Perinatal Quality Collaborative Vermont

presents

Second Victims: Supporting Health Care Providers after Adverse Events

Dr. Aneesa Stewart, MFM Fellow at UVMMC

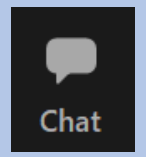
PERINATAL QUALITY COLLABORATIVE VERMONT

VCHIP VERMONT CHILD HEALTH IMPROVEMENT PROGRAM
The University of Vermont | LARNER COLLEGE OF MEDICINE

Housekeeping

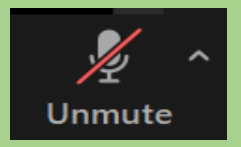
Chat

Use the *Chat* box to type a question.



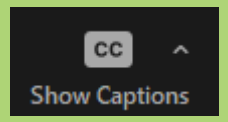
Microphone

You will be muted when you join. If you wish to verbally ask your question during the Q&A portion of the presentation, please unmute your microphone.



Captioning

Click *Show Captions* from your navigation bar to view automated captions.



Evaluation

Before leaving the event, please complete the evaluation by copying and pasting the link provided in the *Chat* into a browser. Thank you!

If you would like to join our listserv, please send an email to VCHIP.PQCVT@med.uvm.edu.

Collaborators

Marjorie Meyer MD

Enid Rivera-Chiauzzi MD

- No financial disclosures

Second Victim Experience (SVE) Survey

OBJECTIVE

1

Discuss definitions for second victim experience

2

Review signs and symptoms to help identify second victims

3

Discuss tiered model of help

4

Discuss current research projects and initiatives

Brief Mental Exercise

- Please think of one of the worst patient events you have had in your career (patient death, hemorrhage, traumatic delivery)
  - How did it make you feel?
  - Did it make you question your choice in choosing your profession?
  - How did you get over it?

This will be the premise for our discussion

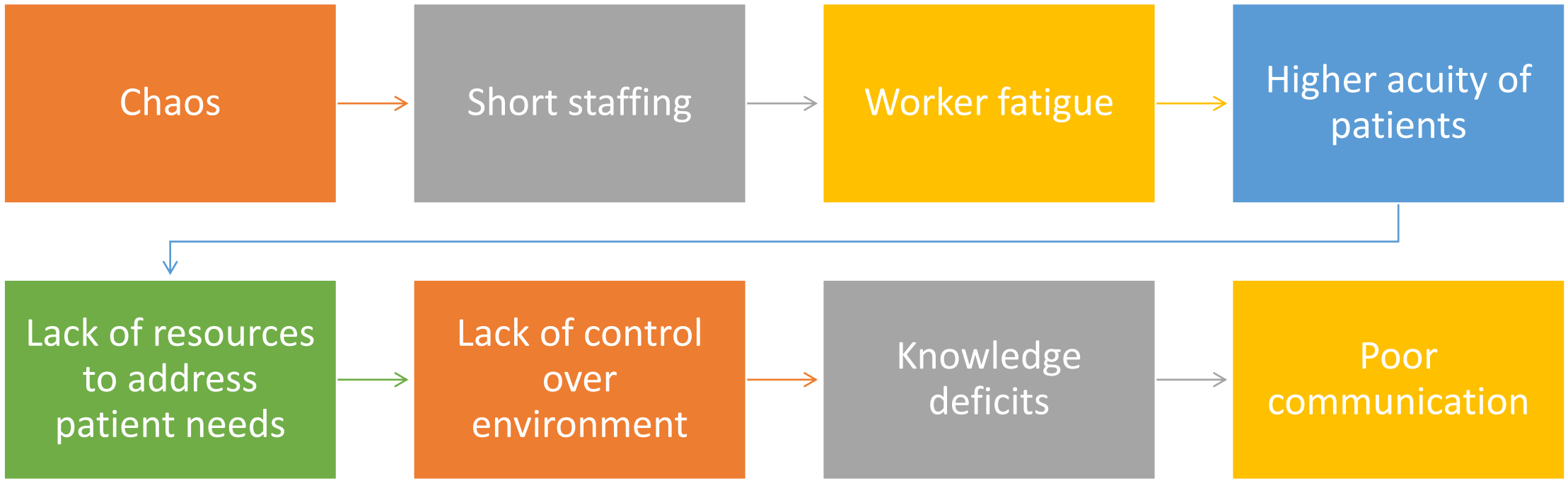
Primary Foundation

- Healthcare workers do not intend harm
- We do the best we can with what is before us
- We are all human
- It is ok to express emotions over things that are not “normal” occurrences. It does not mean that we are weak

Honoring the Primary Victim

- The primary victim is the patient after an adverse event.
- We recognize that the adverse event impacts the patient most significantly
- However, the healthcare worker associated with the event is also impacted

Why do Adverse Events Occur?



What happens after an adverse event to the patient?

- Convey the events of the adverse event to the patient and family
- Apologize- convey sense of sorrow over what happened
- Medical/financial compensation for event if litigation is pursued
- Make them aware that something will be done to address what happened.

What happens after an adverse event?

Debrief of the event

The event gets reported

Report gets reviewed by peers or supervisor

Internal investigation often with risk management

Quality Improvement committee to address systems issues

How do we review primary adverse patient events?

- Peer to peer review
- Multi disciplinary case review
- Root cause analysis
- Morbidity and mortality conferences
- Goal: How to prevent these types of events from occurring in the future

Case Study

- Critically ill newborn in NICU for sepsis
- NICU nurse with 27 years of experience miscalculated calcium chloride dose and gave 1.4 gms instead of 140 mg to the 8 month old
- Neonate died within 24 hrs of administration
- Medical examiner confirmed med administration likely cause of death

What happened afterwards?

- From a system standpoint
  - There was an RCA
  - Hospital implemented new policies and protocols for administration of meds
  - Nurses underwent additional training on med administration. Created a double check
  - Hospital was sued by family with a $2 million settlement
  - Since this event no other incorrect pediatric med admin event occurred

What Happened Afterwards?

Punitive	Nurse fired from the hospital
Medical review board	Put on probation from the state board
Ultimate Impact	Nurse committed suicide 7 months later after medical error

- Events can happen to patients and perhaps unexpectedly have lasting and sometimes harmful impacts on providers

What is the Second victim?

- ”Second victim” refers to healthcare workers involved in adverse and often unanticipated patient outcome such as medical error, patient related injury or death

Term was coined in 2000 by Dr. Wu with primary focus being on physicians.

Concept has been around since 1984

Medical error: the second victim

The doctor who makes the mistake needs help too

Personal view
p 812

When I was a house officer another resident failed to identify the electrocardiographic signs of the pericardial tamponade that would rush the patient to the operating room late that night. The news spread rapidly, the case tried repeatedly before an incredulous jury of peers, who returned a summary judgment of incompetence. I was dismayed by the lack of sympathy and wondered secretly if I could have made the same mistake—and, like the hapless resident, become the second victim of the error.

Strangely, there is no place for mistakes in modern medicine. Society has entrusted physicians with the burden of understanding and dealing with illness. Although it is often said that "doctors are only human," technological wonders, the apparent precision of laboratory tests, and innovations that present tangible images of illness have in fact created an expectation of perfection. Patients, who have an understandable need to consider their doctors infallible, have colluded with doctors to deny the existence of error. Hospitals react to every error as an anomaly, for which the solution is to ferret out and blame an individual, with a promise that improvements that could decrease errors. Many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster. And, although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims.

Virtually every practitioner knows the sickening realisation of making a bad mistake. You feel singled out and exposed—seized by the instinct to see if anyone has noticed. You agonise about what to do, whether to tell anyone, what to say. Later, the event replays itself over and over in your mind. You question your competence but fear being discovered. You know you should confess, but dread the prospect of potential punishment and of the patient's anger. You may become overly attentive to the patient or family, lamenting the failure to do so earlier and, if you haven't told them, wondering if they know.[1–3]

Sadly, the kind of unconditional sympathy and support that are really needed are rarely forthcoming. While there is a norm of not criticising,[4] reassurance from colleagues is often grudging or qualified. One

" Sadly the kind of unconditional sympathy and support that are really needed are rarely forthcoming"

Second Victim

- Term is inclusive of all providers (clinical and non-clinical staff)
- Estimates of this experience vary widely among specialties 10.4-72.5%

It is okay to not like the term second “victim”

Victim: one that is injured, destroyed or sacrificed under a variety of conditions

Victim is associated with things like casualty, loss used in reference to war or catastrophe

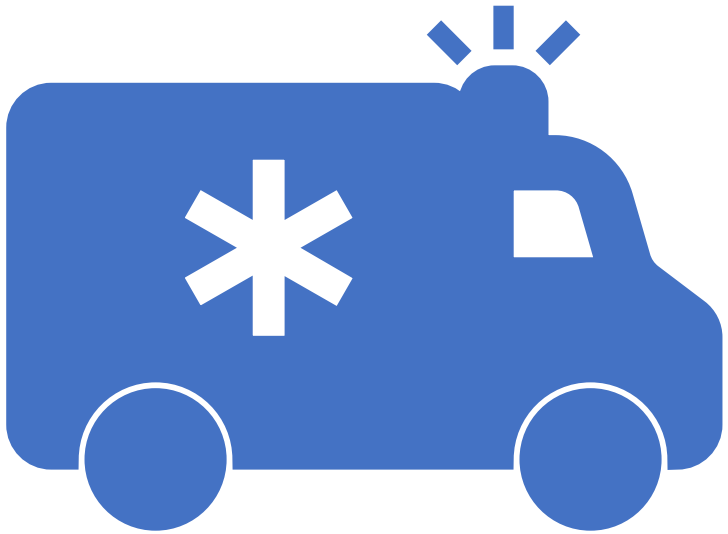
Most victims don't choose the trauma inflicted upon them. All of us have agency in our decision to choose healthcare.

Just because we have chosen this profession does not mean we are immune. We all suffer moral injury from working in a hospital network that inherently does not work for providers and arguably sometimes doesn’t work for patients

Healthcare work is high risk

EVENTS THAT CAN CREATE SECOND VICTIMS IN OBGYN

- Occurs with many different subtypes of experiences
  - OB
    - Maternal and neonatal death
    - Birth trauma
    - Diagnosis of anomalies,
    - Litigation
    - Patient complaints
    - Life threatening hemorrhage/ difficult shoulder
    - Medical mistakes
- GYN
  - Reaching the end of cancer treatment
  - Unintended surgical complications
  - Take backs to OR
  - Missed diagnosis
  - Inability to provide abortion care
  - Sudden death



Second Victim Experience (SVE)

- Refers to the emotional response/ trauma that occurs after the event and to the healthcare worker

Signs and Symptoms

- Symptoms:
  - Psychological effects
    - PTSD, shame, guilt, anxiety/depression, anger
    - Stages of grief
    - May feel personally responsible for an adverse event
    - Feelings of failure
    - Unable to focus on job
  - Physical symptoms (difficulty with sleep, trouble with eating)

Signs and Symptoms

Can be both immediate and delayed.

Most people suffer in silence

Appropriate reaction to abnormal events

6 Stages of Progression of SVE

STAGE 1: CHAOS AND ACCIDENT RESPONSE (HOW AND WHY DID THIS HAPPEN)

STAGE 2: INTRUSIVE REFLECTIONS (WHAT DID I MISS?)

STAGE 3: QUESTIONING OF PERSONAL INTEGRITY (WHAT WILL OTHER THINK?)

STAGE 4: ENDURING THE INQUISITION (HOW MUCH TROUBLE AM I IN? WHAT WILL COME ABOUT IN TERMS OF PERSONAL PERFORMANCE IN THE RCA?)

STAGE 5: OBTAINING EMOTIONAL FIRST AID (WHERE CAN I TURN TO FOR HELP?

STAGE 6: MOVING ON (DROPPING OUT, SURVIVNG, THRIVING)

Short term impacts of SVE on healthcare workers

Sense that we “failed” patients

Professional self doubt, lower self-efficacy

Distracted from clinical duties

Impaired performance

Internal and external turmoil

Intrusive thoughts and re-analysis (why did I do that? If only I could have done something differently?)

Fears after a SVE

Do others think I am incompetent?

Do others think that it was only my fault that this event occurred?

Will people trust me to take care of patients in the future?

Hard to figure out if these thoughts are true or not

Impact of SVE

- Thriving (growing and learning from experience)
- Surviving (constantly coping from experience)
- Dropping out (leaving profession or extremes of suicide)

Long Term Impacts of SVE

Increased risk of burnout

Career abandonment

Long term PTSD, depression/anxiety,

Substance abuse or suicide.

Continued medical errors

Impacts of SVE on Organizations (third victim)

- Absenteeism
- Higher turnover rates
- Low employee morale
- Reductions in quality of care
- Lower patient satisfaction scores
- Increase in malpractice lawsuits

Why is SVE important for hospitals to address?

SVE can lead to massive financial losses

Factors that WORSEN the second victim experience

- Public nature of events (no secerets in medicine)
- Normalization of accepting adverse outcomes and moving on
- Personal barriers
- Lack of time, competing interests (moving onto other patients)
- Increased administrative burden
- Don’t know how to report an event.
- Lack of conducive culture

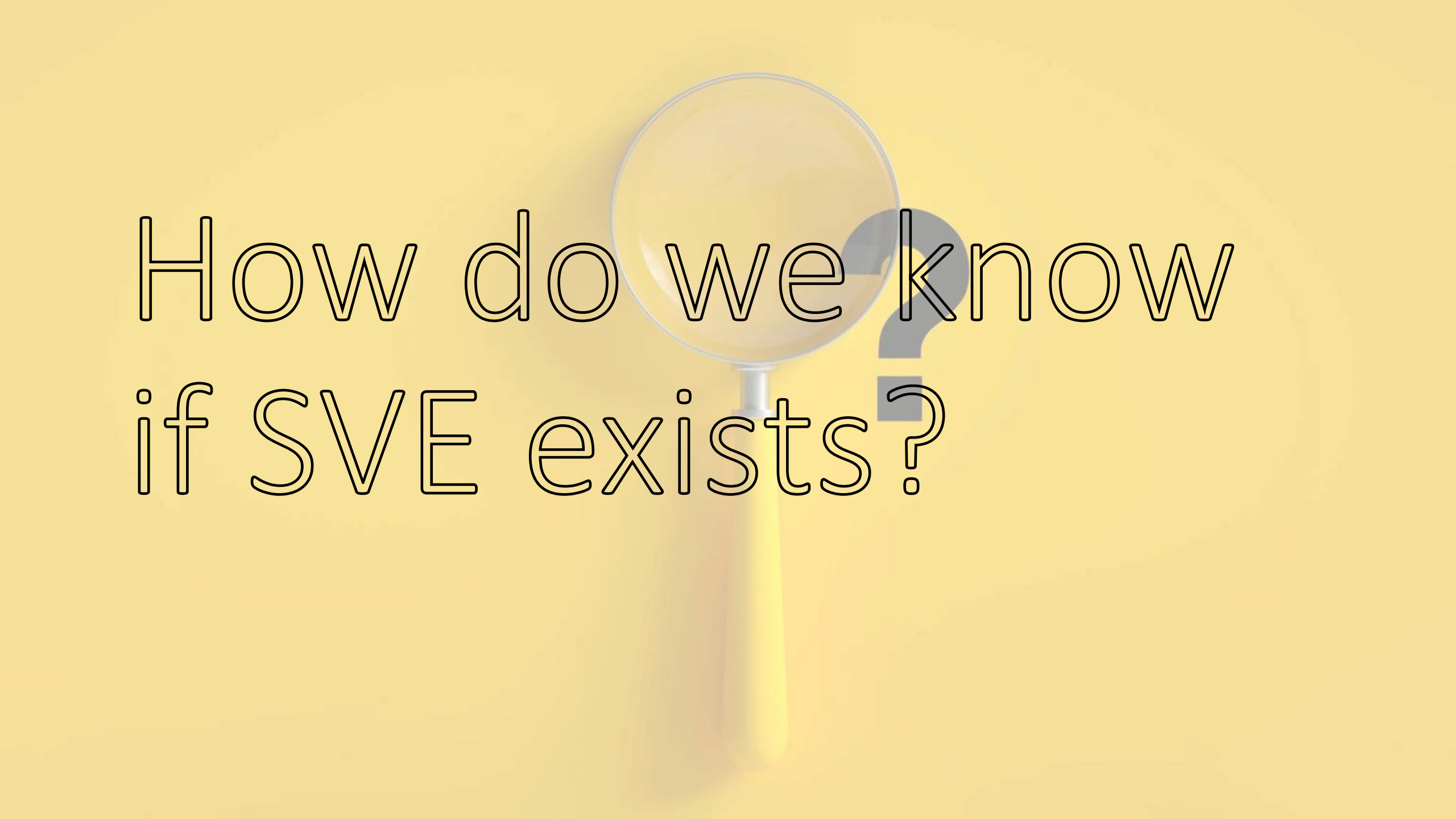
Factors that WORSEN the second victim experience

Inability to debrief situations or reach out for help given high clinical volume

Not knowing where or what resources are available

Lack of recognition at signs/ symptoms of SVE both internally and externally

Lack of recognition and acknowledgement that this can happen to all health care providers, shared experience that no one talks about


How do we know
if SVE exists?

FIRST STUDY ON SVE

- 31 physicians interviewed
- Regardless of sex, years of experience, all reported traumatic events
- Psychological symptoms high
- Beckoned for more surveillance of this issue and call to create surveillance programs to mitigate adverse outcomes

EDITOR'S CHOICE

The natural history of recovery for the healthcare provider "second victim" after adverse patient events

S D Scott, L E Hirschinger, K R Cox, M McCoig, J Brandt, L W Hall

University of Missouri Health System, University of Missouri-Columbia, Columbia, Missouri, USA

Correspondence to:
S D Scott, Office of Clinical Effectiveness, University of Missouri Health System, One Hospital Drive, 1W-29, DC 103.40, Columbia MO 65212, USA;
scotts@health.missouri.edu

Accepted 4 June 2009

ABSTRACT

Background: When patients experience unexpected events, some health professionals become "second victims". These care givers feel as though they have failed the patient, second guessing clinical skills, knowledge base and career choice. Although some information exists, a complete understanding of this phenomenon is essential to design and test supportive interventions that achieve a healthy recovery.

Methods: The purpose of this article is to report interview findings with 31 second victims. After institutional review board approval, second victim volunteers representing different professional groups were solicited for private, hour-long interviews. The semistructured interview covered demographics, participant recount of event, symptoms experienced and recommendations for improving institutional support. After interviews, transcripts were analyzed independently for themes, followed by group deliberation and reflective use with current victims.

error.[2–5] The personal stories were followed by accounts declaring a need for institutional support.[6–12] The term *second victim* was initially coined by Wu[13] in his description of the impact of errors on professionals. Others proposed that second victims experience post-traumatic stress disorder.[14] Wolf *et al*[15] described a unique, traumatic response by second victims in terms of emotional, social, cultural, spiritual and physical characteristics. A survey of more than 3000 physicians validated that, when involved in medical errors, emotional distress is prevalent and support was needed but was largely unaddressed.[16] Crigger[17] described intense struggles given a traditional image of perfection among healthcare professionals. Human fallibility versus perfection is not deeply integrated within many health professional training programs, so preparation for medical error consequences is far from developed.[18] Rosheim[19] warns about excellent clin-

Table 4 Most commonly reported physical and psychosocial symptoms

Physical symptoms	n (%)	Psychosocial symptoms	n (%)
Extreme fatigue	16 (52)	Frustration	24 (77)
Sleep disturbances	14 (45)	Decreased job satisfaction	22 (71)
Rapid heart rate	13 (42)	Anger	21 (68)
Increased blood pressure	13 (42)	Extreme sadness	21 (68)
Muscle tension	12 (39)	Difficulty concentrating	20 (65)
Rapid breathing	11 (35)	Flashbacks	20 (65)
		Loss of confidence	20 (65)
		Grief	20 (65)
		Remorse	19 (61)
		Depression	17 (55)
		Repetitive/intrusive memories	16 (52)
		Self-doubt	16 (52)
		Return to work anxiety	15 (48)
		Second guessing career	12 (39)
		Fear of reputation damage	12 (39)
		Excessive excitability	11 (35)
		Avoidance of patient care area	10 (32)

HOW IS Second Victim Experience STUDIED?

In 2013, a Second Victim Experience and Support Tool was designed and validated as a survey instrument that could be used by healthcare organization in implementing and tracking the performance of support resources for second victims (Burlison, et al)

Initially designed for EM and Pediatrics, however has now expanded to other sub-specialties with modifications allowed

Contained 29 items with 7 dimension and 2 outcome variables

Psychological Distress, Physical Distress,
Colleague/ Supervisor/ Institutional Support
Professional Self- Efficacy
Turnover Intentions/ Absenteeism
Desired Forms of Support

Completed by 303 healthcare professionals in direct patient care.

Assessed for validity, internal consistency and construct validity with confirmatory factor analysis. Confirmed good model fit for the survey.

IMPACT OF USING SECOND VICTIM Experience and support tool

- Pinpoints institutional areas of improvement with respect to the second victim experience
- Site specific understanding of second victim support options desired by personnel
- Puts some focus on metrics that concern worker turnover and absenteeism > costly to organizational outcomes
- Results of SVEST tool often support investment and development of support programs for healthcare workers

SVE in nurses

- 2897 nurse study that looked at SVE in nurses
- High prevalence with high psychological reactions
- Peer support desired

s Manag. 2022 Jan;30(1):260-267. doi: 10.1111/jonm.13490. Epub 2021 Oct 29.

:ond-victim experience and support among nurses mainland China

Rongrong Huang [1], Huimin Sun [2], Guiru Chen [3], Yaling Li [1], Jinbo Wang [4]

Affiliations + expand

PMID: 34592010 DOI: 10.1111/jonm.13490

Abstract

Aims: To investigate the experience and support of nurses as second victims in adverse events and explore factors.

Background: Adverse events have significant negative influences on healthcare professionals. However, there is still a lack of research on the impacts of individual and event factors.

Methods: A cross-sectional survey via a self-report electronic questionnaire was sent to approximately 6400 nurses from six tertiary comprehensive hospitals in mainland China. The socio-demographic, adverse event-related information and second-victim experience and support questionnaires were used.

Results: Approximately 2897 (45.26%) of nurses were involved in at least one adverse event that mainly caused psychological distress. Male nurses, Grade I adverse events, public reports and discussions of adverse events were related to the second-victim reaction. Discussing with a respected colleague was the most strongly desired form of support.

Conclusions: Chinese nurses have reported a high prevalence of psychological reactions. Follow-up studies must consider other potential factors.

Implications for nursing management: Nursing managers should consider the factors that affect second victims and provide support based on the expectations of nurses. Psychological first-aid nd immediate and mid- to long-term support strategies should be provided to help the second ctim alleviate distress.

A cross-sectional survey on nurses' second victim experience and quality of support resources in Singapore

Wen Qi Mok [1], Guey Fong Chin [1], Suk Foon Yap [1], Wenru Wang [2]

Affiliations + expand

PMID: 31789437 DOI: 10.1111/jonm.12920

Abstract

Aim: The study aimed to investigate nurses' second victim experience and quality of support resources in Singapore.

Background: The second victim phenomenon, broadly described as the suffering of providers including nurses in the face of a clinical error, is often overlooked.

Methods: A cross-sectional questionnaire survey was adopted. A total of 1,163 nurses from an acute public hospital in Singapore took part in the study. The Second Victim Experience and Support Tool (SVEST) was employed to assess experience of second victims and the quality of support resources.

Results: The study results showed that nurses experienced second victim-related physical, psychological and professional distress. About 31.8% of the participants had turnover intentions, while 9.3% had absenteeism following an error. Nurses who are younger and less experienced were more likely to experience greater second victim response. Among the support options, peer support was rated as the most desirable.

Conclusion: Nurses, being at the forefront of care delivery, are especially susceptible to being a casualty of the second victim phenomenon.

Implications for nursing management: Acknowledging the second victim phenomenon, together with a strong organizational support, is essential in alleviating the trauma and assisting nurses with reconciliation in the aftermath of an unanticipated error.

Keywords: errors; nurses; second victims.

- High rate of turnover and absenteeism
- Younger and less experienced nurses at higher risk of having a second victim
- Peer support desired

* 51 surveys completed focused primarily in oncology (medical, surgical, radiation oncology, palliative care)
* High rates of PTSD aggravated by a negative work culture
* Rates of second victim experience higher when patient cared for was of similar age, race, background

› Curr Oncol. 2019 Dec;26(6):e742-e747. doi: 10.3747/co.26.5433. Epub 2019 Dec 1.

The physician's Achilles heel–surviving an adverse event

I Stukalin [1], B C Lethebe [2], W Temple [1]

Affiliations + expand

PMID: 31896944 PMCID: PMC6927782 DOI: 10.3747/co.26.5433

Free PMC article

Abstract

Background: Of hospitalized patients in Canada, 7.5% experience an adverse event (ae). Physicians whose patients experience aes often become second victims of the incident. The present study is the first to evaluate how physicians in Canada cope with aes occurring in their patients.

Methods: Survey participants included oncologists, surgeons, and trainees at the Foothills Medical Centre, Calgary, AB. The surveys were administered through REDCap (Research Electronic Data Capture, version 9.0: REDCap Consortium, Vanderbilt University, Nashville, TN, U.S.A.). The Brief cope (Coping Orientation to Problems Experienced) Inventory, the ies-r (Impact of Event Scale-Revised), the Causal Dimension Scale, and the Institutional Punitive Response scale were used to

TABLE I Descriptive statistics of coping strategies, causal attributions, and punitive response from 51 survey respondents

Variable	Mean	Range
Impact of Event Scale–Revised[a]		
Intrusion	15.73±9.27	0–35
Avoidance	11.49±7.46	0–29
Total score	27.22±15	0–62
Self-distraction	3.92±1.98	2–8
Active coping	5.49±1.83	2–8
Denial	2.14±0.49	2–4
Substance abuse	2.31±0.76	2–5
Emotional support	3.98±1.75	2–8
Instrumental support	3.9±1.75	2–8
Behavioral disengagement	2.61±1.02	2–6
Venting	3.37±1.51	2–8
Positive reframing	4.24±1.87	2–8
Planning	5.53±1.96	2–8
Humor	2.39±1.02	2–6
Acceptance	6.8±1.18	3–8
Religion	3.28±1.71	2–8
Self-blame	4.43±1.63	2–8
Causal Dimension Scale[b]		
Locus of cause	3.45±1.51	1–7
Controllability of cause	3.39±1.74	1–7
Institutional Punitive Response scale[c]		
Complications held against physicians	3.76±0.95	1–5
Adequate institutional support	2.24±0.99	1–5
Institution adequate at preventing errors	2.51±1.01	1–4

[a] Higher number indicates more frequent use of coping strategy.
[b] Higher number indicates external locus of cause and uncontrollability of cause.
[c] Higher number indicates agreement.

J Healthc Risk Manag. 2016 Aug;36(2):27-34. doi: 10.1002/jhrm.21239.

Impact of health care adversity on providers: Lessons learned from a staff support program

Maxine Trent [1], Kimberly Waldo [1], Hania Wehbe-Janek [1], Daniel Williams [2], Wendy Hegefeld [1], Lisa Havens [1]

Affiliations + expand

PMID: 27547876 DOI: 10.1002/jhrm.21239

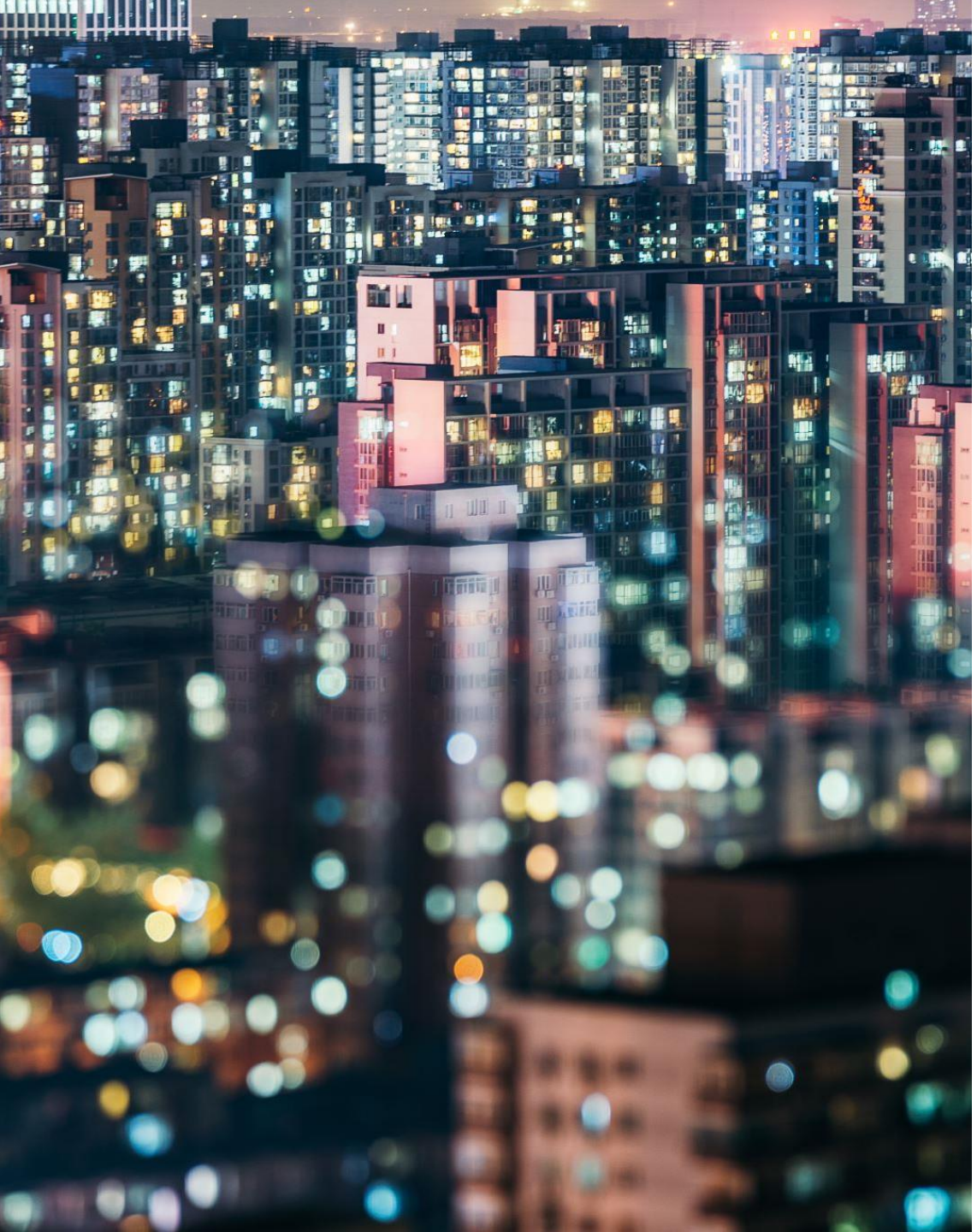
Abstract

Background: Health care providers often experience traumatic events and adversity that can have negative emotional impacts on the profession and on patients. These impacts are typically multifaceted and can result from many different events, such as unanticipated outcomes, licensing board complaints, claims, and litigation. Because health care providers are exposed to diverse situations, they require adequate and timely support, imperative for provider resilience and patient safety. This study evaluated the success of an institution's second victim health care support program and best practices in responding to these traumatic experiences effectively.

Methods: Twenty faculty and medical residents who utilized the support program at a large hospital system located in Central Texas from 2001 to 2012 participated in 1 of 6 focus groups. Qualitative data were collected from these groups to describe program requirements for the adequate delivery of health care adversity support and necessary program improvements. Responses were first transcribed verbatim. Each research team member analyzed data using a

Research on Interventions

- 20 faculty and medical residents utilized support program in central Texas
- Provider experiences in 8 different fields created trauma
- Most providers wanted to communicate in confidential timely manner with peer
- Education regarding risk management and legal process is helpful



SETTINGS IN WHICH SVE IS STUDIED

- Internationally (Italy, Japan, China, Brazil, Nigeria, Malaysia)
  - All places had vastly different health systems compared to us
- Domestically (Minneosta, Missouri, Texas and Tennessee)
  - Large academic centers
  - Largely urban centers

WHAT WE KNOW ABOUT SECOND VICTIM EXPERIENCE FROM STUDIES?

Second Victims Experience exists

SVEST tool can be implemented in a variety of departments and hospitals that leads to data that can be used to make action plans

Most hospitals don't have a structured support system in place.

Peer support network is often desired. No long term data on SVE after peer support

The Second Victim Experience is shared among providers worldwide

The “ Silent” Pandemic

What does SVE look like in OBGYN?

This topic is relatively new and surprisingly so given the extent of events OBGYNs may encounter

What WE KNOW ABOUT SVE IN OBGYN?

ORIGINAL ARTICLE

Understanding the Second Victim Experience Among Multidisciplinary Providers in Obstetrics and Gynecology

Rivera-Chiauzzi, Enid MD*; Finney, Robyn E. DNAP†; Riggan, Kirsten A. MA, MS‡; Weaver, Amy L. MS§; Long, Margaret E. MD*; Torbenson, Vanessa E. MD*; Allyse, Megan A. PhD*,‡

Author Information

Journal of Patient Safety 18(2):p e463-e469, March 2022. | *DOI:* 10.1097/PTS.0000000000000850

Abstract

Objective

The aim of the study was to determine the prevalence of second victim experience (SVE) among obstetrics and gynecology (OBGYN) clinical and nonclinical healthcare workers and compare healthcare workers who did and did not identify as a second victim (SV) in the last year.

- Results:- survey of 205/571 people
- 44.8% identified as an SV with 18.8% in last 12 months
- Institutional support inadequate
- Increased turnover rate
- Neonatal loss/ maternal death and then patient complaints contributed to 80% of SV

What WE KNOW ABOUT SVE IN OBGYN?

- 58.3% of trainees had felt like a SV within the last 12 months
- 55.3% of attending staff had SV in the same time period
- Most common type of support desired was peer support

[illegible] 2021 April ; 174(4): 218–222. doi:10.1[illegible]/SMJ.0000000000001297.

Second Victim Experience among OBGYN Trainees: What Is Their Desired Form of Support?

Vanessa E. Torbenson, MD, **Kirsten A. Riggan, MA, MS**, **Amy L. Weaver, MS**, **Margaret E. Long, MD**, **Robyn E. Finney, DNAP**, **Megan A. Allyse, PhD**, **Enid Rivera-Chiauzzi, MD**
Departments of Obstetrics and Gynecology, Biomedical Ethics Research, and Anesthesiology and Perioperative Medicine, and the Division of Biomedical Statistics and Informatics, Mayo Clinic, Rochester, Minnesota.

Abstract

Objectives: Physician trainees in obstetrics and gynecology (OBGYN) experience unexpected outcomes similar to those of supervising physicians. A relative lack of experience and perspective may make them more vulnerable to second victim experience (SVE), however.

The objectives of our study were to contrast the prevalence of SVE between supervising physicians and trainees and to identify their preferred methods of support.

Methods: In 2019, the Second Victim Experience and Support Tool, a validated survey with

What WE KNOW ABOUT SVE IN OBGYN?

- 115 nurses surveyed
- 74.8% had not heard of second victim
- 47.8% had felt like a SV
- Peer support was most desired by 95% of respondents

STUDY

Second victim experiences of nurses in obstetrics and gynaecology: a Second Victim Experience and Support Tool Survey

December 23, 2020

Finney RE, Torbenson VE, Riggan KA, et al. *J Nurs Manag.* 2021;29(4):642-652.

View more articles from the same authors.

Healthcare professionals who experience emotional consequences after adverse events are referred to as 'second victims'. Nearly half of nurses responding to this survey reported 'second victim' events during their career and experienced psychological distress, greater turnover intention, decreased professional self-efficacy, and lack of institutional support. Nurse respondents expressed desires for more peer support interventions for 'second victim' experiences.

DO THE RESULTS OF THESE STUDIES APPLY TO US?

- Potentially
- Relatively large number of providers surveyed

- Are all OBGYN experiences the same?
- Limitations: Large academic institution with a vast amount of resources and funds
- May not be true of every hospital

Why Should RURAL HEALTH CARE BE a FOCUS?

RURAL OBGYN HEALTHCARE

- Situation of rural OBGYN care is reaching near crisis level
  - Fewer providers for the same number of patients
  - Finite resources (access to anesthesia, RN staffing, OR, specialty care)
  - Increasing maternal OB care deserts
  - Increased travel time for patients to access obstetric and neonatal care
  - Increasing rural healthcare disparities, differences in outcomes

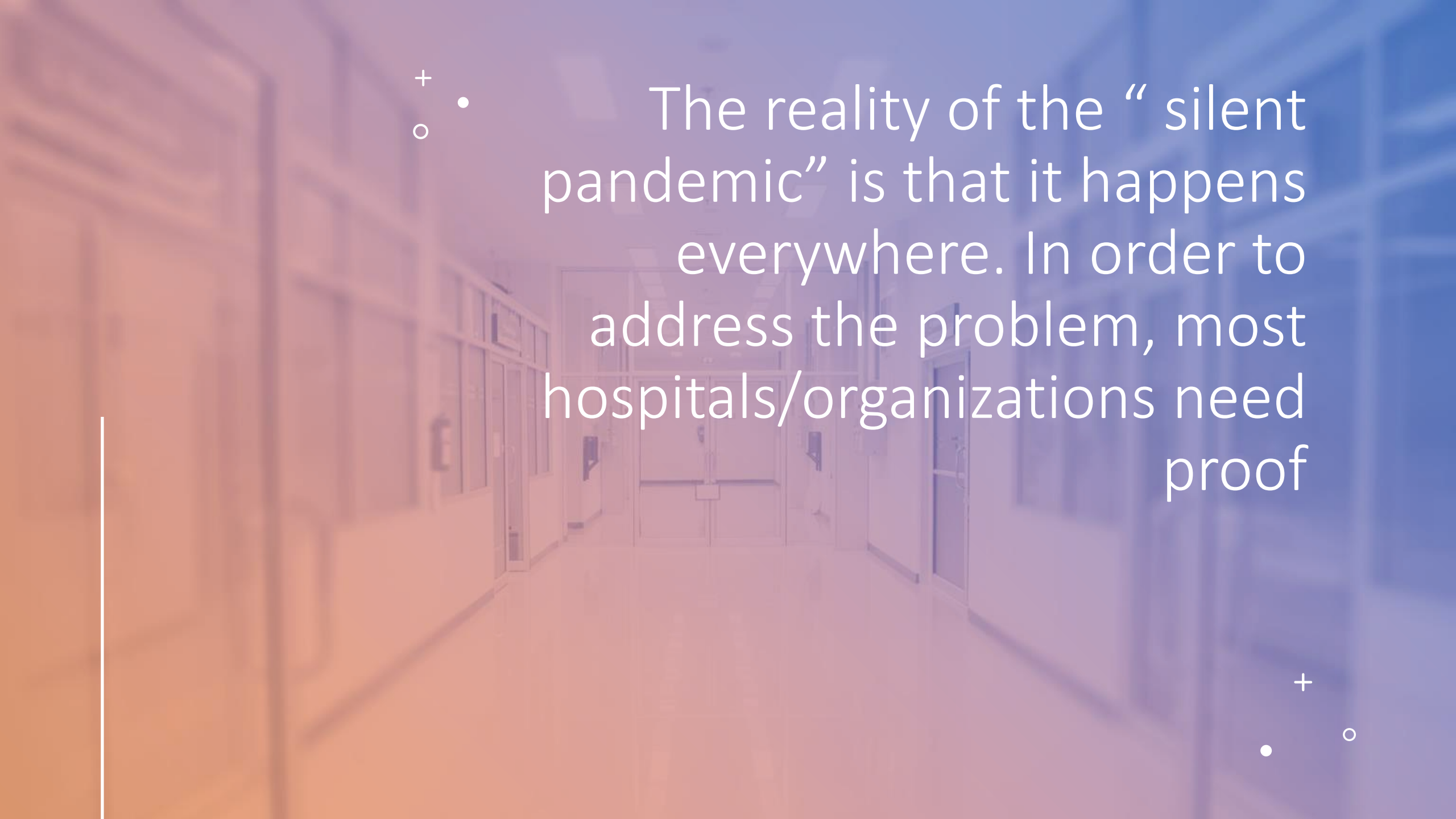
Rural OBGYN Healthcare

We are a unique population of providers faced with unique challenges given our setting

Potential that we may be disproportionately impacted by adverse events because of how our healthcare functions

Why don’t we know that much about SVE in rural areas?

- Reluctance to accept that the realities of clinical practice have personal impacts
- Embarrassment or shame. Few providers to talk to
- Isolation
- Stigma of weakness (generational though)
- Little is known about the topic or discussed in professional settings
- Lack of funding for programs
- Uncertainty of best practices
- Difficult to study



The reality of the “ silent pandemic” is that it happens everywhere. In order to address the problem, most hospitals/organizations need proof

Current Research Initiative

- UVM Study on second victim experiences
- Wide spectrum of providers throughout Maine, New Hampshire, Vermont and upstate New York
- Looking at second victim experiences in rural OBGYN practices
  - Do people know about the “second victim”?
  - Do people at these practices experience SV? How might it be different compared to what we see in other studies?
  - Do people know what resources they have within their hospitals?
  - Do people have a preference for what resources they need?

What do most hospitals do about the second victim effect?

Foster a collegial spirit/ atmosphere

Some hospitals have an EAP

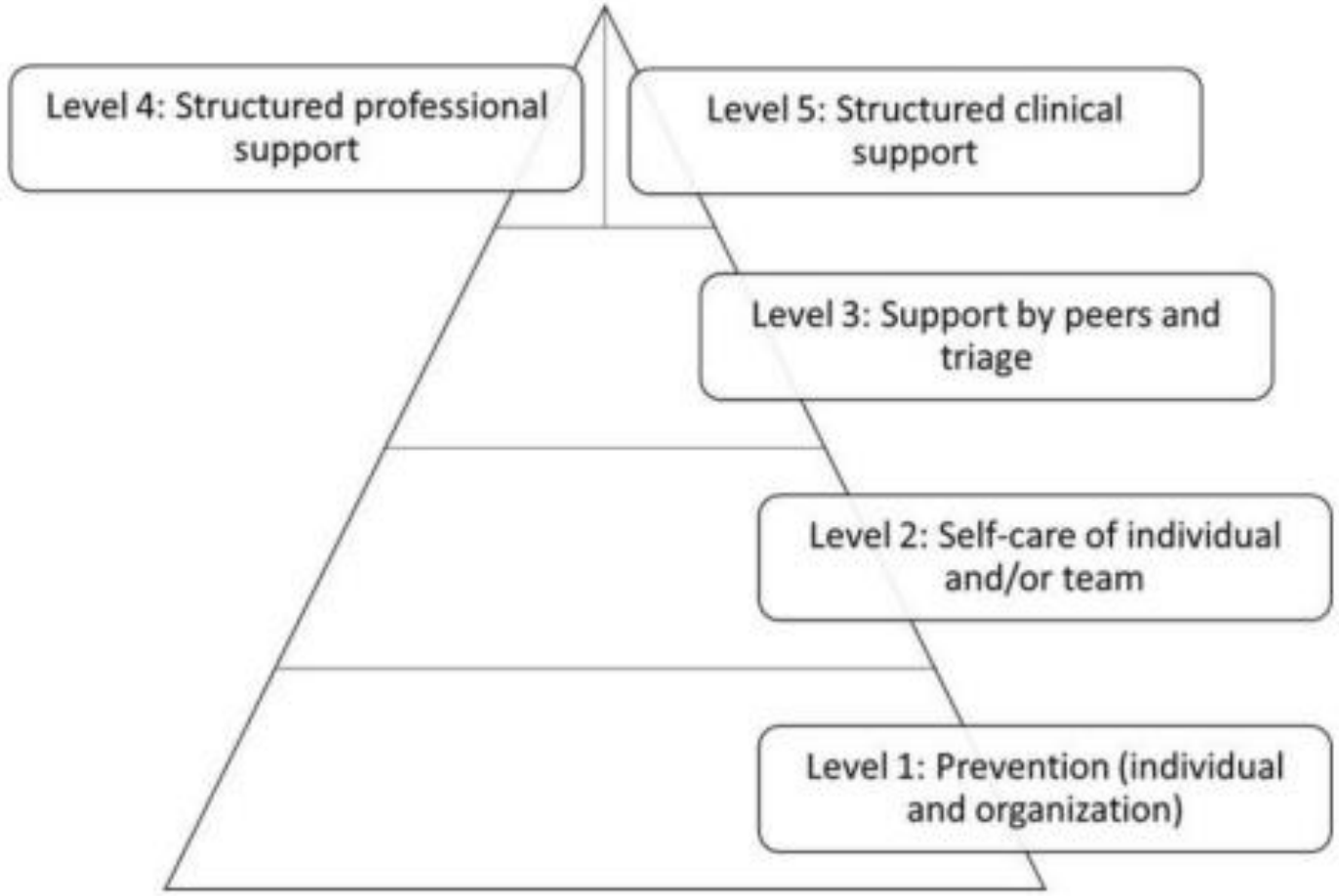
What does the Joint Commission Say?

- Need to create a just culture
- Learn from system defects, communicate lessons learned
- Encourage debriefing with all team members
- Some guidance on how to support staff with peer to peer
- Supplement struggling EAPs

Rights of a Second Victim- TRUST

- Treatment that is just
- Respect
- Understanding and compassion
- Supportive Care
- Transparency

LEVELS OF SUPPORT



Seys et. al

Level 1- Prevention

- Investing in good relationships with colleagues, being supportive, having an environment where there is no punitive responses, avoiding blame, education on this topic

Level 2- Self Care

- Support or feedback from supervisor, time away from unit, ability to go to mental health appointments and other self care

Level 3- Peer Support

Timely support (within 48 hrs of event) and by phone, email, zoom

Peer Support

Research shows us that time and time again people desire other individuals to talk

Desire empathy

Ideal: 24/7 and immediately accessible

Ideally involves people you work with everyday who can understand your life and situation

Emotional first aid: exploring the emotional response after an event


How are you doing? Are you ok?

What does peer support look like?

- Empathetic and active listening
- Thank you for sharing with me
- What are you doing to cope?
- What would you do differently next time?
- Be present
- Advocate for safety and change
- Share resources if the person needs more help than you can offer

What is peer support not?

- Casting judgment on the medical events
  - Why did you do this in this way? I would have done it differently
- Getting co-workers to tell you the details of the event so that you can spread mis-information about events > medical gossip
- Sharing your own experience in a way that minimizes the experience of the person in front of you
  - “I had an experience that was so much worse”
  - There are no medals for outdoing your colleages
- Attempting to ”fix” the situation

Two Processes Simultaneously Happen after one Event

- This is inherently different from quality focused interventions such as root cause analysis and mortality/morbidity review

- Equally important process that needs to occur

Level 4 or 5

Level 4 or 5: Licensed and expert professional health , psychotherapy and meds (Employee Assistance Program)

Limitations

- Not readily available (appointments can be in the future after event has passed)
- Not clinicians who do what you do
- Questions of confidentiality
- Stigma associated with EAP

What can we do about this?

- Education
- Training
- Creation of a peer to peer network
- Statewide initiatives to study this
- Hospital leadership

What can we do about this?

CHANGE CULTURE IN THE WORK PLACE

ADVERSE EVENTS DON'T DEFINE HEALTHCARE WORKERS

INDIVIDUALLY: ASK FOR HELP AND ALSO PROVIDE HELP IF YOU SEE A STRUGGLING CO-WORKER

Goal of SVE Education and Peer Support

- Create a healthcare environment that is optimized
- Create the next generation of medical providers that can navigate difficult situations with more tools/ resources
- Address critical gaps that ultimately do impact patient care

Summary of Learning Points

Second Victim Experience: traumatic experiences providers have as a response to an adverse event

It exists in our specialty and in our respective hospitals

OBGYN healthcare workers are at high risk

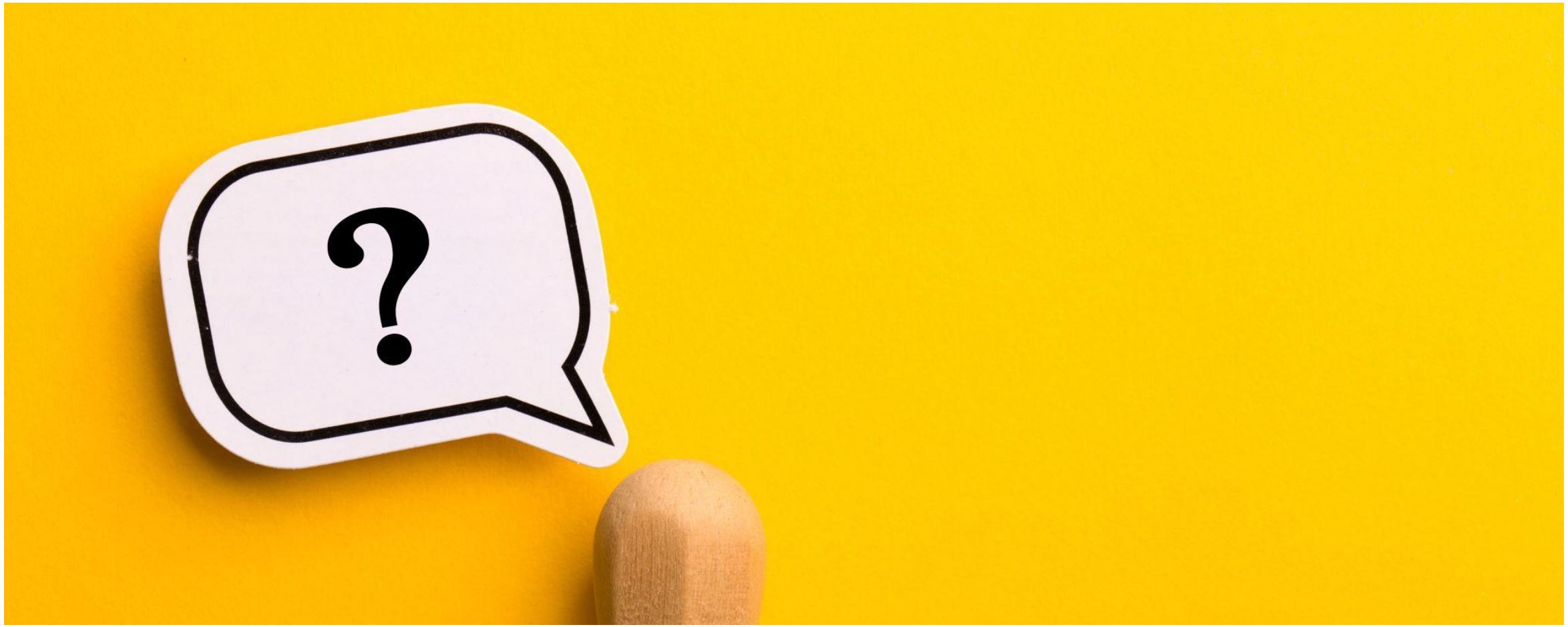
There is a way to recognize signs and symptoms and frameworks of help that although not widely available can be created to support each other

We need to know about what this looks like in rural areas.

References

- Burlison JD, Scott SD, Browne EK, Thompson SG, Hoffman JM. The Second Victim Experience and Support Tool: Validation of an Organizational Resource for Assessing Second Victim Effects and the Quality of Support Resources. J Patient Saf. 2017 Jun;13(2):93-102. doi: 10.1097/PTS.0000000000000129. PMID: 25162208; PMCID: PMC4342309.
- Burlison JD, Quillivan RR, Scott SD, Johnson S, Hoffman JM. The Effects of the Second Victim Phenomenon on Work-Related Outcomes: Connecting Self-Reported Caregiver Distress to Turnover Intentions and Absenteeism. J Patient Saf. 2021 Apr 1;17(3):195-199. doi: 10.1097/PTS.0000000000000301. PMID: 27811593; PMCID: PMC5413437.
- Finney RE, Czinski S, Fjerstad K, Arteaga GM, Weaver AL, Riggan KA, Allyse MA, Long ME, Torbenson VE, Rivera-Chiauzzi EY. Evaluation of a Second Victim Peer Support Program on Perceptions of Second Victim Experiences and Supportive Resources in Pediatric Clinical Specialties Using the Second Victim Experience and Support Tool (SVEST). J Pediatr Nurs. 2021 Nov-Dec;61:312-317. doi: 10.1016/j.pedn.2021.08.023. Epub 2021 Sep 6. PMID: 34500175.
- Finney RE, Torbenson VE, Riggan KA, Weaver AL, Long ME, Allyse MA, Rivera-Chiauzzi EY. Second victim experiences of nurses in obstetrics and gynaecology: A Second Victim Experience and Support Tool Survey. J Nurs Manag. 2021 May;29(4):642-652. doi: 10.1111/jonm.13198. Epub 2020 Nov 18. PMID: 33113207; PMCID: PMC8079544.
- Seys et al. In Search of an international multidimensional action plan for second victim support: a narrative review. BMC Health Services Research. December 2023. doi.org/10.1186/s12913-023-09637-8
- Winning AM, Merandi J, Rausch JR, Liao N, Hoffman JM, Burlison JD, Gerhardt CA. Validation of the Second Victim Experience and Support Tool-Revised in the Neonatal Intensive Care Unit. J Patient Saf. 2021 Dec 1;17(8):531-540. doi: 10.1097/PTS.0000000000000659. PMID: 32175958.

Questions/Thoughts?




Thank You!

Interviews after this event

- Players expressed shock, sadness, anxiety, worry, concern, perseveration over the events. Some needed therapy after witnessing CPR on their friend
- Many people who watched the game had similar experiences
- The entire NFL game stopped out of concern for the players of the Buffalo Bills
- You aren’t at your peak performance if you are traumatized

What was the point of this picture?

- Witnessing/performing CPR on a patient is one of many events we as healthcare providers participate in
- In the prior picture, we see a team banding together and supporting each other after a traumatic event
  - In that picture- we the healthcare providers are the Buffalo Bills team members
  - Medicine is a team support but after an adverse event why does it feel like you are alone?
- We know how expensive games are and yet the NFL willing to stop the game to protect its players instead of forcing them to play in a “return to business as scheduled” manner
  - Why is that model of humanity and compassion not something prevalent in medicine?