Second Victims of Medical Errors: How It Affects The Team of Providers
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Thank you!
The Second Victim: Helping Providers Cope with Medical Errors

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Disclosures

• No financial disclosures
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Objectives

- Describe the concept of “The Second Victim”
- Recognize providers are emotionally affected by a medical error
- Implement strategies to effectively assist providers with coping with medical errors in a Just Culture
- Describe Educational Opportunities to educate trainees on medical errors
Also Referred to As:

  – First Victim - Patient/Family

• Alternative Terms:
  – collateral damage
  – coping with medical mistakes
  – recovering from errors
  – injury from your own mistakes
Triple Tragedy of 1817
HOSPITAL MEDICAL ERRORS KILL 98,000 AMERICANS EACH YEAR. -- HEARST NEWS INVESTIGATION
Challenges and Successes in Patient Safety, Quality and Satisfaction

**Hospital mortality**

251,000

8.9%

Annual estimated deaths due to medical errors, the third-leading cause of death in the U.S.

*Source: BMJ*

Percentage of physicians saying they had made a medical error in the previous three months. Within that group, 1.5% of physicians believe the error resulted in a patient’s death

*—Annals of Surgery, 2009*

**Patient satisfaction**

Star ratings for patient experience among 3,685 acute-care hospitals reporting to the CMS

- 5 stars: 337
- 4 stars: 1,188
- 3 stars: 748
- 2 stars: 259

*—CMS*
Medical Errors Still Challenge the Industry

- 52% of Sentinel Events reported to the Joint Commission between 2005-17 resulted in patient death
- 25% of Sentinel Events during that same period resulted in unexpected additional care

Top five reported Sentinel Events, 2017

<table>
<thead>
<tr>
<th>Event</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unintended retention of foreign body</td>
<td>116</td>
</tr>
<tr>
<td>Fall</td>
<td>114</td>
</tr>
<tr>
<td>Wrong-patient, wrong-site, wrong procedure</td>
<td>95</td>
</tr>
<tr>
<td>Suicide</td>
<td>89</td>
</tr>
<tr>
<td>Delay in treatment</td>
<td>66</td>
</tr>
</tbody>
</table>

—The Joint Commission
Medical Errors - Trainees

- 34% of internal medicine residents reported at least one major medical error during training.
- 18% of multi-disciplinary residents reported an adverse event related to his/her care in the previous week.
- No good data about the frequency of medical errors among attending physicians.
“Doctors are only human” - REALLY?

Reality – There is no room for mistakes in modern medicine

- Technology wonders
- Precise laboratory tests
- Expectation of perfection
  - Over-achievers
Man - a creature made at the end of the week when God was tired.

- Mark Twain
Providers - the “Second Victim” of Medical Errors

• 3-fold increase in depression
• Increase in burnout
• Decrease in overall quality of life
• Feelings of distress, guilt, shame may be long-lasting
• Feelings appear to occur regardless of stage of training

West CP et al. JAMA. 2006;296:1071-1078.
Emotional Impact of Medical Errors on Physicians

- Loss of Confidence: 44%
- Reduced Job Satisfaction: 42%
- Difficulty Sleeping: 42%
- Felt Their Reputation had been Damaged: 13%

Provider Impact – Intrapartum Complications

• 6 index cases
  – Shoulder dystocia
  – Intrapartum fetal deaths

• Next 50 delivers
  – 37% increase in Cesarean deliveries vs. mothers controls (no change)
Medical Errors: Emotional Impact on Health Care Providers

Ultimate Impact

• Leave medical profession
• Suicide
Nurse's suicide highlights twin tragedies of medical errors

Kimberly Hiatt killed herself after overdosing a baby, revealing the anguish of caregivers who make mistakes.
Predictors of Impact of Medical Error

• Patient outcome
  – The more severe the morbidity the greater the impact

• Degree of personal responsibility
  – The more responsible, the more damaging the error

Medical Error Processing for Patients

• Disclosure
  (Explanation, Apology, Prevention of recurrence)
• Family, Friends
• Hospital Support
• Legal Action
Personal Reaction to Medical Error

• “It will never happen again”
• Singled-out
• Exposed
• Replay over and over and over
• Confess, admit, tell
The Medical Error Guilt

- **CONFESSION**
- **RESTITUTION**
- **ABSOLUTION**
  - Discouraged
  - Grieving process mechanisms non-existent

Medical Error Processing for Residents/ Attendings

- Morning Report
- Morbidity / Mortality
- QA / PI
- Root Cause Analysis
- NAME BLAME SHAME GAME

Culture of Blame

• Individual and groups deal with adverse events by identifying one or more individuals to hold accountable for the event and seek resolutions through sanctions.
Whack a Mole

The Price We Pay For Expecting Perfection

David Marx
“Whack a Mole”
The Price We Pay For Expecting Perfection

• Human Error
  – Console

• At-risk Behavior
  – Coach

• Reckless Behavior
  – Punish
Just Culture Definition

- Balancing the need to learn from our mistakes and the need to take disciplinary action
- A culture in which individuals come forward with mistakes without fear of punishment
WASHINGTON
2 planes land while tower chief snoozes

WASHINGTON — Two airliners landed at Reagan National Airport near Washington without control tower clearance because the air traffic supervisor was asleep, safety and aviation officials said Wednesday.

The supervisor — the only controller scheduled for duty in the tower about midnight Tuesday when the incident occurred — had fallen asleep, said an aviation official, who spoke on condition of anonymity.

The National Transportation Safety Board is gathering information on the occurrence, board spokesman Peter Knudson said.

The pilots of the two commercial planes were unable to reach the tower, but they were in communication with a regional air traffic control facility in Warrenton, about 40 miles from the airport.

After the pilots were unable to raise the airport tower, they asked controllers in Warrenton to call the tower, Knudson said. Repeated calls went unanswered, he said.

The Federal Aviation Administration released a statement confirming the incident.

“The FAA is looking into staffing issues and whether existing procedures were followed appropriately,” agency spokeswoman Laura Brown said in an email.

— Associated Press
Event Investigation

• What happened?
• What normally happens?
• What did policy/procedures require?
• Why did it happen?
• How was the organization managing the risk before the event?
Medical Error Processing for Providers

- Focus on Prevention is First KEY
- Accepting responsibility
- Understanding of error event
- Need for Support – “not sign of weakness”
- Discussions with family and colleagues
- Professional and Social networks
- Disclosure
Emotional Impact of Medical Errors on Physicians

- Felt that Hospitals/Health Care Orgs Offered Inadequate Support for Coping with Stress: 90%
- Expressed Interest in Counseling: 82%
- Anxiety about Future Errors: 61%

Processing of Medical Errors – a New Approach

• Institutional support
  – Educational curriculum
  – Employee assistance program
  – One-on-one peer support
  – “Confessor” figures

• Program Director, Chair, Teaching Faculty

Second Victim Conceptual Intervention Model

- Unanticipated Clinical Event
- Second Victim Reaction: Psychosocial & Physical
- Institutional Response
- Clinician Recovery
  - Dropping Out
  - Surviving
  - Thriving
- Supportive Interventions

Credit: University of Missouri ForYOU Team
forYou Team Principles

• Peers with listening and supportive skills
  – Not counselors
• Strictly confidential
• Focus: “second victim’s” emotional response
  – Not event details
• Safe zone of supportive intervention
We’re here for you and your family.

forYou team

Health Care
University of Missouri Health System
The TRUST Team

• Developed by a multidisciplinary advisory committee. The TRUST team was initially founded to support Second Victims but is now being considered to support other front line staff who are facing work related stressors.

• Treatment that is fair and just
• Respect
• Understanding and compassion
• Supportive care
• Transparency and opportunity to contribute
TRUST Team
PROVIDING CARE AND SUPPORT FOR OUR STAFF

TRUST Team provides compassionate and coordinated care to staff involved in a significant medical event, also referred to as The Second Victim.

WHAT DOES SECOND VICTIM MEAN?
Second victims are health care providers or caregivers who are traumatized by adverse patient events. Such events include, but are not limited to:
- Medical errors and/or patient-related injuries
- Any tragic circumstance involving a patient or group of patients
- Unexpected death or debilitation of a patient, despite provision of excellent care
- Litigious action brought on by a patient or patient’s family
- A series of losses within one particular unit or care team without time to adequately process and grieve in between those losses

WHO CAN BECOME A SECOND VICTIM?
Every health care worker can become a second victim. It is estimated that almost 50 percent of all health care providers are a second victim at least once in their career.¹

WHAT DOES TRUST STAND FOR?
TRUST was coined as “The 5 Rights of the Second Victim.”² It stands for:
- Treatment that is just: Second victims deserve the right of a presumption that their intentions were good, and should be able to depend on organizational leaders for integrity, fairness, just treatment and shared accountability for outcomes.
- Respect: Second victims deserve respect and common decency and should not be blamed and shamed for human fallibility.
- Understanding and compassion: Second victims need compassionate help to grieve and heal.

Supportive care: Second victims are entitled to psychological and support services that are delivered in a professional and organized way.

Transparency and opportunity to contribute: Second victims have a right to participate in the learning gathered from the event, to share important causal information with the organization and to be provided with an opportunity to heal by contributing to the prevention of future events.

TRUST TEAM MISSION
The TRUST Team exists to increase organizational awareness of the second victim phenomenon by providing education to leaders and health care providers. The team also provides immediate and ongoing support, mentoring, clinical intervention and linkage to resources needed to support any provider who is a second victim. Efforts are collaborative and coordinated to assure that needs of the second victim are met in a compassionate and safe way. Our goal is to assist second victims in returning to fulfillment in their careers and lives.

PROGRAM COMPONENTS
1. Outreach: Our Outreach Providers will make contact with the second victim to provide support and assessment of additional needs. Outreach Providers are qualified mental health professionals and will assist in addressing immediate and longer term needs with the second victim. These conversations are completely confidential.
2. Peer supports: Our peer supports are volunteer health care providers who have had personal experiences as second victims. They have received training regarding the second victim phenomenon and the mentoring relationship. TRUST Team mentors will meet with you to support and guide you through your journey and link you to resources if greater concerns arise.
3. Employee assistance: The TRUST Team and Employee Assistance Program (EAP) are partnering to assure that second victims who require greater clinical support are linked to a Carilion EAP consultant. EAP consultants are licensed and certified mental health professionals. This level of service is also completely confidential and abide by HIPAA.²
4. Organizational education: Our goal is to educate our health care providers and leaders on the second victim phenomenon and compassionate ways to respond.
5. Planning and development: The TRUST Team is monitored by the Second Victim Steering Committee. This committee will continuously evaluate the organization’s response to the second victim and make recommendations to organizational leadership based on trends and experiences of health care providers who are involved in a significant medical event.
I GOT YOUR BACK
To Err is Human
Preventing “Second Victim” Casualties is Humane
TO SAVE A LIFE!

1. Pick up life ring
2. Grab the rope
3. Keep hold of end of line
4. Throw ring to casualty
5. Pull casualty to shore

IF POSSIBLE SEND SOMEBODY ELSE FOR ASSISTANCE
- DIAL 999 FOR EMERGENCY SERVICES

DO NOT INTERFERE WITH THIS EQUIPMENT

Under the Criminal Damage Act 1971, any person found tampering with this equipment may receive up to a £5,000 fine and/or imprisonment.
Thank You
Complication after surgery? 

Yes 

Was an Anesthesia provider present? 

Yes 

Blame Anesthesia 

No 

Was an OR Nurse in the room? 

Yes 

Blame OR Nurse 

No 

Any Surgical Residents? 

Yes 

Blame the Resident 

No 

Hmm, ok, am I the greatest Surgeon here? 

Yes 

Was anesthesia within 100 feet of patient? 

No 

Did the patient have abnormal anatomy? 

Yes 

Blame the patient 

No 

Was radiology involved at any point? 

Yes 

Blame Radiology 

No 

For previous surgeries, was anesthesia given? 

Yes 

First Question was answered incorrectly There can be no conclusion 

No
Source and Credits

• This presentation is based on the January 2008 AHRQ WebM&M Spotlight Case
  – See the full article at http://webmm.ahrq.gov
  – CME credit is available

• Commentary by: **Colin P. West, MD, PhD**, Mayo Clinic College of Medicine
  – Editor, AHRQ WebM&M: Robert Wachter, MD
  – Spotlight Editor: Tracy Minichiello, MD
  – Managing Editor: Erin Hartman, MS
References

OUP Colleague Support Program

- Includes support after any difficult patient care encounter, critical incident, claim, or other support needed during the process of managing patient and provider risk support.
- Research identifies physicians want support from their peers.
- Mechanism by which clinicians can communicate about their experience and emotions with someone who has ‘been there.’
- Not for the purpose of giving legal advice, medical expert opinions, or professional psychological counseling, but the panel will offer both support and strategies that have helped other clinicians in similar situations.

Contact the Colleague Support Program
Phone: 405-271-1800 or 918-660-3628
Email: oupoumcolleaguesupport@ouhsc.edu
More info: https://www.oumedicine.com/ou-physicians/colleague-support

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OUP Risk Services Policies:

- RM1- Disclosure Guidelines
- RM2- Dismissal of Patients
- RM3- Peer Review
- RM4- Confidential Reporting of Incidents
- RM5- Recalls
- RM6- Informed Consent
- RM7- Disruptive or Impaired Healthcare professional or staff

*found on OUP intranet

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