

Second Victims in Health Care

Stacey Thomas

Lenoir-Rhyne University

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According to the American Nurses Association, “Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations” (American Nurses Association website, n.d., para. 1). As nurses, our job is to care for the injured and infirm. However, as humans we can unintentionally cause harm. In a study by Classen et al. (2011), medical errors/adverse patient events occur more often than was previously thought. In fact, according to the Classen study, adverse patient events occur in 1 out of every 3 patient admissions (Classen et al., 2011). Armed with the knowledge that the public considers nurses trusted healers, how does knowing that they could potentially cause patient harm affect them?

As a profession, medicine is known for being fast-paced, stressful, and constantly evolving, three characteristics that contribute to human errors. In the late 1980’s when hospitals started seeing the admission of more critically ill patients with shorter lengths of stay (LOS), healthcare journals began reporting a phenomenon similar to Post Traumatic Stress Disorder (PTSD) seen with soldiers returning from battle and victims of personal trauma in healthcare professionals (Scott, Hirschinger, & Cox, 2009). However, no one put a name to this phenomenon until the year 2000.

Albert Wu, the director of the Center for Health Services and Outcome Research and professor at Johns Hopkins University Bloomberg School of Public Health, coined the phrase “second victim” to describe healthcare workers experiencing these PTSD-type behaviors (Jones & Treiber, 2012). Wu described the healthcare workers experiencing second victim phenomenon as “suffering emotional and professional injury...[grappling] with feelings of guilt and

inadequacy” (Jones & Treiber, 2012, p. 286). Scott et al. (2009) ultimately put a definition to the second victim phenomenon:

“Second victims are healthcare providers who are involved in an unanticipated adverse patient event, in a medical error and/or a patient related injury and become victimized in the sense that the provider is traumatized by the event. Frequently, these individuals feel personally responsible for the patient outcome. Many feel as though they have failed the patient, second guessing their clinical skills and knowledge base” (p. 326).

Symptoms experienced by these individuals can vary greatly, from mild feelings of “could have, would have, and should have” to extremes of panic attacks and ultimately leaving the profession.

Marion Conti-O’Hare, a psychiatric and mental health nurse specializing in the area of addictions, developed a nursing theory called the Nurse as the Wounded Healer in 2002. The basic premise behind this theory is that everyone, including healthcare providers, has experienced some form of tragedy in their lives. These tragedies influence our views of the world and as we heal from the tragedies, we hopefully become better care givers (Conti-O’Hare, 2002). Conti-O’Hare is of the belief that our experiences and the manner in which we deal with them “cultivates our ability “ to grow and develop as humans (Conti-O’Hare, 2002, p. 33).

The concept of the wounded healer archetype was not developed by Conti-O’Hare, only expanded. The wounded healer archetype has been present for centuries and is even found in Greek mythology. In fact, the very symbol of medicine, the caduceus (a snake wrapped around a staff), is thought to represent the wounded healer. The snake represents “healing and freedom from illness because of [its] ability to shed its skin and when [the snake] is wrapped around a staff...transcendence, healing, and rebirth” are symbolized (Conti-O’Hare, 2002, p. 34).

Conti-O'Hare used aspects of the wounded healer archetype seen in Greek mythology, as well as theories developed by Freud, Jung, and Watson to develop her own wounded healer theory. While those other theories can be applied to many different areas of healthcare, Conti-O'Hare's theory was formulated specifically for nurses. She believes that as nurses gain more professional experience, they are "more likely to recognize their own wounding" and need for coping with that trauma to be better able to care for patients (Conti-O'Hare, 2002, p. 43). Conti-O'Hare points out that issues affecting nurses may not be directly job related. Personal experiences from a nurse's past may be brought to the surface during periods of extreme stress on the job. As nurses, we may not recognize these feelings of stress or be in touch with what initially triggered our reaction. If we do not cope effectively with these feelings, we hurt not only ourselves, but our patients as well (Conti-O'Hare, 2002). According to Conti-O'Hare (2002), when the nurse "understands the nature of the traumatic event" s/he develops a "critical awareness of present and new self-perceptions" that integrate "into a revised personal identity and [reflects] healthy change" which in turn allows the nurse to relate more closely to patients (Conti-O'Hare, 2002, p. 99). She theorizes that if the nurse does not reach this phase of rebirth or transcendence, then s/he will remain traumatized by the wounding event and face the possibility that effects from that event will surface and cause unwanted manifestations (addictions, panic attacks, inability to work in nursing).

Second victims travel through six stages of recovery, much like Kubler-Ross' stages of grief. According to Scott et al. (2009) the stages include:

1. Chaos and Accident Response
2. Intrusive Reflections
3. Restoring Personal Integrity

4. Enduring the Inquisition
5. Obtaining Emotional First Aid
6. Moving On

The first five stages can be traversed in any order and possibly even some at the same time. The sixth stage is by far the most important. Stage Six, Moving On, can be further subdivided into three areas:

1. Dropping Out
2. Surviving
3. Thriving (Scott et al., 2009, p. 326-330).

The manner in which a nurse receives support and treatment through his/her employer will determine which subdivision is taken. Thriving is the ultimate goal; the nurse learns from the error and makes changes to his/her practice that decreases the likelihood that the error will occur again. If the nurse receives very little support from management and co-workers, the wounding event can be crippling and the nurse may change fields of practice or leave nursing altogether. Falling into the surviving category can be just as bad. Here, the nurse stays in the same profession area, but is often times unhappy; job dissatisfaction or worse, poor patient care could be the result (Scott et al., 2009, p. 330).

According to studies conducted by Wu (2000, 2012) and Scott et al. (2009), many organizations do not give nurses the necessary support after adverse patient events occur. Nurses are ostracized by co-workers and made to feel inept, questioning even primary job skills (Nelson, 2013). Management has a tendency to downplay the negative effects of an adverse event on the nurse by not providing an outlet for the nurse to have a debriefing session about the event (Edrees, Paine, Feroli, & Wu, 2011). Without proper acknowledgement and support from co-

workers and management, nurses are left struggling psychologically to deal with the stress of the event (Clancy, 2012; Sirriyeh, Lawton, Gardner, & Armitage, 2010). Conti-O'Hare recognized this dilemma and sought to find a solution to help nurses deal with personal trauma to ultimately become better care providers.

In the Nurse as Wounded Healer Theory, Conti-O'Hare recognizes that for nurses to be able to empathize with patients, they must have shared trauma and recovery experiences. These shared experiences allow the nurse to reflect on his/her own trauma and connect with the patient on a personal level. She has used the Q.U.E.S.T. Model to assist nurses in coping with their own personal life events. The Q.U.E.S.T. Model has the nurse evaluate him/herself to determine where s/he is in terms of dealing with a personal trauma by evaluating six areas: Question, Uncover, Experience, Search for Meaning, Transform, and Transcend (Conti-O'Hare, 2002, p. 146).

In the Questioning step, the nurse is presented with a twenty-question survey that helps to determine if a trauma has affected the nurse's life. There are three predefined answer choices. Each choice has an assigned numeric value. At the end of the questionnaire, the nurse adds up the score and follows a scoring guide to ascertain if a trauma has been experienced or not. Next, the nurse must "Uncover" the trauma by remembering past events and analyzing behavior patterns that have resulted from those past events; this step can often be quite painful because memories may be deeply buried. Experiencing the trauma is the next step. The nurse may be aware of the event, but now must experience it on an emotional level. Once the event has been experienced on an emotional level, the nurse is able to gain a fresh perspective on the event and transcend the wounding. According to Conti-O'Hare, the "Search for Meaning" can be the most critical step because "it seeks to acquire a perspective that will promote healing" (Conti-O'Hare,

2002, p. 149). Creating art through paintings or writings often helps with this step. In the final two steps, “Transform and Transcend,” the nurse is able to come to terms with the past trauma and look toward the future with a positive outlook (Conti-O’Hare, 2002).

Few studies were found that have used the theory of the Nurse as Wounded Healer in relation to the second victim phenomenon. Possible reasons could be that this theory is still relatively new and that the primary focus behind the theory was to help nurses that were suffering from addictions overcome those addictions and relate to patients experiencing those same problems with addiction. Also, because the concept of second victim is still relatively new, medical professionals could still be working on theories that are a closer fit to the issue. Based on the steps of the Q.U.E.S.T. Model though, the theory of Nurse as the Wounded Healer would prove beneficial to help nurses cope with being second victims and allow them to reach that final phase of thriving in healthcare one again.

References

American Nurses Association website. (n.d.).

<http://www.nursingworld.org/EspeciallyForYou/What-is-Nursing>

Clancy, C. (2012). Alleviating “second victim” syndrome: how we should handle patient harm.

Journal of Nursing Care Quality, 27(1), 1-5.

<http://dx.doi.org/10.1097/NCQ.0b013e3182366b53>

Classen, D., Resar, R., Griffin, F., Federico, F., Frankel, T., Kimmel, N., ... James, B. (2011,

April). “Global trigger tool’ shows that adverse events in hospitals may be ten times greater than previously measured. *Health Affairs*, 30, 581-589.

<http://dx.doi.org/10.1377/hlthaff.2011.0190>

Conti-O’Hare, M. (2002). *The nurse as wounded healer: from trauma to transcendence*.

Sudbury, MA: Jones and Bartlett Publishers.

Denham, C. (2007, June). TRUST: the 5 rights of the second victim. *Journal of Patient Safety*,

3(2), 107-119.

Edrees, H., Paine, L., Feroli, E., & Wu, A. (2011). Health care workers as second victims of

medical errors. *Pol Arch Med Wewn*, 121(4), 101-108.

Jones, J., & Treiber, L. (2012, October-December). When nurses become the “second” victim.

Nursing Forum, 47, 286-291.

Let the healing begin: caring for the “Second Victim”. (2013). *ECRI Risk Management Reporter*,

32(1), 1-10.

Nelson, W. (2013, Mar/Apr). Addressing the second victims of medical error. *Healthcare*

Executive, 28(2), 56-59.

- Saver, C. (2013, May 1). "Second victim" rapid-response team helps fellow clinicians recover from trauma. *OR Manager*, 29(5).
- Scott, S., Hirschinger, L., & Cox, K. (2009). The natural history of recovery for the healthcare provider "second victim" after adverse patient events. *Qual Saf Health Care*, 18, 325-330.
- Seys, D., Wu, A., Van Gerven, E., Vleugels, A., Euwema, M., Panella, M., ... Vanhaecht, K. (2012, September 12). Health care professionals as second victims after adverse events: a systematic review. *Evaluation & the Health Professions*, 36(2), 135-162.
<http://dx.doi.org/10.1177/0163278712458918>
- Sirriyeh, R., Lawton, R., Gardner, P., & Armitage, G. (2010). Coping with medical error: a systematic review of papers to assess the effects of involvement in medical errors on healthcare professionals' psychological well-being. *Qual Saf Health Care*, 19(e43), 1-8.
<http://dx.doi.org/10.1136/qshc.2009.035253>
- Wu, A. (2000). Medical error: the second victim. The doctor who makes the mistake needs help too. *British Medical Journal*, 320, 727-728.