TRUST: How to build a support net for ObGyns affected by a medical error

⊗ Physicians who are affected by a medical error can show signs of distress. Identifying those signs, and addressing them by providing crucial support, can make all the difference for an ObGyn in need.

Patrice M. Weiss, MD

An estimated 98,000 Americans die each year due to medical errors. This is an attention-grabbing statistic—from the year 2000.[1] A recent study (published in 2016) reported that medical errors are the third leading cause of death in the United States, ranking just behind heart disease and cancer.[2]

As expected, much has been done to reduce medical errors and improve patient safety as a result of these publications. Quality, safety, and outcomes are paramount, as evidenced by the Institute of Health Care Improvement's "triple aim": reduce cost of care, improve quality of care, and improve patient outcomes.[3]

While these 3 aims are of paramount importance, this article seeks to portray the "quadruple aim," with an additional focus on physician well-being. Patients and their families (first victims) are not the only ones affected by medical errors. Clinicians are, too, and these effects can be devastating. Here I offer concrete strategies to support providers involved in medical errors, including tips on developing a formal support program. First, however, I describe the devastating effects medical errors can have on providers and the signs of a second victim.

The scope of the problem

In 2000, it was Dr. Albert Wu's publication in *The British Medical Journal* titled "Medical Error: The Second Victim" (the doctor who makes mistakes needs help too), that first addressed this important topic.[4] In his article he shared a case of another house officer who missed signs of a pericardial tamponade and was judged incompetent by peers due to his mistake.

As physicians, we do not intrinsically support colleagues who have experienced a medical error. We all have taken, with pride and commitment, our Hippocratic Oath of "do no harm," yet we are often held to standards of perfection by society, peers, and, above all, ourselves. Have technologic wonders and precise laboratory tests supplanted the adage "doctors are only human"? Dr. Wu also points out in this landmark essay his observation and dismay at the lack of empathy,

Dr. Weiss is Professor in the Department of Obstetrics and Gynecology at Virginia Tech Carilion School of Medicine and Chief Medical Officer and Executive Vice President at the Carilion Clinic in Roanoke, Virginia.

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HAVE **YOU** HEARD?

🔊 Dr. Weiss zeroes in on "Medical errors: caring for the second victim (you)" in an audiocast at obgmanagement.com

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sympathy, and compassion shown by peers when medical errors occur. All of these elements are needed for the healing of those involved to take place. If they are not provided, dysfunctional coping mechanisms ensue.[4]

Incidence of medical errors

Despite the Institute of Medicine report from 2000[1] and the recent study from Johns Hopkins,[2] determining the exact number of errors and incidents is not easy. Most data reporting is sparse. A prospective longitudinal study of perceived medical errors and resident distress estimated medical errors to be between 5% and 10% in hospitalized patients, but that it could be up to 50%.[5] According to a 2005 study, approximately one-third of internal medicine residents report at least 1 major medical error during their 3 years of training, while 18% of multidisciplinary residents report an adverse event under their care in the previous week.[6]

Who is at risk of becoming a second victim?

Any and all clinicians can become a second victim, and the state can be realized at varying points in the process of an experienced medical error. The circumstances of the initial error and the severity of the effect on the patient and/or the damaged physician–patient relationship can affect whether or not there is a second victim. A second victim also can emerge as a result of peers' or colleagues' comments and lack of empathy or support. Certainly a lawsuit can produce a second victim.[7]

How often do physicians become second victims?

The prevalence of second victims has a large variation in estimates. A 2006 study estimates a prevalence of 10.4%.[8] In 2010, the estimate was 30%, and a prevalence of 43.3% was reported in 2000.[9,10] Regarding emotional distress within a year of a major adverse event, 30% of almost 900 providers reported these feelings.[11] Other studies note 50% of health care workers reported feelings consistent with those of a second victim.[7]

The signs of, and long-lasting risks for, a second victim

Second victims are at risk for several well-documented symptoms, regardless of their stage of training, including[6]:

- depression (in fact, they have a 3-fold risk)
- decrease in overall quality of life
- increase in burnout
- increase in feelings of distress, guilt, and shame, which may be long lasting.

Health care providers as second victims also may experience shock and hopelessness, sleep disturbance, social avoidance, intrusive thoughts and nightmares, and poor memory and concentration. Interestingly, these emotions and reactions are indistinguishable from posttraumatic stress disorder. These continued symptoms can have short- and long-term implications for physicians, patients, and the health care organization.[12]

How to support *all* of those affected by a medical error

Over the past decade or so, much attention has been paid to creating safer health systems, improving outcomes and patient satisfaction, and recognizing the needs of patients and families of first victims when medical errors occur. Much less has been done to acknowledge and address the needs of struggling clinicians.

Provide nurturing discussions and sympathy

Hospital systems do have embedded processes to review outcomes and medical errors, including, among others, peer review, quality improvement, morbidity and mortality review, and root cause analysis. Unfortunately, often a "name, blame, shame game" can result from the overall process, with certain individuals or groups of individuals singled out, and only worsen the incidence and effects of the second victim. Ideally, system processes for addressing medical errors should allow for an environment more focused on nurturing discussions to prevent error and recognize all the factors contributing to an error.

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Second victims are at risk for and can show signs of depression, burnout, decreased quality of life, and feelings of distress, guilt, and shame

Of course in any outcome or error investigation, the goal is to identify what happened, what factors contributed to the incident, and what can be done to prevent future occurrences. The concern for the family as priority is understandable, as is the desire to prevent a lawsuit. The lack of attention and sympathy to the health care provider involved contributes to the second victim.[7]

It is all too easy to blame, even in a Just Culture. Deficiencies in sympathy and attention can occur without a system whose culture is focused on "name, blame, shame." A Just Culture, as defined by the Institute for Healthcare Improvement, is one in which individuals come forward with a mistake without fear of punishment. Such a culture balances the need to learn from our mistakes and the need to have disciplinary action.[13]

David Marx, an outcomes engineer and author of "Whack a Mole: The Price We Pay for Expecting Perfection," touts a Just Culture as one having the following sets of beliefs:

- recognition that professionals will make mistakes
- recognition that even professionals will develop unhealthy norms
- a fierce intolerance for reckless conduct.

He strongly asserts that human error be consoled while reckless behavior be punished.[14] Punishing human error is a setup for the second victim.

Tips for developing a coping program

In 2009, Scott and colleagues described 6 stages of a second victim. These are:
- Stage 1: Chaos and event repair
- Stage 2: Intrusive thoughts, "what if"
- Stage 3: Restoring personal identity
- Stage 4: Enduring the inquisition
- Stage 5: Obtaining emotional first aid
- Stage 6: Moving on or dropping out; surviving and/or thriving

Throughout the stages, second victims look

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TABLE The Joint Commission's 10 modules for establishing a support program for clinicians who have experienced a medical error[17]

Module	Example
Internal culture of safety	Organization's patient safety environment level of maturity
Organization awareness	Just-in-time support for clinicians
Multidisciplinary advisory committee	Assess existing internal support resources (both formal and informal)
Leadership buy-in	Soliciting administration approval and endorsement
Risk management considerations	Commitment to rapid disclosure
Policies, procedures, and practices	Formal and predictable crisis communication plan following a clinical event
Operational	Operational details for triggering clinician support
Staff training	Potential educational topics/training requisites
Communication plan	Educational efforts and marketing campaigns to internally advertise the availability of clinician support
Learning and improvement opportunities	Feedback from users of the support services

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The majority of health care organizations lack support systems for second victims, but The Joint Commission offers a toolkit to assist with implementing change

for support and share their experience of the medical error event, as well as their personal and professional impact of the error.[15]

A 2007 study that examined the emotional impact of medical errors on physicians revealed some startling data. A full 82% of physicians expressed interest in counseling to help cope with their distress. And 90% felt there was inadequate support at their hospitals or health care organizations for this distress.[16]

Use The Joint Commission's toolkit

Unfortunately, there are only a few well-documented second-victim support programs in the United States, despite the growing evidence of the emotional distress that second victims experience. Many hospitals do not know how to develop or implement such a support system. Recognizing this challenge, The Joint Commission developed a toolkit to assist health care organizations in developing a second-victim program. The toolkit consists of 10 modules (**TABLE**) designed to assist organizations not only to implement a second-victim support process but also to customize it to their specific institutional culture. This toolkit can be downloaded for free or used online. Within the first year of its availability, over 6,000 people visited the website and there were more than 700 requests for a download.[17]

Follow forYOU's example

An example and well-recognized second-victim support program is the "forYOU" team at the University of Missouri. The program is free to employees, confidential, and available 24-7. Its purpose is "providing care and support to our staff," by helping members understand the phenomenon of the second victim and quickly returning members to a satisfying professional practice.[18]

The "forYOU" team was created in 2007 under the direction of the University of Missouri Health Care's Office of Clinical Effectiveness with the goals of increasing institutional awareness, providing a second victim with a "safe zone," and allowing for the expression of emotions and reactions in a confidential setting. Team members are multidisciplinary and include physicians, nurses, respiratory therapists, social workers, and chaplains. They strive to normalize the feelings and thoughts second victims experience after a stressful outcome or event. Team members are highly trained in second-victim responses and the stages of coping. The program has established institutional actions to each of the 6 stages (**FIGURE,** page 34).[19]

Establish TRUST

At the Carilion Clinic in Roanoke, Virginia, we too have developed a second-victim support program for all of our employees: TRUST. In

FIGURE ForYOU's institutional actions for second victims' stages of coping[19]

Stage	Proposed institutional action
1: Chaos and event repair	Identify second victims, activate the support team
2: Intrusive thoughts, "what if"	Ensure support team continues observation for lingering symptoms
3: Restoring personal integrity	Provide management oversight of the event, control rumors among staff, assess for whether emotional event debrief is indicated
4: Enduring the inquisition	Identify and interview those involved in the event, answer why it happened
5: Obtaining emotional first aid	Ensure emotional response plan in progress as needed, ensure staff are aware that patient safety/risk management staff are available
6: Moving on	Dropping out—provide ongoing support and allow for alternative employment search
	Surviving—provide ongoing support and open dialogue

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Peer mentors are crucial to a support program but, to value their own time, should establish relationship parameters at the outset of working with a second victim

the beginning stages, we quickly reaffirmed the challenges in developing such a program. **Initial challenges you will face.** First, education on what a second victim is needs to be recognized. The fact that not everyone experiences second-victim emotions needs to be validated. Administrators and staff must be convinced that needing support is not a sign of weakness. And the program must ensure confidentiality and recruit mentors. These are just a few of the obstacles we faced on our path to program realization. Our journey to develop our second-victim program was approximately 5 years and required participation, affirmation, and support from all levels of the organization.

Our program name embodies its inherent purpose and goals. TRUST 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.

Employ peer mentors, who serve a vital role

We have identified the need to develop a more direct and active approach to the TRUST program's recruitment and established a subcommittee to begin this process. We began by asking leaders to nominate potential peer mentors and spoke about the program and asked for volunteers at various hospital committees. Once we had most disciplines represented, leaders were asked to take an assessment for emotional intelligence.

Other than the initial training for the TRUST program, the time requirement for participation for peer mentors is likely less than an hour per month. The dedicated time certainly is dependent on how much support the second victim is requiring, however, and varies. We encourage the peer supporters to be aware of their time constraints and establish parameters for the relationship in a direct but supportive way.

Since the inception of the TRUST Team in September 2014, we have trained 12 peer mentors, 10 of whom currently still serve in that capacity. We have 3 additional peers awaiting training. To date, The TRUST team has supported 19 clinicians/staff, including 3 ACPs, 9 nurses, 6 physicians, and 1 other

(pharmacist). Of those 10, 3 are still actively receiving support so closing data have yet to be collected. Of the 16 who have been closed, 6 were referred for ongoing support and 10 were able to return to baseline with TRUST Team Supports.

Just surviving the medical error is not the goal

Medical errors are inevitable, and the effects on providers can be devastating. It is important that physicians and institutions are aware of the signs and symptoms of a second victim as well as provide support to them. Institutions must have a just culture in which all members of the health care team can come forward with medical errors without the fear of punishment. Ideally, these institutions also have a second-victim support system that identifies those who need assistance and assist all health care clinicians not only to survive the effects of medical errors but also to thrive after receiving the necessary support. ⊘

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