Those that enter the healthcare field knowingly put themselves into situations that are likely to be emotionally charged and stressful during their career. Decisions are made on a dime that can have catastrophic results if not the right decision; not only to the patient and family members, but to the provider and the entire healthcare team. The impact can be felt by the young and new providers, as well as by the older more experienced and seasoned provider. Without immediate support and intervention, the recovery of the provider and a potential career could be at stake.

"National patient safety and quality movements in health care recognize the emotional impact that medical errors and unanticipated outcomes have on patients, families, and clinicians". The IOM report, To Err Is Human, estimated that 98,000 people die from medical errors each year. The Institute for Healthcare Improvement’s 5 Million Lives Campaign went even further, and calculated that there are approximately 15 million adverse medical events each year, 6 million of which cause harm to the patient resulting in a significant deviation in the patient care process.

In the hospital setting, this conservatively translates to 12 million health care providers and 12 million affected family members who are emotionally impacted each year. Despite the large number of patients, families, and health care providers affected, only a small number of systems have been set up that address the emotional impact of these events.

The emotional response of the provider was first described in the literature by Albert Wu as the “second victim” phenomenon. Wu noted “…although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the ”second victims”. Additionally, Scott describes a “second victim” as a health care provider involved in a medical error, an unanticipated adverse patient event, and/or a patient-related injury who becomes victimized in the sense that the provider is traumatized by the event. Second victims frequently feel personally responsible for these unexpected patient outcomes and feel they have failed their patients, second-guessing their clinical skills and knowledge base.

Scott et al in their study to understand the phenomenon of the “second victim”, which was done in order to design and test supportive interventions, found that the participants developed their own ways of coping, yet all described a predictable recovery trajectory. The six stages were identified and named as follows: (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. They can be loosely compared to the stages of grieving, with the effects analogous to post traumatic stress disorder. The literature further describes provider’s feelings of shame, anger, self-doubt, depression and guilt among many other feelings of inadequacy. These effects may be long lasting, with some physicians feeling “permanently wounded” as a result. The feeling of responsibility for a serious medical error enters a vicious cycle by provoking burnout, depression and reduced empathy, which in turn can result in suboptimal patient care and higher odds for future errors.

While institutions do not have a legal obligation to offer support to the “second victim”, an ethical obligation exists. Many studies show that health care providers struggle to find support to help them cope with the myriad of emotions that exist, and in many instances found the issues were not addressed at all. The available studies suggest that physicians involved in errors usually do not feel supported in coping with this experience by the institutions they work in. At best, many report that support is random and dependent on the others involved in that event.

Wu et al. reports that nearly a third of surveyed house officers indicated that “the hospital atmosphere inhibited them from talking about the mistakes” and 20% reported that the “administration was judgmental about the mistakes”. In another published study 90% of surveyed physicians disagreed that health care organizations lend adequate support in coping with stress associated with medical errors (37% disagreed strongly). We treat our clinicians who are involved in human error and system failures with both blame and shame, and, what may be most harmful, abandonment.

We are taught to aim for perfection, which makes it difficult to admit mistake, and thus ask for assistance when one occurs. It has long been the culture to remain silent about errors, which
not allowed us to provide the compassion and support which is essential. Providers are afraid to reach out for fear of litigation and not being sure what is appropriate to discuss and with whom. We often investigate the events in silos, not sharing our pertinent findings, again hindering the support we provide our "second victim", as well as hindering our efforts to learn from our mistakes and thus improve patient safety. Only recently has begun to shift the culture from the name and blame game to one of transparency, which will ultimately improve the care that we give our patients and our care providers. The traditional way that errors have been discussed in institutions is through Mortality and Morbidity (M&M) conferences. This forum allows discussion of the event and error(s) and integrates them into clinical practice and "best practices" for patient safety and outcomes. However, in actual practice, these forums have been found to be an ineffective mechanism to support the "second victim." Current data shows that M&M conferences are insufficiently used to establish a learning and supportive environment for staff involved in errors.16

Providing de-briefing for all providers involved, including those who are directly and indirectly involved, when going through the above described six stages can help mitigate some of the gossip, self-doubt and self-loathing that are exhibited. However, while physicians report communication and interaction with colleagues or supervisors as most helpful to deal with the emotional distress after error involvement, affected individuals often struggle to find support.17 With well-established systems and practices in place, the question of who the "second victim" can go to in order to get support is no longer of issue. The isolation that is often felt by the "second victim" can also be alleviated with adequate support systems; knowing that they are not alone can help ease them through the remaining stages.

When talking about patient safety, and specifically medication safety, we implore our providers to adhere to "The Five Rights": the right patient, the right drug, the right time, the right dose and the right route. Denham has adopted that concept and proposed "The Five Rights of the Second Victim".18 They are the five human rights that our health care leaders must consider as an integral part of a fair and just culture when patients are harmed during the process of care; TRUST (Treatment that is just, Respect, Understanding and compassion, Supportive Care, and Transparency and the opportunity to contribute to learning).19 In summary, Denham's concepts are:

**Treatment that is just:** to provide the compassion and caring that we provide to our patients. In a “Just Culture,” a non-punitive approach of just treatment is adopted that can lead to improving the system that allowed the error to occur. **Respect:** Nurses, pharmacists, and all members of the health care team are susceptible to error and vulnerable to its fallout. In the immediate period after an event, it is second nature to fall into a name-blame-shame cycle, often denying our colleagues even the most basic elements of respect and common decency. We must practice “the golden rule” and treat our colleagues with the same respect we would expect. Leaders must encourage their organizations to respect those involved in an event. **Understanding and Compassion:** The instant preventable and unintentional harm occurs to a patient, their caregivers become patients. The caregiver needs time and compassionate help to be able to grieve; to go through the stages articulated by Kubler Ross: denial, anger, bargaining, depression, and acceptance. Leadership must understand the pathophysiology of psychological emergency that occurs when a caregiver unintentionally harms a patient. They must reach out to the second victims with the very compassion that they espouse or seek to deliver to their own patients. **Supportive Care:** Our caregivers are entitled to psychological and support services and we must take a systematic approach to delivering this care in as professional and organized way as we would in treating any other patient. **Transparency and the Opportunity to Contribute:** Improving patient safety hinges on the ability of health care providers to accurately identify, disclose, and report medical errors. We need to allow workers the opportunity to "make things right" when their behavior has contributed to unintentional harm.20

Interventions should be established as soon as possible, and the existence of support program/services should be widely publicized. Clinicians should be part of the response to the event. The response effort should also be tailored to the specific institution- some types of programs might work better in some institutions than others. In addition, specific programs (peer support, employee assistance programs or counseling) for specific sectors of the work force might prove useful.21 No program will be successful unless there is support by senior leadership (the C-suite). Noted are the comparisons of the "Five Patient Rights" to the "Five Rights of the Caregiver". A program can be developed similar to a Rapid Response Team (RRT) for rescuing a patient to a Rapid Response System (RRS) for rescuing the "second victim".22 The typical RRT is a group of dedicated, experienced professionals charged with responding to the acute clinical deterioration of a patient rapidly. The RRS in turn would be a dedicated team with knowledge and experience in supporting clinicians during the acute stages following the event.23
The University of Missouri Health Care System undertook the task of putting together a RRS. It began in earnest in 2006 where an inter-professional team started to review the literature surrounding the "second victim". They also looked at other support programs that were in existence: The Medical Induced Trauma Support Services (MITSS) and the Critical Incident Stress Management (CISM). A qualitative study of health care providers (small sample size of 31) was then conducted from October 2007 - January 2008. Interviews were designed to understand the experience of the "second victim" and to learn what interventions these providers felt would be most beneficial in their recovery.24

The second stage of their research was much broader, including 5300 faculty and staff, using a Web-based survey. The survey consisted of four demographic questions and three "yes/no" items to quantify knowledge of the term "second victim" prior experience as a "second victim", and institutional support received.25 The next two items focused on recent personal experience and support received. The final item was an open-ended text box for the participant to recommend supportive strategies that he or she believed would promote healing and to record what he or she desired from the organization.26 More than one third of those who responded had heard of the term "second victim", and one third responded that they were "second victims".27 Approximately 15% reported seriously thinking about leaving the profession as a result of the event, and 65% reported working the issues out on their own.28 When it was offered, 35% reported receiving support from colleagues and peers, and 29% received support from supervisory personnel.29 Eight themes were identified to describe the characteristics of the programs to aid the "second victim". The most frequently cited characteristic was to provide support immediately after the event in a place away from the event (somewhere else in the institution) to allow the "second victim" to re-group. Support was preferred to be at the unit base, departmental level, and should be readily accessible and should be staffed by professional, trained counselors.30

Based on these findings, senior leadership supported the implementation on an on-demand RRS for the "second victim".31 It provided support twenty four hours a day, seven days a week and was activate in March 2009. The model used has a three-tiered approach:

**Tier 1** promotes basic emotional first aid at the departmental level. It's that immediate "Are you okay?" response. It was estimated that 60% of "second victims" will receive support at this level.

**Tier 2** provides additional guidance and nurturing, and will meet the needs of an additional 30% of "second victims". The support is provided by specially trained peer supporters who are adept at noticing the signs and symptoms suggestive of a "second victim" response and can provide instantaneous one-to – one support. The supporters can also provide debriefings for entire teams if needed.32

**Tier 3** ensures availability and access to professional counseling support and guidance when the stress of the "second victim" exceeds the expertise of the peer RRS. It is estimated that 10% of "second victims" require escalation to the third tier. Examples of members of the tier 3 team include Employee Assistance program personnel, social workers, clinical psychologists and chaplains. Additionally, support is provided to all the team members, who meet monthly for their own debriefing and mentoring.33

As stated above, the University of Missouri Health Care System studied the CISM and MITSS peer support programs that were already in place when developing their own program. These support programs are summarized below as knowledge of these programs in addition to the University of Missouri Health Care System’s RRS may be helpful for an organization embarking on establishing their own unique peer support program.

**Critical Incident Stress Management (CISM)** is an intervention protocol designed for dealing with traumatic events, and is used by aviation and pre-hospital personnel after post traumatic community events.34 Examples of where it has been used include after the Oklahoma City bombing and the terrorist attacks of September 11, 2001. It was first developed for use with military combat veterans and then first responders, but has been adapted for use in other venues.

Some commonly used techniques are debriefing, which is a proactive intervention involving a group meeting or discussion about a particularly distressing critical incident.35 The CISD is designed to mitigate the impact of a critical incident and to assist the persons in recovery from the stress associated with the event. Ideally it is conducted within 24 and 72 hours after the incident. Defusing is an intervention that is a shorter, less formal version of a debriefing.36 It generally lasts from 30 to 60 minutes and is conducted within one to four hours after a critical incident. Like a debriefing, it is a confidential and voluntary opportunity to learn about stress, share reactions to an incident and vent emotions.37

Grief and Loss Session is a structured group or individual session following a death and assists people in understanding their own grief reactions, as well as creating a healthy atmosphere of openness and dialogue around the circumstances of the death.38 Crisis Management Briefing is a large, homogeneous group intervention used before, during and after crisis to present facts, to facilitate a brief, and to allow
for controlled discussion, Q & A and information on stress survival skills and/or other available support services. 20

**Medically Induced Trauma Support Services (MITSS)** has provided a predictable support network for patients, families, and clinicians following adverse medical events since 2002. 21 It was founded by Linda K. Kenney to "Support Healing and Restore Hope" to patients, families, and clinicians following adverse medical events. MITSS recognizes that everyone involved in an adverse event needs support. They provide direct support to patients and families as well as individual clinicians from the beginning. As an organization, MITSS has advocated that healthcare institutions build their own infrastructures of support for their staff. 22

In conclusion, a large portion of the health care workforce continues to suffer in relative silence unsupported after a serious event has occurred. As a society, we are implored to provide a readily accessible and effective support structure for all health care providers beginning the moment that events causing anxiety and stress are discovered, and as long as necessary. These initiatives should be established and disseminated throughout an institution so that providers will know the logistics; what is available, what can be expected, and how to access assistance in the aftermath of clinical events.

As discussed throughout this article, given the profound impact of adverse medical events on clinicians, patients, and their families, it is essential that health care leadership provides appropriate support to its staff. Errors are most often ultimately the failure of leadership, organizations and systems – not the front line staff. 23 The culture "as is" has expected staff to do no harm and to perform their tasks perfectly 100 percent of the time, which we know is not possible; as we are human. Given that the large majority of errors are due to failures of faulty systems and not bad people, providing support to clinicians and other staff at the sharp end of medical care is simply not just the right thing to do; it's the respectful and compassionate thing to do. 24

We must establish and nurture a culture of quality and safety that is honest, empathetic, respectful, and forgiving. Health care leaders must play an active role in nurturing a climate of compassion and mutual respect. Front line peers, supervisors and other administrators can be trained to provide support at the time of the event. However, commitment from the top levels of leadership with the needed infrastructure and allocation of necessary resources are key elements of the successful support models that have been described. We must respond promptly and proactively in the event of an error, ensuring that all affected staff members are treated with respect, compassion and support from leaders and their colleagues. 25 Anything less and we have not learned our lessons and have failed our patients, their families and our staff. And our staff is our most valuable asset.

2 Id
3 Id
4 Id
9 Id
12 Wu, supra note 6.
13 Schwappach, supra note 11
14 Wu, supra note 6
15 Id
16 Schwappach, supra note 11
19 Id
20 Id
22 Scott, supra note 7.
23 Id
24 Id
25 Id
26 Id
27 Id
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