

Medical Errors and the Second Victim

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The impact of medical errors on health care professionals needs to be addressed to provide support and healthy coping strategies.

Since the release of the 1999 Institute of Medicine (IOM) report *To Err Is Human: Building a Safer Health System*, much attention has been focused on medical errors.¹ This report estimated that up to 98,000 deaths from medical errors occur annually in the United States. These data were shocking to many, to say the least.

Following the IOM report, a culture of patient safety developed, with an emphasis on avoidance of system failures, including use of technology, safe practices, procedures, and policies, all of which combine to form an “organizational culture.”² This culture includes disclosure of medical errors to patients and their families, the so-called first victim.

Also gaining more attention and emphasis in recent years is the impact that medical errors have on health care providers, deemed the “second victim.” The concept of the term *second victim* was coined by Dr Albert Wu, a leading voice in medical errors and the resultant impact on clinicians.³ However, the history of health care professionals being impacted by an unexpected situation or error dates back to 1817. Coincidentally, the one involved was an obstetrician, Sir Richard Croft, MD.

The 1817 second victim story is, in fact, really a “triple tragedy” involving Princess Charlotte, the only legitimate grandchild of

George III. Her child was the only heir to be King of England in that family lineage. However, after a torturous 2-day, 50-hour labor, Princess Charlotte delivered a 9-lb stillborn son. Five hours later, Princess Charlotte died from shock and postpartum hemorrhage. Unable to live with the criticism and responsibility for 2 lost lives, Croft committed suicide 3 months later.⁴

The Triple Tragedy of 1817 is an extreme example of the impact of medical errors on health care providers. However, today in modern medicine there is often no place for mistakes. Despite the often-heard “doctors are only human,” innovations such as precise laboratory and diagnostic testing have created expectations of near perfection from clinicians by patients and, at times, hospitals.³

When errors or patient harm occurs, clinicians can experience shame, guilt, and a sense of failure. Moreover, they are discouraged from talking about these events, for fear of litigation, yet they want open discussion with colleagues about medical errors as part of a hospital culture, to feel supported and work through powerful personal emotions.⁵

“INTOLERABLE PARADOX”

In 1984, David Hilfiker, MD, published in the *New England Journal of Medicine* the following, describing the perils of medical mistakes on the clinician, medicine as a profession, and society:

The drastic consequences of our mistakes, the repeated opportunities to make them, the uncertainty about our own culpability when results are poor, and the medical and societal denial that mistakes must happen all results in an intolerable paradox for the physician. We see the horror of our own mistakes, yet, we are given no permission to deal with their enor-

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mous emotional impact....The medical profession simply has no place for its mistakes.^{6,7}

Clearly, medical mistakes do occur, and health care professionals are emotionally affected. Unfortunately, the support and sympathy needed to deal with these mistakes are often lacking.

At best, one can hope for a lack of public criticism or judging. Clinicians feel singled out, agonize over the event, and replay it many times in their mind; they question their level of competency. Lacking the ability or mechanisms to deal with the error, they often develop dysfunctional responses as a mean to protect themselves.

Responses can range from anger to blame elsewhere, defensiveness, and callousness. Added to this is the potential for being a defendant in a medical malpractice claim. The degree to how one reacts to being named a defendant varies by individual; however, whether or not the medical error results in a malpractice suit, there is an emotional, personal, and professional drain.³

Physicians in training are also affected with distress in medical errors. A 2006 study assessed the frequency of self-perceived medical errors and the impact on residents. Results confirmed that self-perceived medical errors were associated with a significant decrease in quality of life, worsening burn-out, increased positive screening for depression, depersonalization, emotional exhaustion, and lower personal accomplishment.⁸

This can affect subsequent patient care, as young clinicians who perceive they have made medical errors in the past demonstrate less empathy and feelings. They are then at greater risk for subsequent errors. Those who are depressed are 2 times more likely to make additional errors.⁹

With well-documented effects of medical error on health care professionals (attending, nurses, and residents), what are the interventions to help deal with personal and professional impact of medical errors? How can escalation of the second victim be prevented or minimized?

GUILT AND SHAME

First, consider that making an error that harms a patient can be the greatest distress clinicians experience in their professional careers. Feelings of failure and fear of disci-

plinary actions and malpractice allegations may result in shame, grief, and guilt.

In a recent article, the author distinguishes between the feelings of guilt and shame, a distinction useful in helping clinicians cope with medical errors.¹⁰ Referencing Aaron Lazare, the writer explains that guilt is usually associated with a particular event, while shame reflects a failure of one's entire self. Guilt prompts a person to make amends, while shame prompts a desire to hide.¹⁰

Confession, restitution, and absolution are means to deal with feelings of guilt. However, a confession is often discouraged for fear of litigation or simply because no appropriate forums exist to confess (ie, to discuss the events).³

Morbidity and mortality conferences often focus on "who did what incorrectly" and "who missed what," with a resultant name, blame, and shame scenario. This type of setting offers no assistance for clinicians to deal with errors and makes no acknowledgement that often the health care system itself contributes to the medical error for which the professional is harboring shame or guilt.¹⁰

INSTITUTIONAL SUPPORT

Department leaders, section chiefs, and residency program directors need to pay special attention to the format and environment on morbidity and mortality reviews. Is there an added focus on what can be done from a system (not individual standpoint) to prevent recurrences? Is there public acknowledgement as reference to the error impact on the health care team or individual professional? For these to occur, the leaders must implement these forward changes.

The first step is a general acknowledgement within the medical profession that medical errors are inevitable. Further, clinicians need to be trained in managing these errors both for their patients and for self.⁶ We can also recognize and verbalize our understanding of the impact of errors on our colleagues. Asking about the emotional impact of the mistake and how they are coping is also helpful. Sharing personal experiences with medical errors and successful coping strategies can help reduce a colleague's sense of isolation.³

FOCUSPOINT
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TABLE 1. Second Victim Stages¹¹

Stage	Name	Features
1	Chaos	Error realized and recognized, how and why did this happen, care for the patient
2	Intrusive reflections	Reevaluate event with haunted reenactments, self isolation
3	Restoring personal integrity	Managing gossip, questioning trust, fear
4	Enduring the inquisition	Realization of seriousness, wonder about repercussions, who can I talk to
5	Obtaining emotional first aid	Seeking personal and professional support, where can I turn to for help
6	Moving on	One of the following:
6a	Dropping out	Changing professional role, leaving profession or new practice location
6b	Surviving	Coping, continue plagued by event but performing at expected level
6c	Thriving	Gains insight and perspective into error, learns from event, and not focused solely on the error

To best understand and ultimately assist clinicians involved in medical errors, one must understand the phenomena of the second victim and the associated stages. As described in 2009 by a University of Missouri study, there are 6 predictable and identifiable stages in the second victim phenomena. These are summarized in Table 1.

It is key to recognize these steps, even if our colleagues are not self-aware of them. Resources within hospitals, department, and institutions must assist. These include risk managers, clergy, employee assistance programs, and confessor figures (could include section chief, department chair, residency program director, or neutral confidential third party within the system).¹¹

Clinicians often bear the burden of medical errors in isolation. Institutional mechanisms must be developed and utilized to help health care professionals deal with the impact of medical errors. While often counseled not to discuss the case or events, confidential venues must be established to deal with the personal impact of the error. The critical need is for acknowledgement, recognition, and intervention to assist the clinician in coping with the medical error to minimize the second victim role and actively prevent any tragedies.⁶

Also, physicians are required to disclose medical errors to patients. This requirement

and the ethical issue of disclosure can also assist the clinician in dealing with the error. Therefore, it is imperative that they are trained and comfortable in the process of disclosure of medical errors and anticipated options.¹² Disclosure is a component of coping strategies for the second victim.⁶ These strategies are summarized in Table 2.

PEER SOLIDARITY

One program that warrants attention for its effort to assist clinicians dealing with medical errors is the University of Missouri Health System (UMHS) "Second Victim—forYOU Team." Since 2007, the forYOU Team has provided "emotional first" interventions to help health care providers during difficult times surrounding unanticipated outcomes.

The forYOU Team is available to all UMHS staff and is confidential. Members of the team are not counselors but peers with supportive and good listening skills. Conversations focus not on the actual event or event details but on the second victim's emotional response.¹³

This program eliminates or greatly diminishes the potential for clinician isolation, while at the same time providing access to a confidential "confessor" figure. Because forYOU Team members are peers and not counselors, second victims may

TABLE 2. Second Victim Coping Strategies⁷

1	Responsibility accepted
2	Discussions with colleagues
3	Patient disclosure and apology
4	Analysis and evaluation of error
5	Practice adaptations to reduce repeat errors
6	Advocate for medical error cultural change in medical profession

FOCUSPOINT
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more easily relate to them clinically, while avoiding a potential stigma of “seeing a counselor.”

The goals of the forYOU Team are to explore the natural history of second victim suffering and recovery by interviewing previously traumatized clinicians. Further, they seek to create a general awareness about the second victim concept and provide education and supportive approaches for effective healing and restoration. Additionally, to provide “emotional first aid,” there is an internal rapid response team of formally trained peers who can be dispatched immediately, if needed.¹³

CONCLUSION

In summary, health care professionals involved in medical errors oftentimes are greatly affected both emotionally and personally. Feelings of isolation, shame, guilt, anger, loss of confidence, loss of empathy, and depression are all possible responses.

Institutions can help prevent second victims by recognizing the potential impact medical errors can have on clinicians and

implementing formal programs to assist them. Emphasis must be placed on confidentiality and immediate emotional first aid response to clinicians. Further, institutions and departments must advocate a culture of support and trust—not one of the “name, blame, shame” game.

To paraphrase the IOM, “To err is human: To survive intact is humane.”

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