International Focus on Second Victim Work

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Leuven in Belgium – always welcome!

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Session Objectives

- How do we define 1st, 2nd & 3rd victim
- Overview on research & training:
  - Belgium / France / Scotland / England / Switzerland / Sweden & Italy
- Future initiatives & opportunities

1. FIRST VICTIM

Impact Severity of Harm

- Patient
- Family
- Social Network
2. SECOND VICTIM

Impact Severity & Claims

Healthcare worker (human contribution)
Team
Management
Senior Management & Board members
Family members of involved healthcare workers

3. THIRD VICTIM

Impact (social) Media

Involved Healthcare Organization(s)
Healthcare Community
Research performed in Europe

1. Systematic literature reviews
   - Coping with medical error
   - Second victims
   - Second victim support systems

2. Symptoms of second victims:
   - Clinicians
   - Managers

3. Prevalence of second victims:
   - General Practitioners in training
   - Midwifery & Nursing in training
   - Hospital Medical Doctors & Nurses

4. Support plans & guidelines
5. Educational courses & training
1. Systematic Literature Review (1)

- Impact of involvement in medical errors

- Key findings:
  - 24 studies up to 2010 - mostly small scale
  - Common feelings of shame; guilt; anxiety; depression
  - Lack of work around support & coping
  - Lots of different measures used - difficult to generalise

1. Systematic Literature Review (2)

- Impact of adverse events on health care professionals.

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<tbody>
<tr>
<td><strong>Table 2. Definition and Descriptions of a “Second Victim”</strong></td>
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<td><strong>Definition</strong></td>
<td>“…a health care provider involved in an unpunished adverse patient event, medical error, and/or a patient-related injury who becomes undermined in the sense that the provider is blamed by the event. Frequently second victims feel personally responsible for the unexpected patient outcomes and feel as though they have failed their patient, second guessing their clinical skill and knowledge.” (Dube et al., 1998)</td>
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<td><strong>Description</strong></td>
<td>“Frequently second victims believe that their efforts to make a fast mistake. You feel out of place, and you are ashamed of your actions.”</td>
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<td><strong>Table 4. Overview of Coping Strategies</strong></td>
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<td><strong>Coping Strategy</strong></td>
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<td>Seeking social support</td>
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<td>For example, talking to someone about feelings, accepting sympathy, and understanding from someone taking a relative or friend for advice</td>
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<td>Accepting responsibility</td>
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<td>For example, promoting to things differently, criticizing or letting oneself speculate or doing something to make up</td>
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<td>Distancing</td>
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<td>For example, not letting it get to them going on as if nothing has happened, trying to forget the whole thing</td>
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<td>Emotional self-criticism</td>
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<td>For example, trying to keep feelings from interfering with other things, being able to keep feelings to themselves</td>
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<td>Religious-observance</td>
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<td>For example, wishing the situation would go away or be over, having fantasies of how things might have been, trying to make themselves feel better by eating, drinking, using drugs or medications</td>
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<td>Problem-solving</td>
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<td>For example, concentrating on what to do next, knowing what had to be done, working together to make up a plan of action and following it</td>
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1. Systematic Literature Review (3)

- Literature search on support systems for health care professionals as second victims.


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<tr>
<th>Table 2</th>
<th>Overview of identified considerations and interventional strategies to support second victims.</th>
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<tr>
<td><strong>Considerations</strong></td>
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<tr>
<td>• Time between adverse event and support is crucial with 24/7 availability (Schellbreid and Nord, 2007; Scott et al., 2010)</td>
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<td>• Structured sessions need to be provided (Engel et al., 2006)</td>
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<td>• Highly respected physicians or physicians in a senior position should be encouraged to discuss their errors and feelings (Levinson and Dunn, 1989)</td>
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<td>• Programs which focus to prevent, identify and treat burnout (West et al., 2006)</td>
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<td>• Promote empathy within the team (West et al., 2006)</td>
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<td><strong>Strategies</strong></td>
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<td>• Talk and listen to second victims (Amidt, 1994)</td>
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<td>• Organize and facilitate open discussion of the error (Engel et al., 2006; Fischer et al., 2006; Meurier et al., 1998)</td>
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<td>• Share experiences with peers (Engel et al., 2006)</td>
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<td>• Organize special conferences on the issue of second victims to increase awareness (Levinson and Dunn, 1989)</td>
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<td>• Provide a professional and confidential forum to discuss their errors (Levinson and Dunn, 1989)</td>
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<td>• Inquire about colleague coping (Wu, 2009)</td>
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<td>• Exposure writing (Wu et al., 2008)</td>
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Research performed in Europe

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4. Support plans & guidelines

5. Educational courses & training
2. Symptoms (1)

- **Symptoms of second victims (clinicians)**
  - Study Karolinska Hospital Sweden (Ovretveit et al.2012)
    - 21 semi structured 1-2 hour interviews with HC workers from 1 hospital
    - + 50% described “significant reactions” after the incident including depression, anxiety, guilt, sadness, flashbacks and damaged prof reputation
    - Most reported emotional distress & job-related stress for months, some for years
  - Study Piedmont Region Italy (Panella et al.2012 to be submitted)
    - 33 semi structured interviews with mainly nurses, physicians and midwives from different hospitals
  - Physical symptoms: ↑ breathing(61%), extreme fatigue(56%), ↑ pulse(52%)
  - Psychosocial symptoms: concentration↓(79%), frustration(79%), ↓job sat(73%)
  - Study Flanders Region Belgium (Van Gerven et al.2012 to be submitted)
    - Intermediate results: Multicenter semi structured interviews with physicians, nurses & midwives (n=18)
    - Symptoms: fear for involvement in additional events, sleepless, anger, panic, crying, ...

2. Symptoms (2)

- **Symptoms of second victims (clinicians)**
  - Survey of UK (N=155) and US (N=165) health professionals (Sirriyeh et al 2012, under review):
    - Common experiences in UK & US of negative emotions
    - Use of problem-focused coping
    - Nurses experience stronger emotional response to error
  - UK physicians, nurses & pharmacists (Sirriyeh et al 2012, to be subm)
    - Focus group (n=26)
    - Professional group differences in perception of patient safety are influential in aftermath of error for health profs
2. Symptoms (3)

- **Symptoms of second victims (Managers)**
  - In hospice service (n=15) & NHS Sector (n=26) in England
    - Sirrieh et al 2010 & Sirrieh et al 2012
    - Managers suffer after errors; lack support; pressure from patients, clinicians and senior management team; often overlooked
    - Hospital managers (in depth interviews n=8 organizations)
      - Impact both professional and personal
      - However: depends on severity of AE, contact with first victim, own personality, contact with other second victims, experience with this kind of situations, media attention, training and education in clinical setting
      - Support for management as second victim: none

3. Prevalence (1)

- General practitioners in training France (Venus et al, BMJ Q&S, 2012)
  - 70 of the 392 (18%) interns replied to the questionnaire & 10 semi-structured interviews were then conducted
  - 97% of the participants had already made a medical error
  - 64% was strongly affected by their error => Emotional impact: feelings such as guilt that could remain for more than 2 years after the event
  - 74% made constructive changes to their work after the error
  - 33% would have liked to talk more about it with their superior
- Nurses & Midwives in training Belgium (Van Gerven et al, 2012, to be submitted)
  - 970 nursing & midwifery students conducted structured online survey
    - Adverse event on the unit in the past 6 months?
      - 41% yes (n=393)
        - 27 cases with permanent damage
        - 31 cases resulted in death of the patient
    - Impact (n=325)
      - No impact: 40%
      - Impact on professional life: 42%
      - Impact on personal life: 4%
      - Impact on both: 14%
      - Thinking about ending the training: 4%
3. Prevalence (2)

- Medical doctors & Nurses Belgium (Vanhaeckt et al, 2012 to be submitted)
  - Sample: MD: 1200 RN: 4638
  - Involved in adverse event within last 6 months
    - MD: 14% RN: 8%
  - Adverse event within their team
    - MD: 48% RN: 38%
  - Burnout in group involved in AE is
    - Risk of Burnout: MD: 28% vs 16%
      RN: 19,5% vs 11,8%
    - Burnout: MD: 9,5% vs 4,8%
      RN: 11,7% vs 6,4%

4. Support plans & guidelines (1)

Respectful Management of Serious Clinical Adverse Events.

Jim Conway, Frank Federico, Kevin Stewart, Mark Campbell
4. Support plans & guidelines (2)

http://www.healthcareimprovementscotland.org/

4. Support plans & guidelines (3)

Soon available on: www.secondvictim.be
5. Educational courses & training

From short lectures up to 3 day workshops

- Switzerland:
  - Swiss Patient Safety Foundation
- Scotland:
  - University of the West of Scotland & NHS Ayrshire & Arran
- Belgium
- KU Leuven
- UC Louvain
- England
- Bradford Institute for Health Research
  - Royal College of Physicians
- Italy
- University of Piedmont
- Sweden
- Karolinska Institutet

Future initiatives & opportunities

Networking & Knowledge sharing between European Research Institutes on:
- Research opportunities
- Teaching & Training
- Supporting each other

www.ernstv.org
References