

The Second Victim: Effect of Medical Errors on Providers

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Disclosures

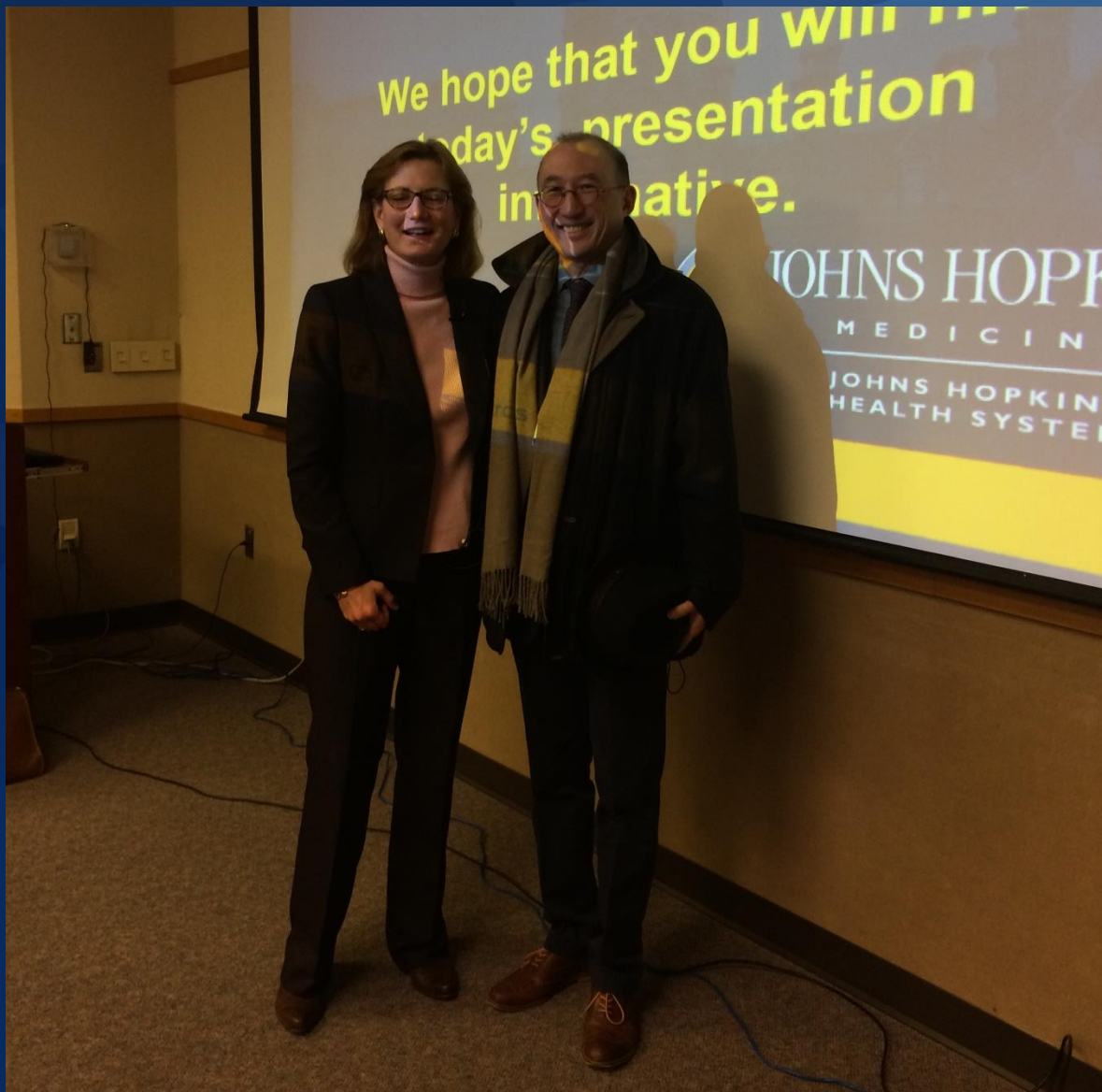
- No financial disclosures
- No conflicts of interest

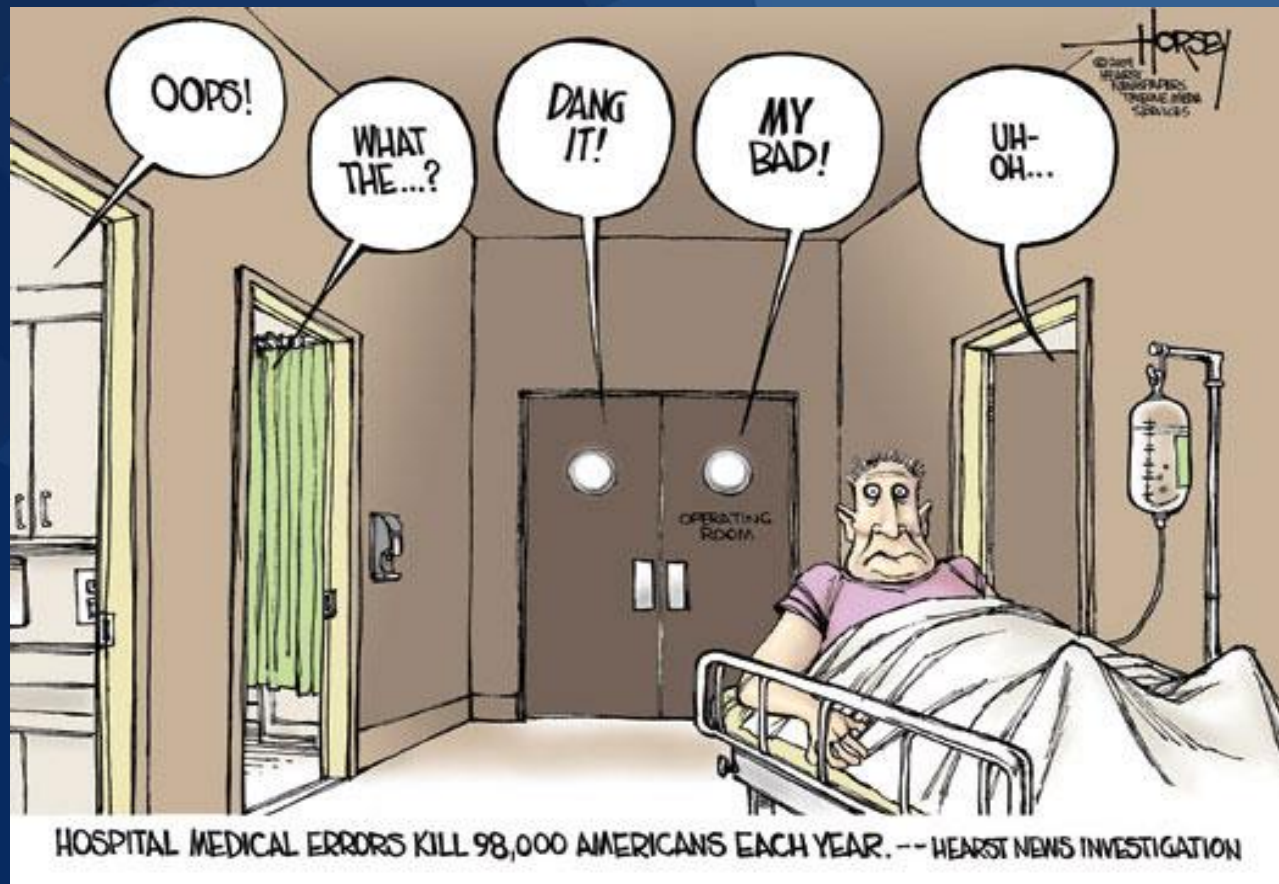
Objectives

- 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

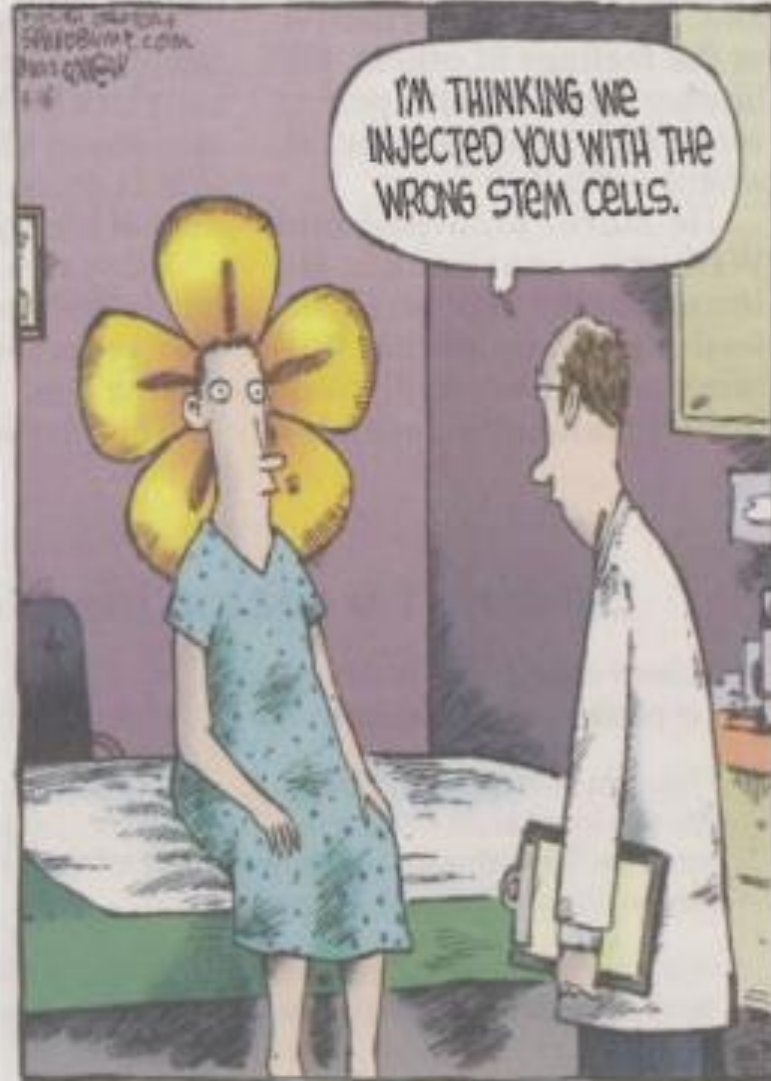
Also Referred to As:

- “The Second Victim” — Wu AW BMJ.2000;320:726-27.
 - First Victim - Patient/Family
- Alternative Terms:
 - *“collateral damage”*
 - *“coping with medical mistakes”*
 - *“recovering from errors”*
 - *“Injury from your own mistakes”*

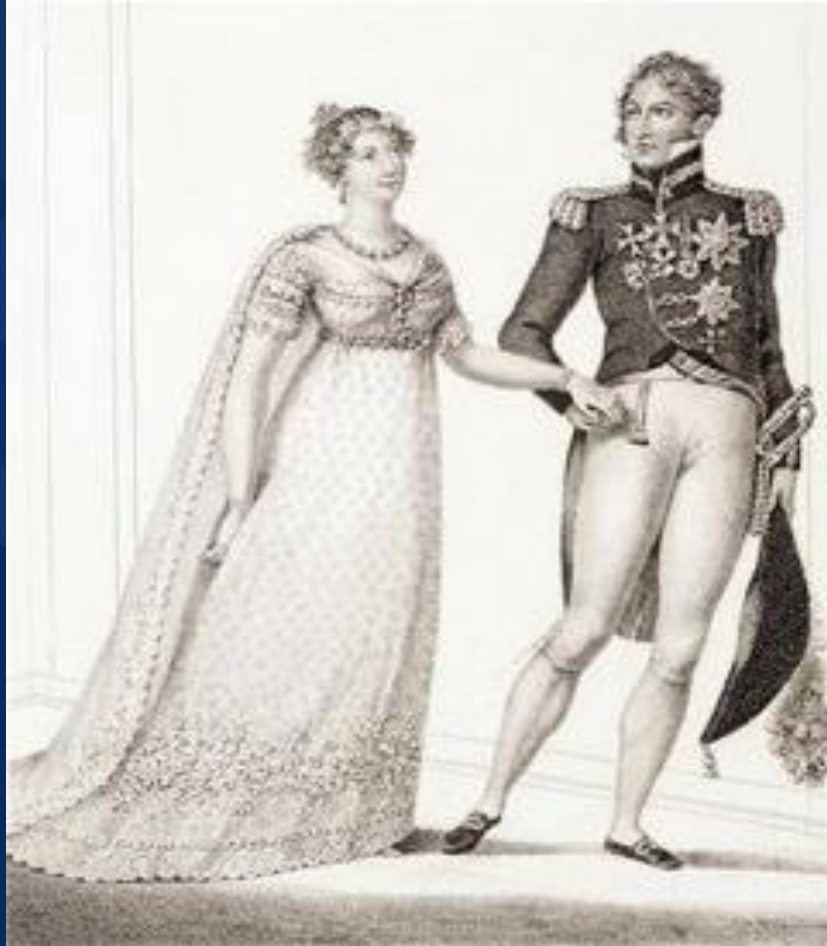




SPEED BUMP Dave Coverly



Triple Tragedy of 1817





Medical Errors: Emotional Impact on Health Care Providers

- Medical errors occur in approximately 5-10% of hospitalized patients
 - Up to 50%
- Reporting of Medical Errors and Follow-up has been Patient Focused
 - “The First Victim”
- Effect on Resident and Attending Physicians

www.webmm.ahrq.gov Jan 2008

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

www.webmm.ahrq.gov Jan 2008

“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

BMJ 2000;320: 726-7

Mark Twain

**Man - a creature
made at the end
of the week when
God was tired.**

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



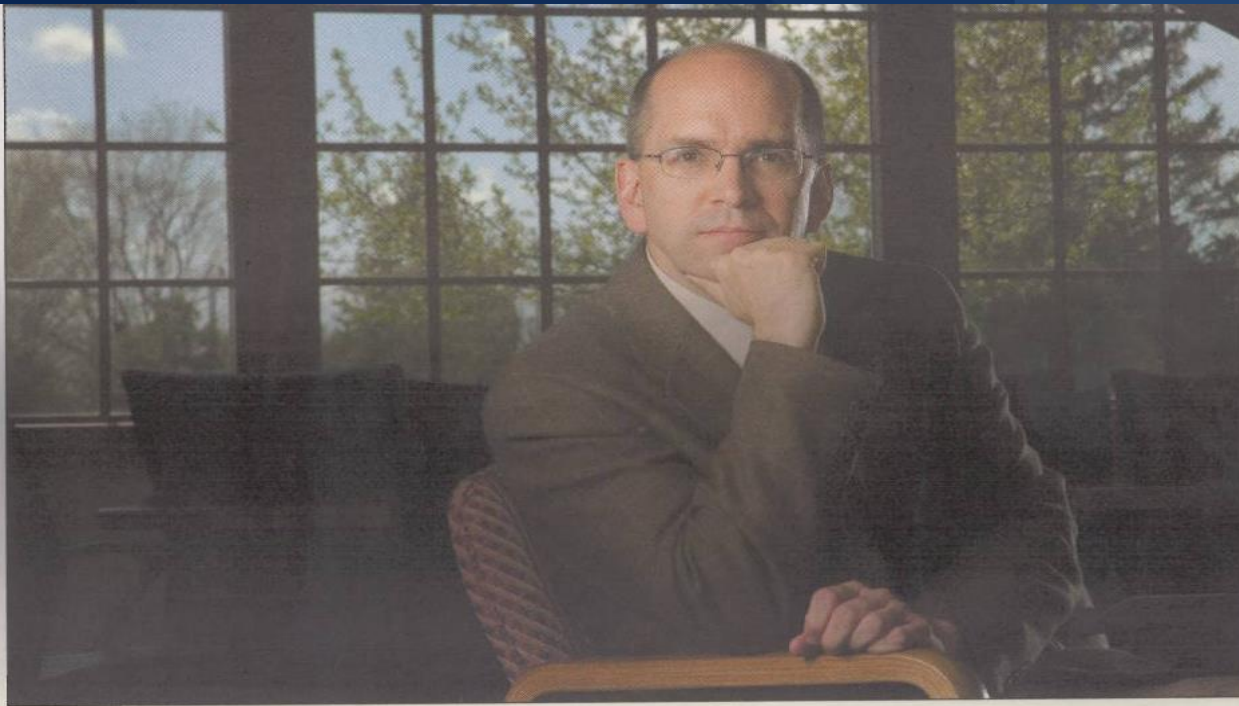


PHOTO BY MIKE ELICSON

Radiation oncologist Stephen Lutz, MD, feared he would have to leave Findlay, Ohio, after going through a medical liability lawsuit. But after he was found not liable in the 2008 court case, he continues to practice in the small town and holds leadership positions in the community. "If you know in your heart that you did

Doctors often experience depression and alienation after being sued. The way they practice medicine also is affected. Here's how some were able to move on.

Amednews.com/Profession AMN – May 23, 2011

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)

Obstetrics & Gynecology, Vol 94, No. 2 August 1999 – Adverse Perinatal Events and Subsequent Cesarean Rate

Medical Errors: Emotional Impact on Health Care Providers

Ultimate Impact

- Leave medical profession
- Suicide

www.webmm.ahrq.gov Jan 2008

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



msnbc.com

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updated 6/27/2011 8:39:55 AM ET 2011-06-27T12:39:55

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

Engel KG, et al. Acad Med. 2006;81:86-93

Medical Error Processing for Patients

- Disclosure (Explanation, Apology, Prevention of recurrence)
- Family, Friends
- Hospital Support
- Legal Action

www.webmm.ahrq.gov Jan 2008

Personal Reaction to Medical Error

- “It will never happen again”
- Singled-out
- Exposed
- Replay over and over and over
- Confess, admit, tell

Acad Med. 2006; 81:86-93

The Medical Error Guilt

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

Hilfiker, N Engl J Med, 1984



Medical Error Processing for Residents/ Attendings

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

Wu AW, et al. West J Med 1993; 159: 565-569

Support for Providers Involved in Medical Errors

- Traditional Morbidity and Mortality conference
 - Errors regarded as lapses resulting from unacceptable personal fallibility
- Risk for public humiliation and shame
- Changing emphasis of such conferences could provide powerful opportunity for professional role-modeling of error acknowledgment and open discussion



See Notes for References.

M&M Video



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.

Institute for Healthcare Improvement

In a Culture of Blame

- People tend to cover up errors
- Information flow decreases
- People grab on to the most obvious short term fix
 - Reinforces 'quick fix' model

Institute for Healthcare Improvement

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

A Just Culture

- A Set of Beliefs
 - A recognition that professionals will make mistakes
 - A recognition that even professionals will develop unhealthy norms
 - A fierce intolerance for reckless conduct

Outcome Engineering: David Marx

Institute for Healthcare Improvement

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

Institute for Healthcare Improvement

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



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Event Investigation I

- What happened?
- What normally happens?
- What did policy/procedures require?
- Why did it happen?
- How was the organization managing the risk before the event?

Processing of Medical Errors – a New Approach

Morbidity and Mortality Review

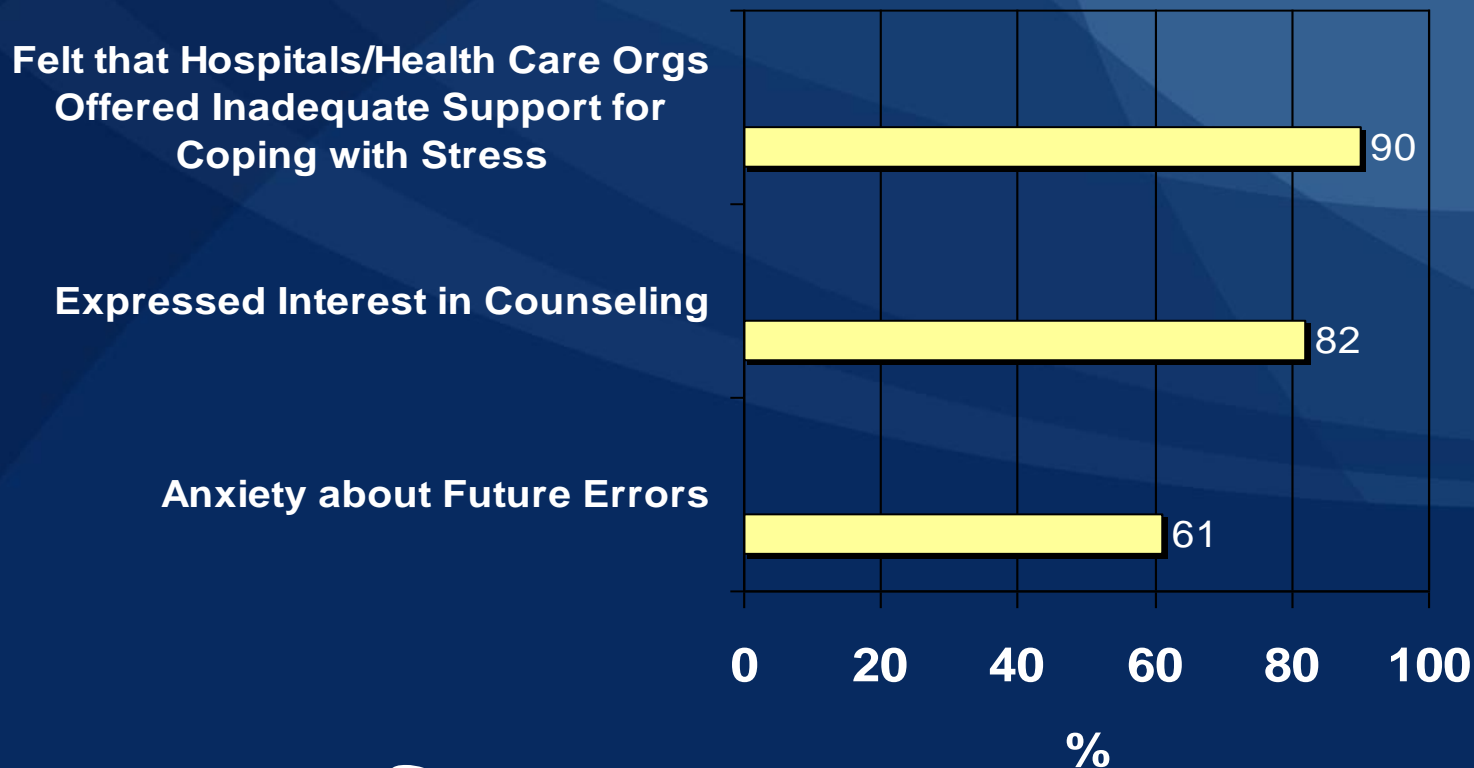
- Framed differently
- Role modeling
- Error acknowledgment
 - System
 - Individual
- Attention to personal impact not just clinical

www.webmm.ahrq.gov Jan 2008

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 (cont.)



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

Wu Aw, et al. West J Med 1993; 159: 565-569

forYou Team Principles

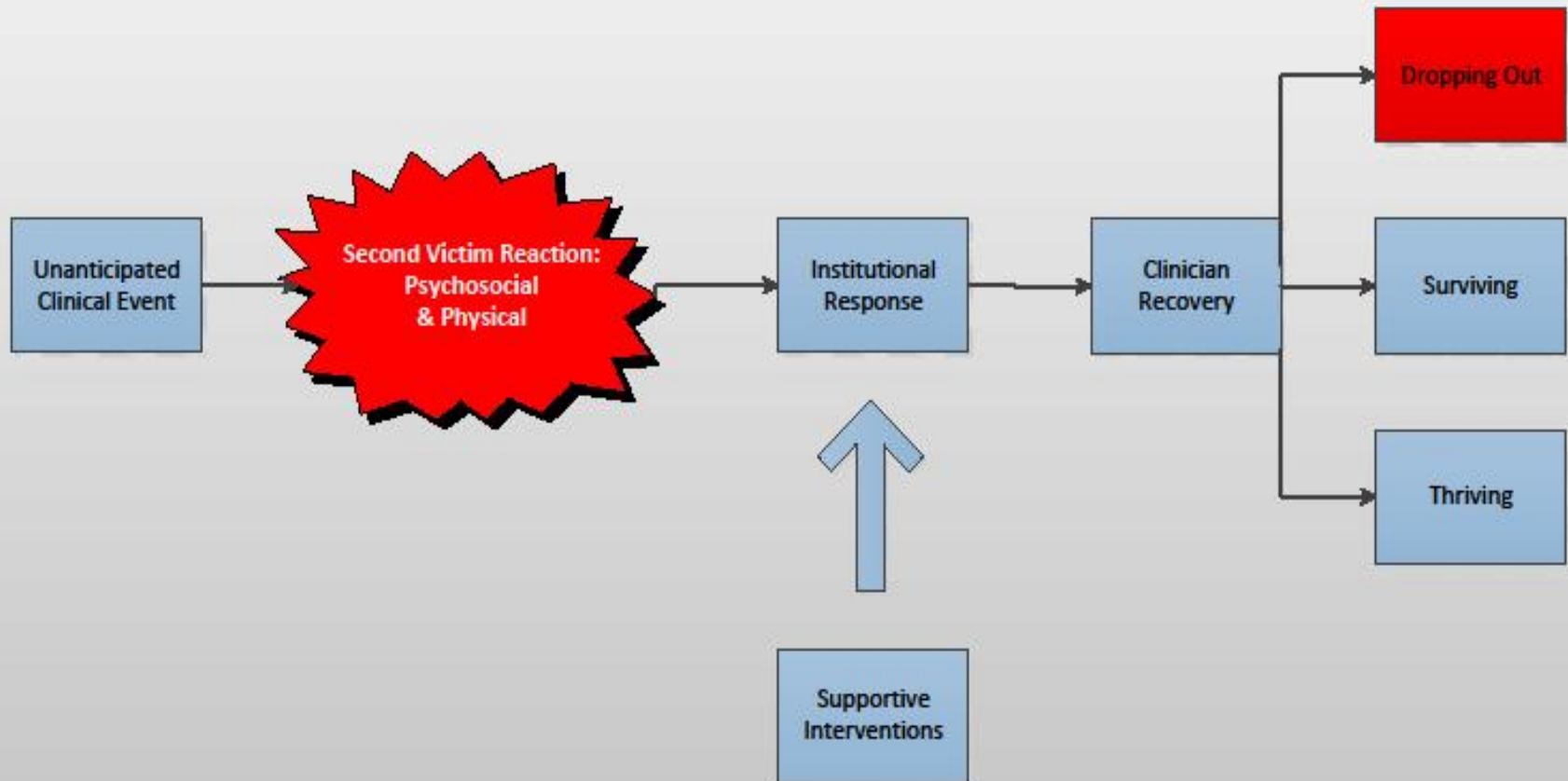
- Peers with listening and supportive skills
 - Not counselors
- Strictly confidential
- Focus: “second victim’s” emotional response
 - Not event details
- Safe zone of supportive intervention

www.muhealth.org

forYou Team Goals

- General awareness about second victim vulnerabilities
- Healthcare leaders & peers are “safety nets”
- Internal rapid response team
- Immediate “emotional first aid”
- Effective “second victim” healing and restoration

Second Victim Conceptual Intervention Model



The TRUST Team

- Developed by a multidisciplinary advisory committee and chaired by Carilion's Chief Medical Officer, 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

Peer Mentors

- Once a SV is identified, they are “matched” using their preferences with a mentor who supports them until they are fully recovered from the event.
- A multidisciplinary group of Pharmacists, RNs, Physicians, CRNAs, ACPs, and Techs were trained in how to mentor peers who had become second victims of medical error.

Early Results

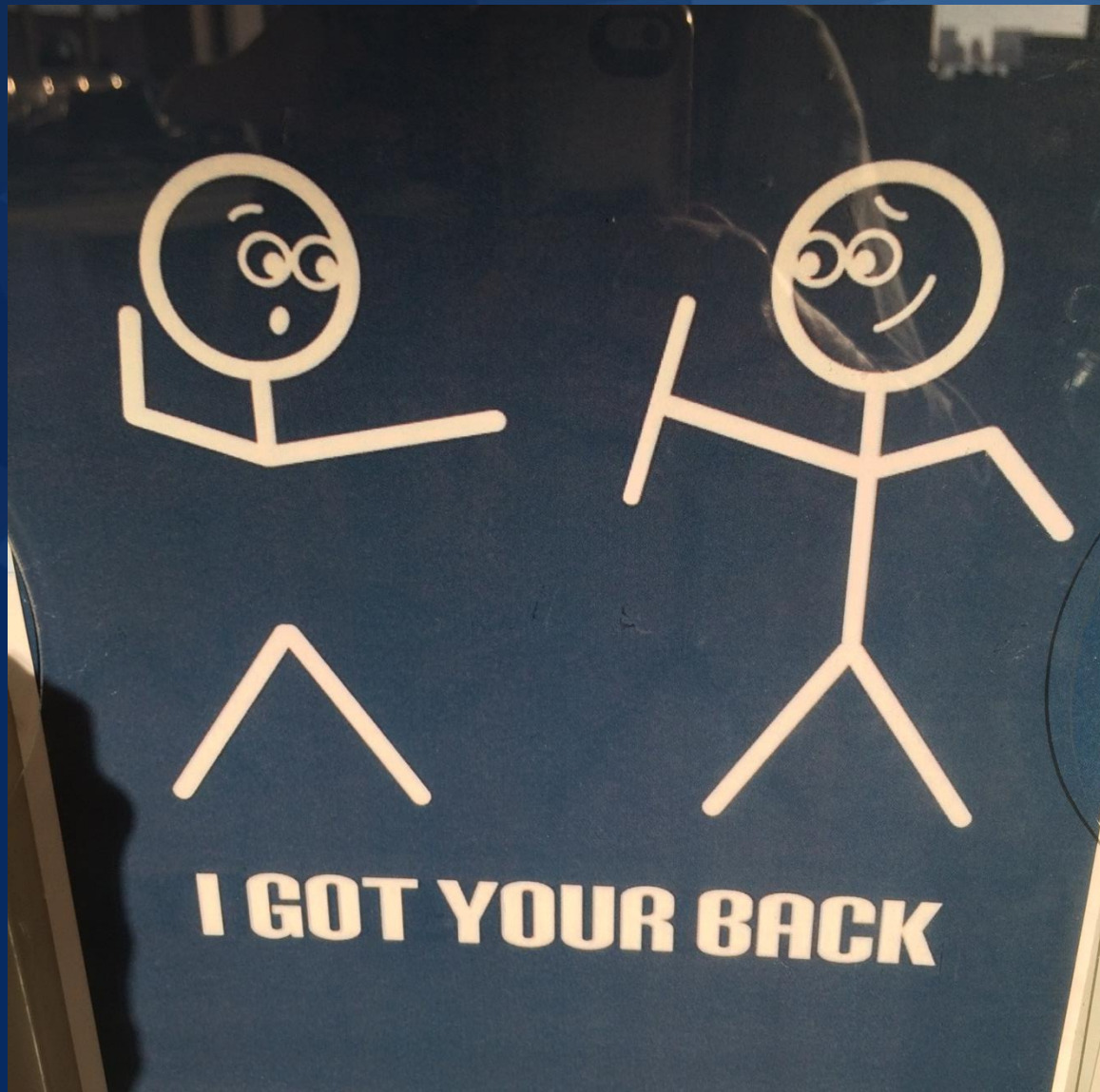
The TRUST Team has been utilized for eight second victims of medical errors/unexpected patient outcomes.

- This includes attending physicians, residents, CRNAs, nurses, and pharmacists.
- Seven of the eight experienced quick recovery and did not miss any time from work. They voiced gratitude from the support they received from the TRUST Team and their leadership.
- The one SV who did suffer long term psychological impact continues to be supported by the team.
- Two of the second victims who received support have sense become trained mentors to support their colleagues.

Take-Home Points

- Medical errors are an inevitable part of medical practice resulting in significant distress for providers
- Coping strategies are necessary and range from personal approaches to formal organized forums for discussion of errors
- Institutional efforts should focus on implementing curriculum in medical errors at all levels of medical training
- Culture shift will be necessary to create a productive process for the provider sharing the medical error





To Err is Human

Institute of Medicine-2001

Preventing “Second Victim” Casualties is Humane



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

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