Second Victim: Gaining A Deeper Understanding To Mitigate Suffering

Susan D. Scott1, RN, MSN, Laura E. Hirschinger1, RN, MSN, Myra McCoig1, Julie Brandt2, PhD, Karen R. Cox1,2 PhD,RN, Leslie W. Hall1,2 MD

1University of Missouri Health Care System
2University of Missouri Center for Health Care Quality
Columbia, Missouri

Key contact Email: scotts@health.missouri.edu

Background:

When patients suffer unanticipated adverse outcomes, health professionals caring for them often become “second victims” of such events.1 Although some information regarding second victim responses exists,2-7 a more systematic understanding of commonly experienced symptoms and behaviors could lead to the design of supportive interventions.

University of Missouri Health Care (UMHC) is an academic medical center with more than 5,000 employees providing comprehensive health care services throughout the state. The Office of Clinical Effectiveness (OCE) is charged with transforming the safety culture within UMHC, to include managing the system’s response to preventable events and unexpected outcomes. In 2007, OCE added second victim questions to our patient safety culture survey and 15% (n=175/1,160) reported they had experienced a patient safety event in the past year that caused personal problems such as anxiety, depression, or concerns about job capabilities.

Purpose:

The OCE interviewed second victims to gain a better understanding of the phenomenon and to identify institutional support strategies that could mitigate suffering.

Methods:

Following IRB approval, second victim volunteers representing three professional groups were solicited for private, hour-long interviews. The 23-item semi-structured interview tool covered basic demographics, participant recount of event circumstances, symptoms experienced,
and recommendations for institutional support. Interview tapes were transcribed by one person and double-checked for accuracy by a second. Transcripts were analyzed with the goals of understanding and naming the trajectory and formulating support recommendations. Research team meetings were convened until consensus was achieved.

Results:

Forty-four individuals were contacted, 38 (86%) agreed to be interviewed, 5 never scheduled interviews, 2 declined after consent review. Thirty-one interviews were completed with physicians (n=10), RN’s (n=11), and others (n=10). Average years of experience were 14, 58% were females and time since event ranged from 1-45 months. Participants experienced a variety of physical and psycho-social symptoms which did not differ by gender or professional group (Figures 1 and 2 contain the most commonly reported symptoms). Six stages were named in the second victim trajectory and Table 1 summarizes these stages along with common questions victims ask themselves and institutional supports to respond to the individual stage. In addition, 71% (22/31) described ‘triggering’ events that caused them to experience flashbacks, even long after the event. Several reported that involvement in improvement work or becoming an advocate for patient safety helped them to once again enjoy their work. With regard to supportive institutional actions second victims encouraged early identification of suffering, provision of ongoing emotional support from peers, coordination of the institution’s overall event response to include gossip control, and inviting second victims to become members of the event-related improvement team.

Conclusions and Implications

The identification and trajectory of second victims is largely predictable. Institutionally-developed programs that screen at-risk professionals immediately after events complimented by deployment of appropriate support could influence their recovery and potentially career
outcomes. Programmatic evaluation will be essential for ongoing refinement of institutional support strategies.

References


Figure 1: Most Commonly Reported Symptoms, Showing Comparison By Gender
Figure 2: Most Commonly Reported Symptoms, Showing Comparison By Professional Group

- **Frustration**
  - MD: 29%
  - RN: 29%
  - Other: 26%

- **Decreased Job Satisfaction**
  - MD: 23%
  - RN: 19%
  - Other: 26%

- **Anger**
  - MD: 29%
  - RN: 29%
  - Other: 26%

- **Extreme Sadness**
  - MD: 65%
  - RN: 65%
  - Other: 65%

- **Difficulty Concentrating**
  - MD: 20.7%
  - RN: 23.6%
  - Other: 23%

- **Flashbacks**
  - MD: 13%
  - RN: 29%
  - Other: 29%

- **Loss of Confidence**
  - MD: 65%
  - RN: 65%
  - Other: 65%

- **Grief**
  - MD: 20%
  - RN: 16%
  - Other: 16%

- **Remorse**
  - MD: 9.6%
  - RN: 25.7%
  - Other: 25.7%
<table>
<thead>
<tr>
<th>Table 1: Research Team Consensus Chart - The Second Victim Trajectory</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 1</strong>&lt;br&gt;Chaos &amp; Accident Response</td>
</tr>
<tr>
<td><strong>Stage 2</strong>&lt;br&gt;Intrusive Reflections</td>
</tr>
<tr>
<td><strong>Stage 3</strong>&lt;br&gt;Restoring Personal Integrity</td>
</tr>
<tr>
<td><strong>Stage 4</strong>&lt;br&gt;Enduring the Inquisition</td>
</tr>
<tr>
<td><strong>Stage 5</strong>&lt;br&gt;Obtaining Emotional First Aid</td>
</tr>
<tr>
<td><strong>Stage 6</strong>&lt;br&gt;Moving On&lt;br&gt;(One of Three Trajectories Chosen)</td>
</tr>
<tr>
<td><strong>Surviving</strong>&lt;br&gt;Coping, but still have intrusive thoughts&lt;br&gt;Persistent sadness, trying to learn from event</td>
</tr>
<tr>
<td><strong>Thriving</strong>&lt;br&gt;Maintain life/work balance&lt;br&gt;Gain insight/perspective&lt;br&gt;Does not base practice/work on one event&lt;br&gt;Advocates for patient safety initiatives</td>
</tr>
</tbody>
</table>