Too Many Abandon the "Second Victims" Of Medical Errors

Matthew Grissinger, RPh, FASCP

Mr. Grissinger, an editorial board member of P&T*, is Director of Error Reporting Programs at the Institute for Safe Medication Practices in Horsham, Pennsylvania. (www.ismp.org).*

In 2011, a 50-year-old nurse committed suicide just seven months after making a mathematical error that led to an overdose of calcium chloride and the subsequent death of a critically ill infant. According to media reports, after investigation of the event, hospital leaders made a difficult decision to terminate Kimberly Hiatt's employment after 27 years of service for undisclosed reasons, including factors not directly associated with the event. To satisfy state licensing disciplinary actions, Kimberly agreed to pay a fine and accepted a four-year probation that included medication administration supervision at any future nursing job. Just before her death, she had aced an advanced cardiac life support certification exam to qualify for a flight nurse position. But according to media reports, this and countless other efforts produced no job offers, increasing her isolation, despair, and depression. As a testament to her longstanding compassionate and competent nursing care, many patients and families who received care from Kimberly attended her memorial service to honor her.

We recognize that the health care industry as a whole has not widely communicated or implemented effective support mechanisms to address the deeply personal, social, spiritual, and professional crises often experienced by the "second victims"[1] of fatal errors. Although the first victims of medical errors are the patients who are harmed and their families, the second victims are the caregivers and staff who sustain complex psychological harm when they have been involved in errors that harm patients while caring for them.[1–4] We are all implicated in Kimberly's death by our all-too-often tacit acceptance of the way we currently treat—or fail to treat—these second victims of errors. We still tend to respond to harmful and fatal medical errors in a manner that punishes and/or isolates involved individuals.

Not too long ago, we kept secrets about medical errors, trying in vain to maintain an image of perfection in health care. Today, we may be making headway with improved reporting and transparency of medical errors. But, too often, we remain silent and abandon the second victims of errors—our wounded healers[4]—in their time of greatest need.

Suffering of Second Victims

In the very best of times, health care practitioners are repeatedly exposed to emotional turmoil caused by patient tragedies such as loss of life, even when it is clinically anticipated.[5] The deaths of patients illustrate the complex sorrow[3] intrinsic to the work of health care practitioners. Thus, it is not difficult to see how patient tragedies caused by medical errors can shake the involved practitioners to their very core. In many cases, their lives fall apart. Second victims suffer a medical emergency equivalent to post-traumatic stress disorder (PTSD).[5,6] The instant patient harm occurs, the involved practitioner also becomes a patient of the organization—a patient who will often be neglected.[2]

Fatal errors and those that cause harm are known to haunt health care practitioners throughout their lives.[3] The impact of the errors is felt in their private lives, in interactions with professional colleagues, and in the context of their social lives. Immediately after the error is recognized, practitioners typically experience stress-related psychological and physical reactions related to sadness, fear, anger, and shame.[1–6] They are immediately panicked, horrified, and apprehensive, which is manifested by disbelief, shock, an increased blood pressure and heart rate, muscle tension, rapid breathing, extreme sadness, appetite disturbances, and difficulty concentrating.[1–4] While awaiting investigation of the error, the second victim is often plagued with fears of losing a job and the financial consequences of

unemployment and levied fines; being labeled as incompetent or careless by colleagues, their family, and the patient's family; loss of coworkers' respect; involvement in a civil or criminal court proceeding; and loss of a professional license.[3–5]

Further buffeted by isolation from colleagues and their organization, within the first weeks after the error, second victims often experience a fear of returning to work, loss of confidence, self-doubt, remorse, depression, intrusive memories, excitability, nervousness, guilt, worry, embarrassment, anguish, humiliation, a wish to make amends, frustration, and hypervigilance.[2–6] The months that follow are characteristic of PTSD, which is expressed as an inability to successfully process the feelings of fear, sadness, guilt, and shame.[6] The traumatic event leads to insomnia, other sleep disturbances, flashbacks, thoughts of suicide, and a damaged self-perception and inner security.[3,4,6] Serious errors also result in competent practitioners losing their licenses or leaving the profession.[3]

Supporting Second Victims

The second victims of errors have often suffered in silence. It is our moral imperative to change our current culture of abandonment, isolation, and punishment of second victims to a culture that provides accessible and effective support for these wounded healers.[4] This support must begin the moment an event with the potential for causing emotional distress is discovered, and must extend for as long as deemed necessary.[6] As an industry, we also need to facilitate the receptiveness of second victims to accept this support through widespread understanding and recognition of the enormous emotional toll second victims endure after involvement in a harmful event.

The second victims of errors have the right to be treated with respect, to participate in the process of learning from the error, to be held accountable in a fair and just culture, not to be abandoned by the health care organization, and to be supported by their peers and organizational leaders.[2] We need to take care of the

patients and families who are harmed by medical errors, but we also need to take care of the practitioners involved in the errors, especially when they meant to do good and now find themselves in a situation where a patient has been harmed by the unintended consequences of their actions.[2]

This is not a new issue in health care, but one that has taken a backseat to others. We can no longer ignore the issue or fail to provide the resources necessary to support the second victims of errors.[1–6] The health care organization itself can become a "third victim" of medical error, sustaining a wound that can either be worsened or lessened by the behavior of its leaders.[2]

Support initiatives for second victims need to be established and widely communicated so that staff members are aware of available resources, are receptive to accepting help, and know how to access assistance. A number of resources are available to organizations in this regard.[1–7]

Five Rights of Second Victims

Proposals have been suggested for the five human rights of second victims,[2] which can be remembered by the acronym **TRUST**:

- **Treatment that is just**. Second victims deserve the right of a presumption that their intentions were good, and they 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 their human fallibility.
- **Understanding and compassion.** Second victims need compassionate help to grieve and heal, and leaders must understand the psychological emergency that occurs when a patient is unintentionally harmed.
- **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 error to share important causal information with

the organization and to provide the victims with an opportunity to heal by contributing to the prevention of future events.

MITSS Tool Kit

Medically Induced Trauma Support Services (MITSS) is a nonprofit organization whose mission is to support healing and restore hope to patients, families, and clinicians affected by adverse events. Their website (www.mitsstools.org/tool-kit-for-staff-support-for-healthcare-organizations.html) provides an extensive set of **Tools for Building a Clinician and Staff Support Program**. Included in the tool kit are a quick one-page assessment designed to give organizations a snapshot of where they stand in terms of staff support in the wake of an error, and a comprehensive work plan for building a support system.

ISMP Referral

Since its inception, the Institute for Safe Medication Practices (ISMP) has provided free professional and emotional support to the second victims (as well as the third victims) of serious errors. Ongoing discussions at any time of the day, support and follow-up as needed, assistance with meeting requirements for presenting or attending educational programs and providing community service, and onsite support and/or testimony during licensing board hearings and criminal proceedings are just a few of the services ISMP offers to second victims of errors. We can also provide these victims with a sense of community, rather than isolation, by putting them in contact with other second (and third) victims who have been through similar experiences.

IHI White Paper

The Institute for Healthcare Improvement (IHI) offers a white paper[7] on *Respectful Management of Serious Clinical Adverse Events,* which can be found at www.ihi.org/knowledge/Pages/IHI-WhitePapers/RespectfulManagementSeriousClinicalAEsWhitePaper.aspx. This comprehensive resource for responding to harmful patient events includes supportive actions for the second victims of errors.

Second-Victim Rapid-Response Team

Susan Scott et al.[5] provides details about deploying a second-victim rapid-

response team in the immediate wake of a harmful error. Similar to medical rapid-response teams used to manage acute patient deterioration, a dedicated team with knowledge and experience in supporting practitioners during the acute stages of emotional trauma can significantly aid the recovery of second victims, the authors show.

Conclusion

ISMP urges organizations to develop a crisis management plan that includes a formal infrastructure for second-victim support before it is needed. Make no mistake, harmful events happen in all organizations, and you need to be prepared before the emotions of a harmful event lead organizational leaders down a reactive and punitive pathway that could later lead to regret.

We can't help but grieve the senseless death of a nurse by her own hand after making a fatal medication error. In no way do we minimize the tragedy of the infant's death in this event. However, the death of Kimberly Hiatt is no less tragic. It's too late for Kimberly, but her story can serve as a catalyst for one of the most needed changes in health care—support of the second victims of errors, our wounded healers.

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