Education Grand Rounds

University of Oklahoma Health Sciences Center

Second Victims of Medical Errors: How It Affects The Team of Providers

Patrice M. Weiss, M.D.
Chief Medical Officer, Carilion Clinic
Professor, Virginia Tech Carilion School of Medicine

Co-Sponsored by Office of the Vice Provost for Academic Affairs & Faculty Development, Educators for Excellence Advisory Panel, College of Medicine Academy of Teaching Scholars and the HSC Bird Library Society

Cell phones and electronic devices should be turned to silent or off.
Thank you!

The Second Victim: Helping Providers Cope with Medical Errors

Patrice M. Weiss MD
Chief Medical Officer
Carilion Clinic
Professor
Virginia Tech Carilion School of Medicine

CARILION CLINIC

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 in a Just Culture
- Describe Educational Opportunities to educate trainees on 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*

Triple Tragedy of 1817

HOSPITAL MEDICAL ERRORS KILL 98,000 AMERICANS EACH YEAR. -- HEARST NEWS INVESTIGATION

Challenges and Successes in Patient Safety, Quality and Satisfaction

Hospital mortality

251,000 Annual estimated deaths due to medical errors, the third-leading cause of death in the U.S.

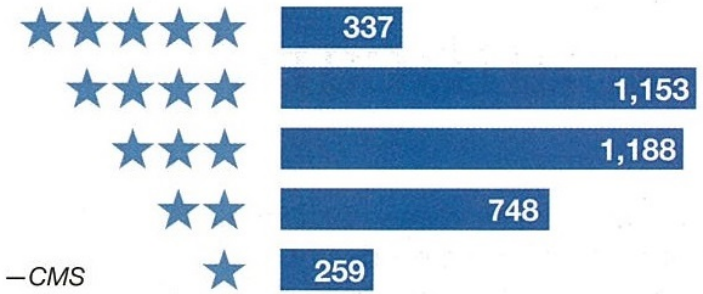
Source: BMJ

8.9% Percentage of physicians saying they had made a medical error in the previous three months. Within that group, **1.5%** of physicians believe the error resulted in a patient's death

—Annals of Surgery, 2009

Patient satisfaction

Star ratings for patient experience among 3,685 acute-care hospitals reporting to the CMS

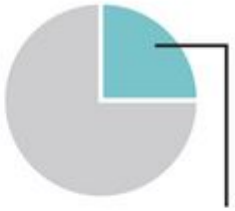


—CMS

Medical Errors Still Challenge the Industry

52%

Percentage of Sentinel Events reported to the Joint Commission between 2005-17 that **resulted in patient death**



25%

Percentage of Sentinel Events during that same period that **resulted in unexpected additional care**

—The Joint Commission

Top five reported Sentinel Events, 2017

Unintended retention of foreign body	116
Fall	114
Wrong-patient, wrong-site, wrong procedure	95
Suicide	89
Delay in treatment	66

—The Joint Commission

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

“Doctors are only human”- REALLY?

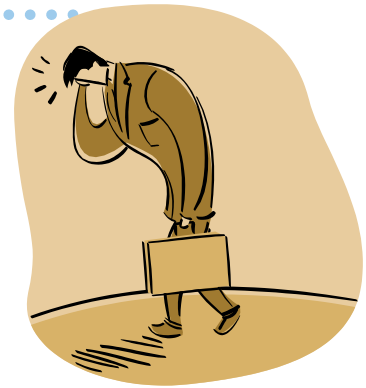
Reality – There is no room for mistakes in modern medicine

- Technology wonders
- Precise laboratory tests
- Expectation of perfection
  - Over-achievers

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

- Mark Twain

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

Emotional Impact of Medical Errors on Physicians

Waterman AD, et al. Jt Comm J Qual Patient Saf. 2007;33:467-476.

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)

Medical Errors: Emotional Impact on Health Care Providers

Ultimate Impact

- Leave medical profession
- Suicide

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
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

Personal Reaction to Medical Error

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

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

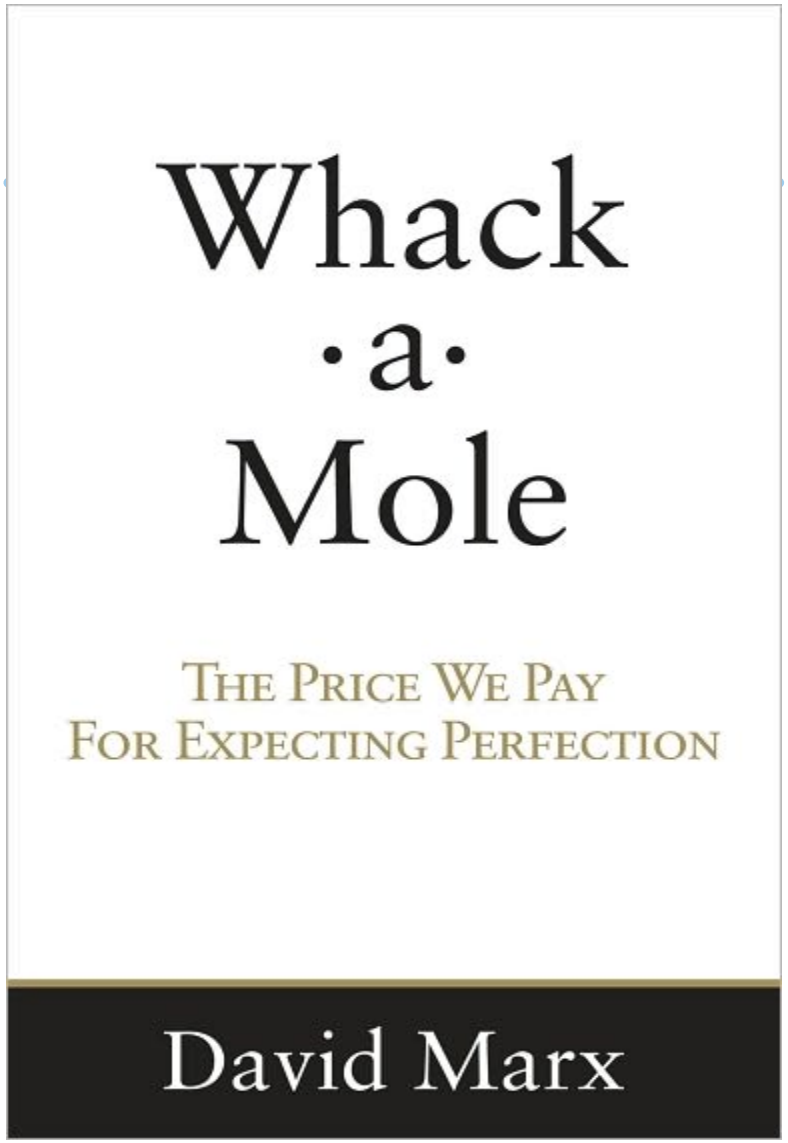
- Morning Report
- Morbidity / Mortality
- QA / PI
- Root Cause Analysis
- **NAME BLAME SHAME GAME**

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

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.


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

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

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

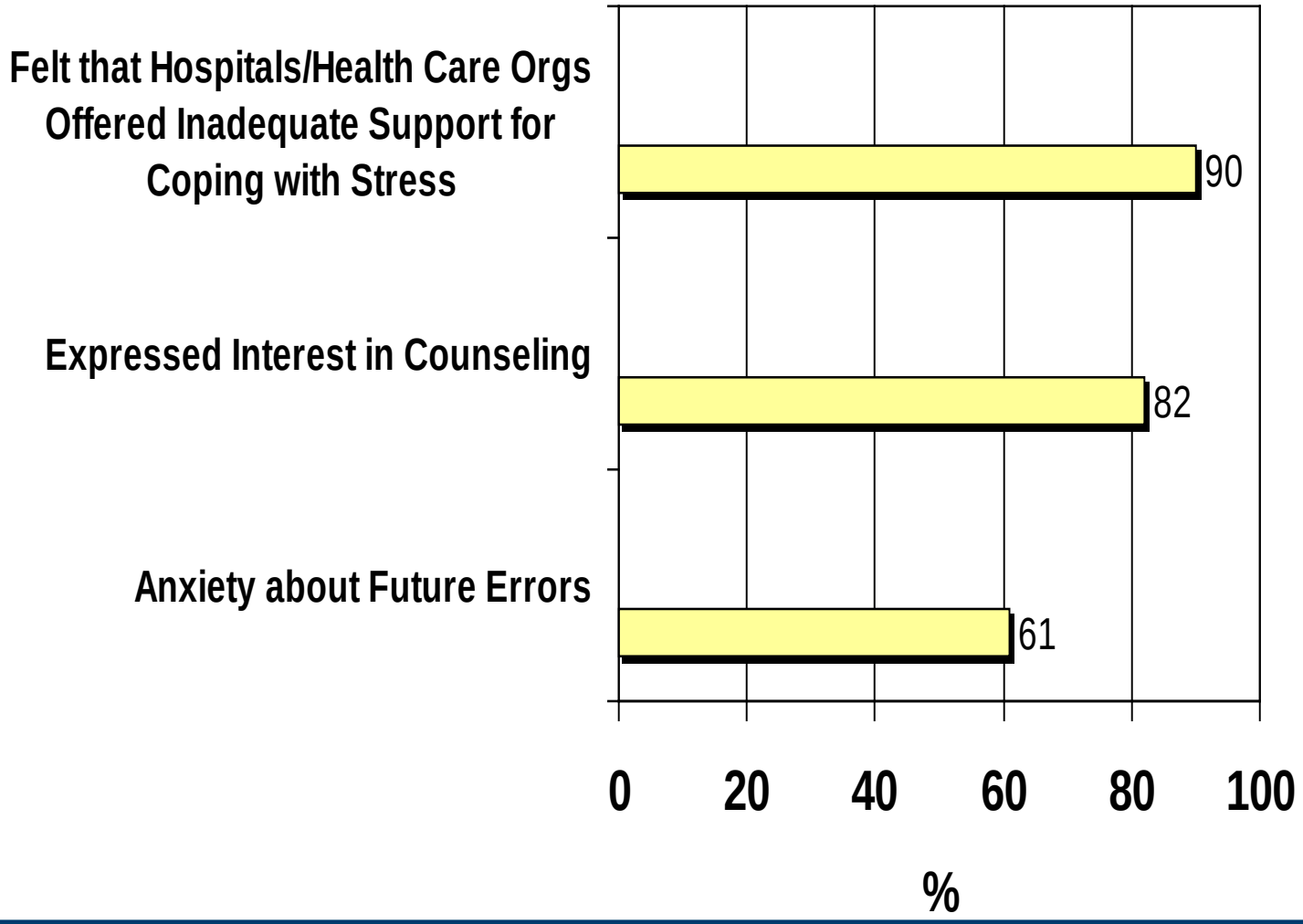
Event Investigation

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

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



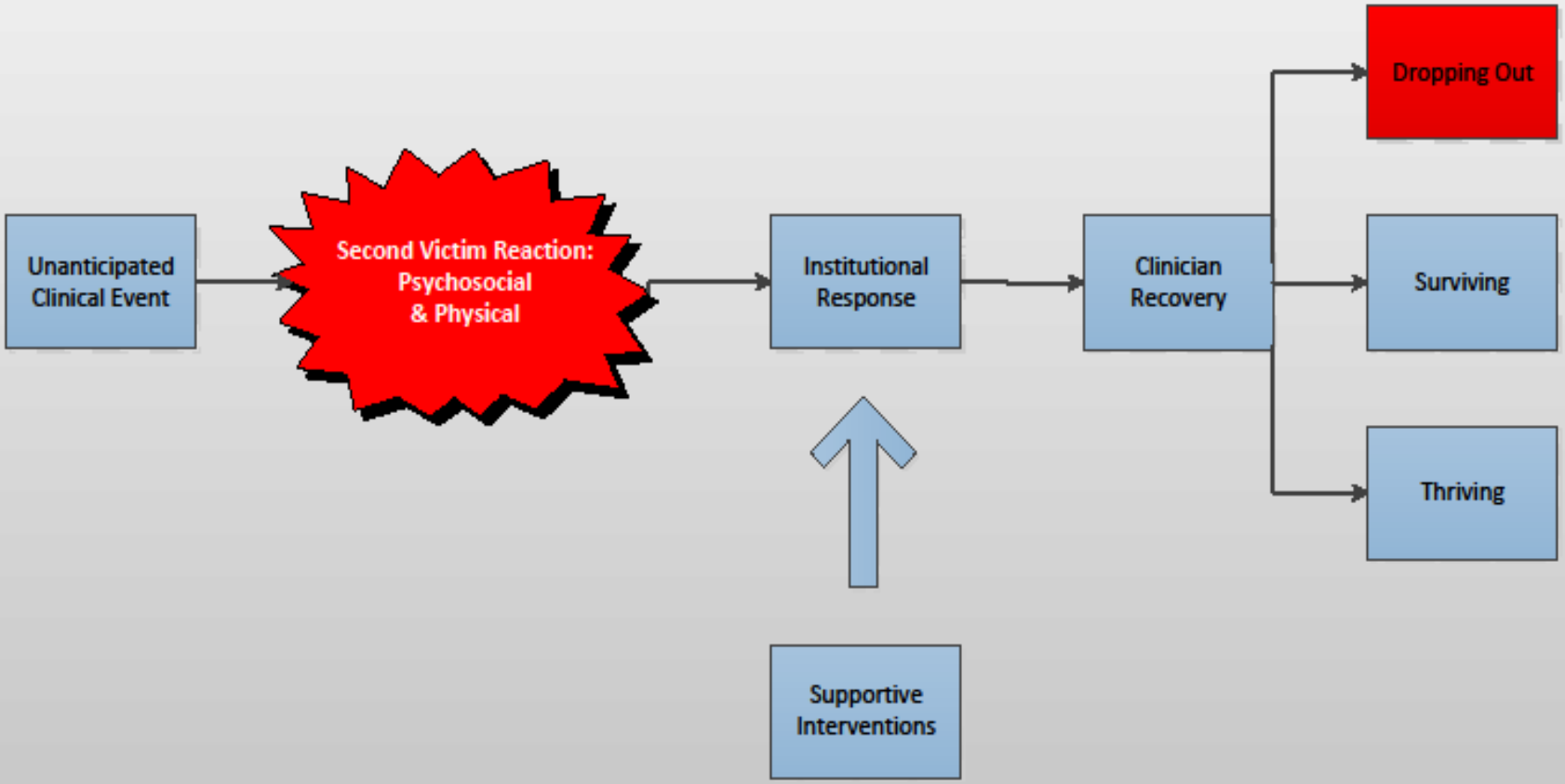
Waterman AD, et al. Jt Comm J Qual Patient Saf. 2007;33:467-476.

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

Second Victim Conceptual Intervention Model

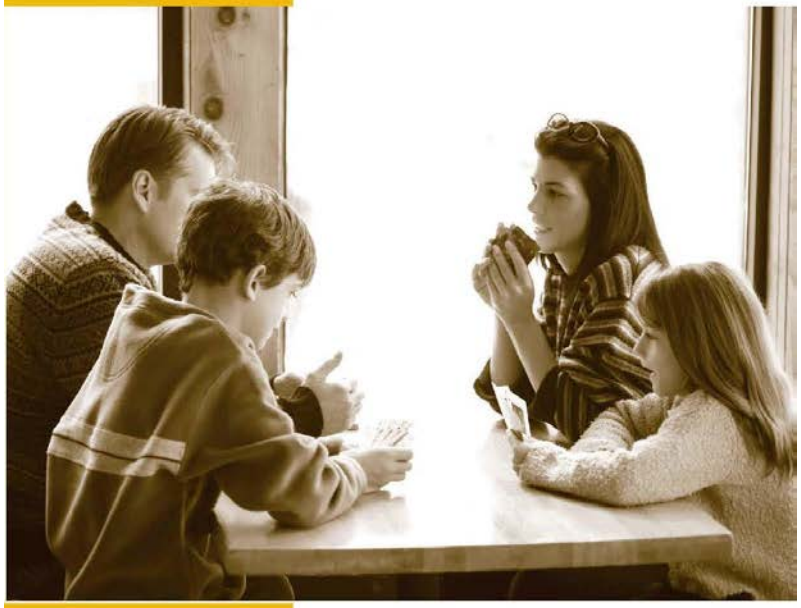


Credit: University of Missouri ForYOU Team

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

We're here for you and your family.



forYOU team

Health Care

University of Missouri Health System

The TRUST Team

- Developed by a multidisciplinary advisory committee. 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.

  - **T**reatment that is fair and just
  - **R**espect
  - **U**nderstanding and compassion
  - **S**upportive care
  - **T**ransparency and opportunity to contribute

TRUST Team

PROVIDING CARE AND SUPPORT FOR OUR STAFF

CARILION CLINIC

TRUST Team
PROVIDING CARE AND SUPPORT FOR OUR STAFF

TRUST Team provides compassionate and coordinated care to staff involved in a significant medical event, also referred to as The Second Victim.

WHAT DOES SECOND VICTIM MEAN?

Second victims are health care providers or caregivers who are traumatized by adverse patient events. Such events include, but are not limited to:

- Medical errors and/or patient-related injuries
- Any tragic circumstance involving a patient or group of patients
- Unexpected death or debilitation of a patient, despite provision of excellent care
- Litigious action brought on by a patient or patient's family
- A series of losses within one particular unit or care team without time to adequately process and grieve in between those losses

WHO CAN BECOME A SECOND VICTIM?

Every health care worker can become a second victim. It is estimated that almost 50 percent of all health care providers are a second victim at least once in their career.[1]

WHAT DOES TRUST STAND FOR?

TRUST was coined as "The 5 Rights of the Second Victim."[2] It 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.

TRUST TEAM MISSION

The TRUST Team exists to increase organizational awareness of the second victim phenomenon by providing education to leaders and health care providers. The team also provides immediate and ongoing support, mentoring, clinical intervention and linkage to resources needed to support any provider who is a second victim. Efforts are collaborative and coordinated to assure that needs of the second victim are met in a compassionate and safe way. Our goal is to assist second victims in returning to fulfillment in their careers and lives.

PROGRAM COMPONENTS

1. Outreach: Our Outreach Providers will make contact with the second victim to provide support and assessment of additional needs. Outreach Providers are qualified mental health professionals and will assist in addressing immediate and longer term needs with the second victim. These conversations are completely confidential.

2. Peer supports: Our peer supports are volunteer health care providers who have had personal experiences as second victims. They have received training regarding the second victim phenomenon and the mentoring relationship. TRUST Team mentors will meet with you to support and guide you through your journey and link you to resources if greater concerns arise.

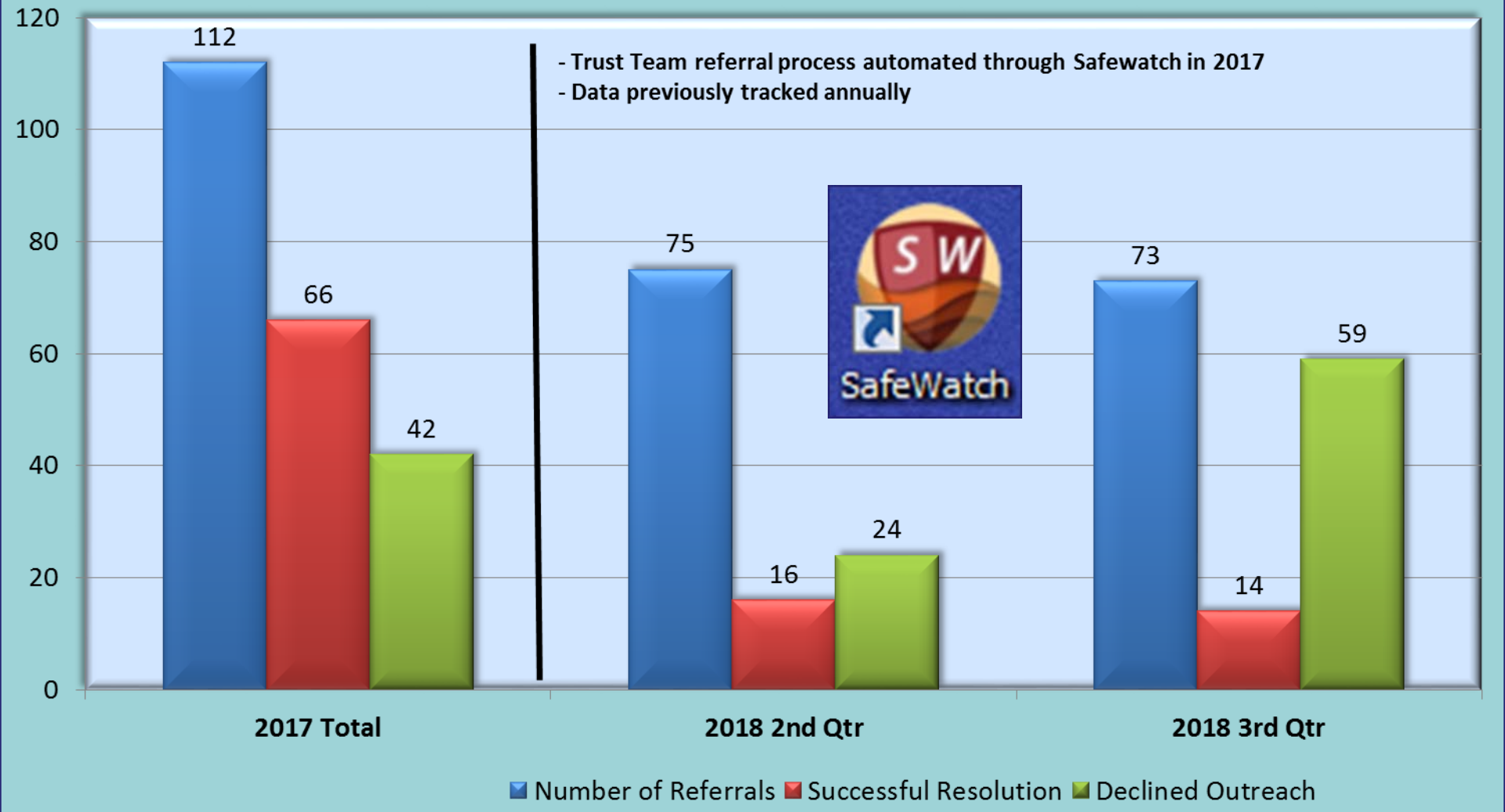
3. Employee assistance: The TRUST Team and Employee Assistance Program (EAP) are partnering to assure that second victims who require greater clinical support are linked to a Carilion EAP consultant. EAP consultants are licensed and certified mental health professionals. This level of service is also completely confidential and abides by HIPAA.

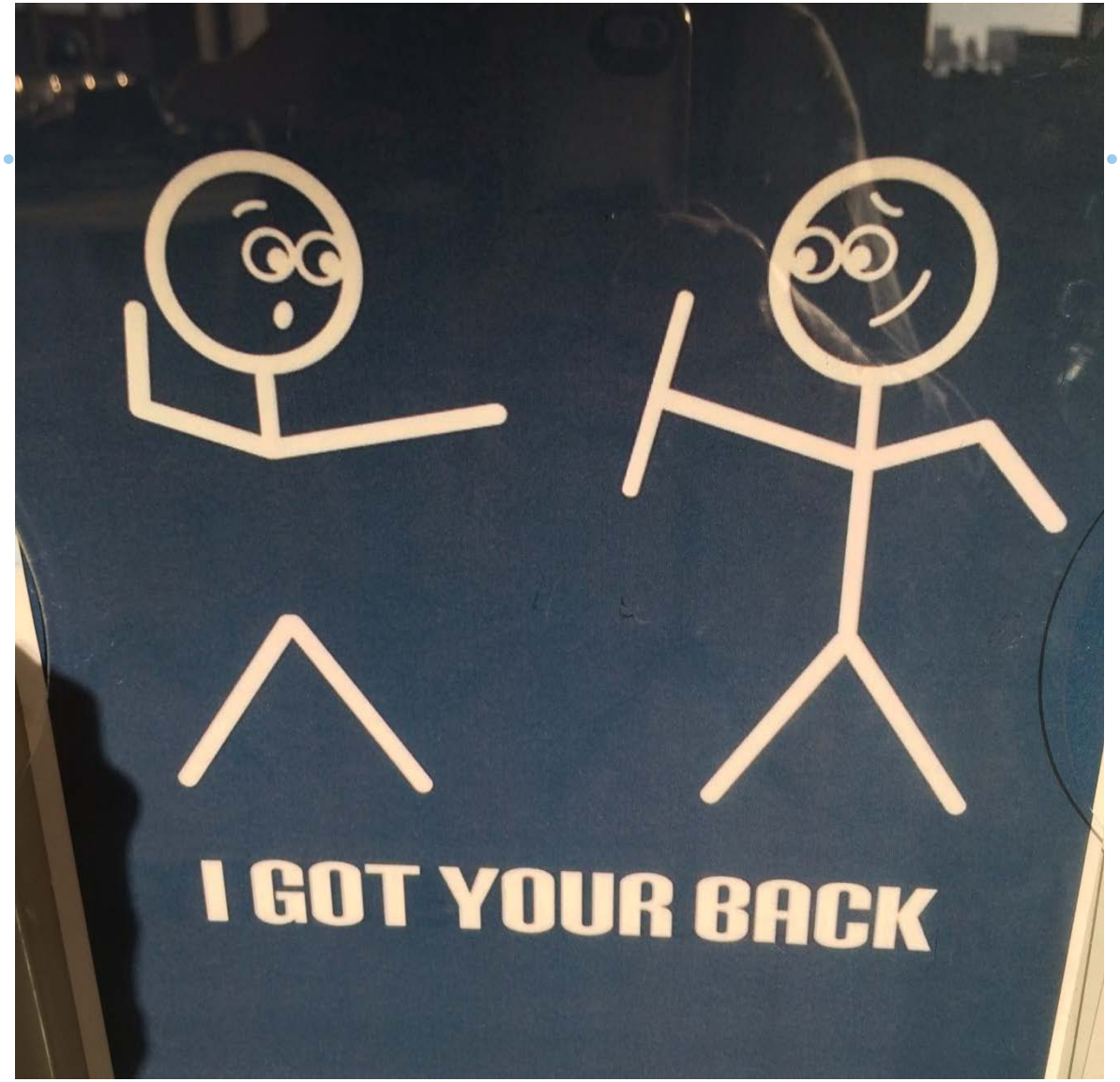
4. Organizational education: Our goal is to educate our health care providers and leaders on the second victim phenomenon and compassionate ways to respond.

5. Planning and development: The TRUST Team is monitored by the Second Victim Steering Committee. This committee will continuously evaluate the organization's response to the second victim and make recommendations to organizational leadership based on trends and experiences of health care providers who are involved in a significant medical event.

TRUST Team

Trust Team Referrals



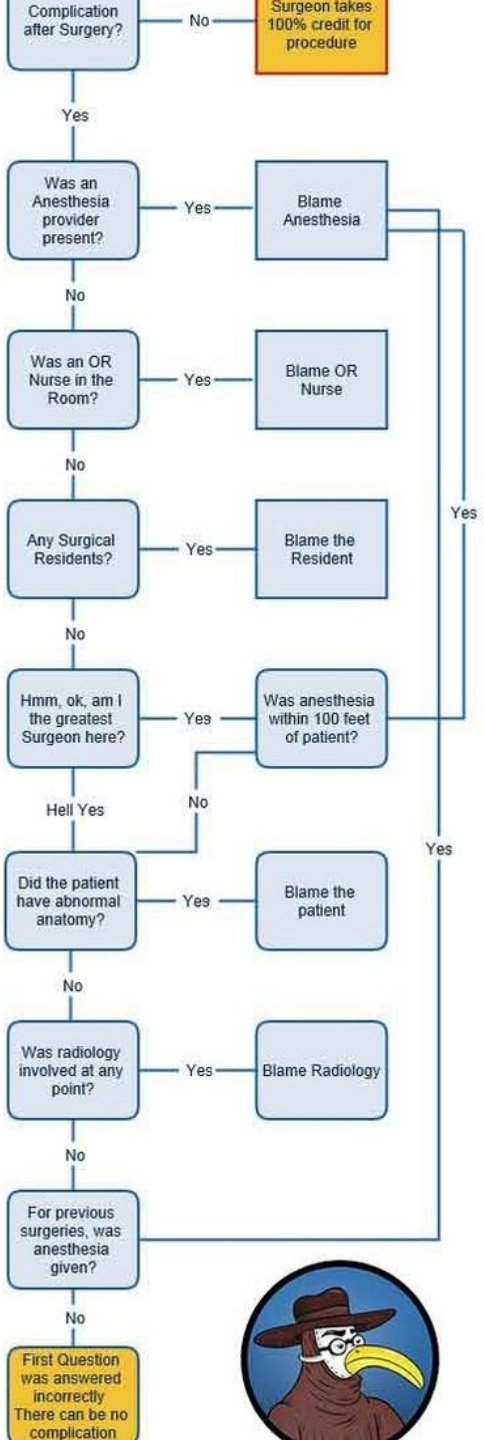

I GOT YOUR BACK

To Err is Human

Preventing “Second Victim” Casualties is Humane


It is recommended that the rope and attachments are inspected at regular intervals
TO SAVE A LIFE!
Pick up life ring
Grab the rope
Keep hold of end of line
Throw ring to casualty
Pull casualty to shore
IF POSSIBLE SEND SOMEBODY ELSE FOR ASSISTANCE - DIAL 999 FOR EMERGENCY SERVICES
DO NOT INTERFERE WITH THIS EQUIPMENT
Under the Criminal Damage Act 1971, any person found tampering with this equipment may receive up to a £5,000 fine and/or imprisonment.
Glasdon
Glasdon Manufacturing Limited
Telephone: 01253 881131
Web: www.glasdon.com

Thank You



http://gomerpedia.org/wiki/Blame_Anesthesia_Algorithm

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

References

1. Banja JD. Medical errors and medical narcissism. Sudbury (MA): Jones and Bartlett Publishers; 2005.
2. Disclosure and discussion of adverse events. ACOG Committee Opinion No. 380. American College of Obstetricians and Gynecologists. Obstet Gynecol 2007; 110:957-8.
3. Engel KG, Rosenthal M, Sutcliff K. Residents' responses to medical error: coping, learning, and change. Acad Med 2006; 81:86-93.
4. Hilfiker D. Facing our mistakes. N Engl J Med 1984 Jan 12;310(2):118-22.
5. Vohra PD, Johnson JK, Daugherty CK, Wen M, Barach P. Housestaff and medical student attitudes toward medical errors and adverse events. Jt Comm J Qual Patient Saf 2007; 33:493-501.
6. Waterman AD, Garbutt J, Hazel E, Dunagan WC, Levinson W, Fraser VJ, et al. The emotional impact of medical errors on practicing physicians in the United States and Canada. Jt Comm J Qual Patient Saf 2007; 33:467-476.
7. West CP. How do providers recover from errors? Agency for Healthcare Research and Quality WebM&M: Case & Commentary. January 2008. Available at http://www.ahrq.gov/case.aspx?caseID-167. Retrieved April 8, 2008.
8. Wojcieszak D, Saxton JW, Finkelstein MM. Sorry works! Disclosure, apology, and relationships prevent medical malpractice claims. Bloomington (IN): AuthorHouse™; 2007.
9. Wu AW, Medical error: the second victim. BMJ 2000; 320:726-7.
10. Wu AW, McPhee SJ, Lo B. How house officers cope with their mistakes. West J Med 1993; 159:565-569.

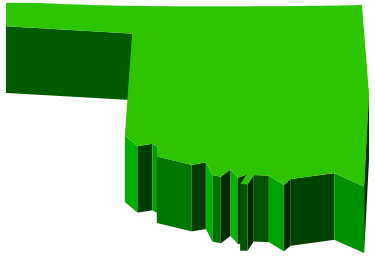
OUP Colleague Support Program

- Includes support after any difficult patient care encounter, critical incident, claim, or other support needed during the process of managing patient and provider risk support.
- Research identifies physicians want support from their peers.
- Mechanism by which clinicians can communicate about their experience and emotions with someone who has 'been there.'
- Not for the purpose of giving legal advice, medical expert opinions, or professional psychological counseling, but the panel will offer both support and strategies that have helped other clinicians in similar situations.

Contact the Colleague Support Program

Phone: 405-271-1800 or 918-660-3628
Email: oupoumcolleaguesupport@ouhsc.edu
More info: https://www.oumedicine.com/ou-physicians/colleague-support

OUP Risk Services Policies:



- RM1- Disclosure Guidelines
- RM2- Dismissal of Patients
- RM3- Peer Review
- RM4- Confidential Reporting of Incidents
- RM5- Recalls
- RM6- Informed Consent
- RM7- Disruptive or Impaired Healthcare professional or staff

*found on OUP intranet