems (and corporations) have EAPs (employee assistance programs) in place, which generally are contracted agencies that provide professional, confidential counseling. However, evidence shows that following adverse events engendering a second victim response, clinicians (especially physicians) prefer peer support as opposed to non-specific agencies such as EAPs.[4] Peers can relate to the expectations and pitfalls of the specific clinical discipline, can speak the jargon, and most importantly they carry the weight of healing in their words of affirmation and understanding. A peer can not only offer empathy, but has the power to help the second victim find real resilience − "to adapt to and absorb the experience into his or her life and change (for the better) as a result."[3]

A second victim might reach out to a peer informally in the wake of an adverse event if there is a trusted relationship in place and the confidence that he or she will not be judged. However, the stigma of imperfection in healthcare is powerful. Clinicians may feel that if they disclose their vulnerable feelings about failure or mistakes to anyone (especially a colleague), it will leave them professionally ineffective, unable to handle the swell of emotions that surface.[5] They may fear institutional censure, investigation, or just a quiet judgment that spreads throughout their department. A second victim also may not have a close relationship with anyone in the workplace or within their peer group to feel comfortable enough asking for support.

3. The peer support model

Formalized peer support programs are an alternative to EAPs or to simply relying on the availability of a colleague in the wake of an adverse event. A peer support program can be established by any group of healthcare workers in a specific department, clinical unit or service line. Institutional and departmental leaders do not have to be involved in planning and piloting the program, but it is vital that they endorse and champion the program within the system in order to maximize accessibility and visibility.

There are several considerations at the outset: what training does a peer supporter need? Will the support be confidential? What are the criteria for a peer supporter to reach out to a potential second victim?

For most people, supporting someone who is in the midst of a crisis is a daunting task. Helping mitigate another person's emotional fallout is intimidating and for some can be downright terrifying. It is essential that those who wish to do the brave work of peer support have adequate training before they are asked to respond to a second victim

in need of intervention. The department also owes it to second victims to offer them a competent peer in their time of need.

Before any training begins, peer support team planners should invite participation from clinicians who have good overall reputations and some natural ability for empathy.[11] A peer supporter should ultimately be a volunteer role, because any person in crisis would likely be appalled to realize that their designated peer supporter was mandated to support them. A soft call for volunteers in a department is a good place to start, and program planners could also invite department members to nominate those whom they feel would excel in the role. However, this does not mean everyone is suited to this work. Is it imperative that leadership and experienced department members have buy-in during the recruitment phase to ensure that high quality peer supporters are chosen.

Once a group of committed volunteers is in place, the next step is to offer them some sort of structured and evidence-based training for the work. Elements of CISM (Critical Incident Stress Management) can offer a good foundation, as the CISM model has been utilized for decades in support of emergency responders. The various elements of CISM, which this paper will not cover, are geared to offer "structured assistance for a normal reaction to an abnormal event."[3] CISM offers a guided opportunity for people to name and give voice to thoughts and emotions following a traumatic event – a first step toward resilience. An important aspect of CISM (and of peer support) is that its focus should not be on the details of an event, but instead on normalizing and mitigating the reactions of the person involved.[3]

General elements of formal peer support training should involve 1) defining the second victim phenomenon, to include a literature review, 2) role-playing exercises to practice likely scenarios, 3) a time of reflection and learning from the role-playing scenarios, and 4) education about institutional and general resources available to second victims.[1,8] The trainers should be experts in behavioral health, peer support, social work, CPE (Clinical Pastoral Education), or a similarly related discipline that specializes in reflective listening and insight into human behavior. Trainers also should be at least somewhat familiar with the setting in which the peer support team will be offering their services. Peer support team planners can reach out to these experts within their healthcare system or a neighboring system to see who has offered this type of training in the past, or who would feel competent putting together a curriculum.

If no experts are available within or nearby the healthcare system to give the training, the planners can utilize a psychological first aid workshop (in person or virtual) or a nationally recognized healthcare peer support training program, such as the Brigham and Women's Hospital Peer Support Program.[12,13] Both of these options could be costly for the organization or for the peer supporters themselves, however in the absence of local trainers it would be an excellent catalyst for clinicians who are passionate about starting a peer support program. One such surgery department at Columbia University Irving Medical Center recently called upon Dr Jo Shapiro from Brigham and Women's Hospital for exactly this kind of training to get their peer support program up and running.[14]

Following formal training, peer supporters should feel that they have a working strategy to engage second victims. Important elements of this strategy during a peer support session are: 1) emphasizing confidentiality, 2) avoiding a rehash of specific details of the adverse event, 3) reflective listening and acknowledgement, 4) reviewing and normalizing common symptoms the second victim may feel, and 5) creating a plan together by identifying coping mechanisms and reviewing existing support systems.[1] Peer supporters should also have regular support and debriefing available within their team in order to maintain their own resilience, share strategies and difficulties, and continue building best practices for the peer support program. The RISE (resilience in stressful events) peer support program team at Johns Hopkins Hospital implemented a standard for a debriefing to be held after each peer support encounter so the team could give feedback and support to the peer who conducted the intervention9. This is a vital part of any peer support program – caring for the caregiver.

4. Promoting the peer support program

A perfect peer support program is useless unless clinicians in need are aware of its existence. Once peer supporters are trained and ready to engage, program planners and directors should promote the program at hospital grand rounds, in local organizational publications, and in departmental meetings and huddles.[4] A confidential method to contact the peer support team should be made readily available via bulletin boards, group emails, and hospital intranet sites. Each healthcare setting has unique and preferred methods of communicating, and peer support programs should maximize their outreach using these methods. Program leaders should welcome general inquiries about the program as well as confidential requests for peer support, and they should be proactive in educating colleagues

about the need for the program, supportive literature and resources, and best practices that were followed in program design. Elements of the peer support strategy (noted in the previous paragraph) can be used in flyers and presentations about the program. Personal stories are also powerful tools to use in promoting the program, displaying that even the most seasoned clinicians can make mistakes and that they too experience the fallout of emotions that come from adverse events.

As methods of promotion vary from setting to setting, preferred methods of referral for second victims also vary. If a setting is small and tight-knit, a referral may be more likely to happen by word of mouth or by a simple phone call about an event. In larger settings, it is important for the team to have more formal criteria: should peer supporters reach out confidentially after adverse events as part of an event review checklist? Should the peer support team take a more passive approach and wait for the second victim to reach out, relying on institutional promotion? Some larger settings have designed confidential digital event reporting structures.[8] The answer depends on the setting, but the team should choose a dedicated approach to begin with, adapting as necessary when the service gets up and running.

A clinician who becomes a second victim remains a valuable resource to the institution, provided he or she is offered empathy, insightful tools and peer support that can facilitate resilience. Creating a culture of peer support within an organization is not only morally sound, it strengthens the entire institution. As Rushton notes, resilient clinicians do not hide their scars but instead utilize the strength and wisdom acquired through adversity to build up their peers and treat their patients. Second victims may feel guilty, isolated and trapped — and by participating in a culture of healing can offer support to the next clinician who finds themselves in a similar situation. "Many clinicians experience a sense of relief when they realize that their suffering is not unique and that they are no longer isolated in their suffering… by recognizing our own suffering, we can begin a process of transforming our practice at the bedside."[5]

Conflicts of interest

No financial or ethical conflicts of interest exist for the author of this article.

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