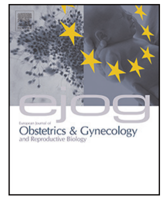
European Journal of Obstetrics & Gynecology and Reproductive Biology 213 (2017) 11–16

Contents lists available at ScienceDirect

European Journal of Obstetrics & Gynecology and Reproductive Biology

journal homepage: www.elsevier.com/locate/ejogrb



Review article

The Second Victim: a Review

B. Coughlan[a], D. Powell[b,*], M.F. Higgins[c,*]

[a] UCD Midwifery, School of Medicine, University College Dubli, Republic of Ireland
[b] Department of Risk Management, Connolly Hospital, Dublin
[c] Perinatal Research Center, UCD Obstetrics and Gynaecology, School of Medicine, National Maternity Hospital, University College Dublin, Republic of Ireland

ARTICLE INFO

Article history:
Received 16 January 2017
Received in revised form 7 March 2017
Accepted 1 April 2017

Keywords:
Second Victim
Domino Effect
Maternity

ABSTRACT

Amongst the lay and media population there is a perception that pregnancy, labour and delivery is always physiological, morbidity and mortality should be "never events" and that error is the only cause of adverse events. Those working in maternity care know that it is an imperfect art, where adverse outcomes and errors will occur. When errors do occur, there is a domino effect with three groups being involved – the patient (first victim), the staff (second victims) and the organization (third victims). If the perceived expectation of patients on all clinicians is that of perfection, then clinicians may suffer the consequences of adverse outcomes in isolation and silence.

More recently identification and discussion on the phenomenon of the second victim has become a popular research topic. This review aimed to study not only the phenomenon of second victim in general medical care but to also concentrate on maternity care where the expectation of perfection may be argued to be greater. Risk factors, prevalence and effect of second victims were identified from a thorough search of the literature on the topic. The review focuses on the recent research of the effect on maternity staff of adverse outcomes and discusses topical issues of resilience, disclosure, support systems as well as Learning from Excellence.

It is now well documented that when staff members are supported in their disclosure of errors this domino effect is less traumatic. It is the responsibility of everyone working in healthcare to support all the victims of an error, as an ethical duty and to have a supportive culture of disclosure. In addition, balance can be provided by developing a culture of learning from excellence as well as from errors.
© 2017 Elsevier B.V. All rights reserved.

Contents

Debriefing . . . 13
Coping and Recovery . . . 14
Experience of reporting . . . 14
Resilience . . . 14
System support . . . 15
Providing a balance . . . 15
Conclusion . . . 15
ACKNOWLEDGEMENTS . . . 15
References . . . 15

Medicine is an imperfect art. Sixteen years ago it was estimated that medical errors caused up to 98,000 deaths per year in the United States [1], at the time considered the fourth most common cause of death. More recently it has been suggested that this may be an underestimation, as previous studies rely on errors extractable from health records, include only inpatients, or, in the United States, rely on cause of death based on International Classification of Disease (ICD) codes that do not capture human or system factors [2]. The current best *estimation* is that medical error

* Corresponding author. Mary Higgins, UCD Obstetrics and Gynaecology, 65–66 Lower Mount Street, Dublin 2, Republic of Ireland.
E-mail address: IrelandMary.higgins@ucd.ie (B. Coughlan).

http://dx.doi.org/10.1016/j.ejogrb.2017.04.002
0301-2115/© 2017 Elsevier B.V. All rights reserved.

is the now the third biggest cause of death in the US [2], with a mean rate of death from medical error of 251,454/year.

Maternity care, as a discipline within medicine, is also an imperfect art. Though the rate of mortality in maternity care is low, some maternal deaths in the United Kingdom and Ireland have been associated with sub-standard care [3][3]. With regard to morbidity, one in twelve labours can result in adverse outcome to mother or baby [4][4]. Contributory factors including patient demographics, work overload, task saturation, distractions, poor teamwork, sub-optimal communication, mental models, fixation and lack of leadership, as well as situational awareness may not have always caused the adverse outcome but may contribute to the response to the outcome and may result in an implication of medical error [5][5]. This is further confounded by a widespread perception amongst the lay population and the media that pregnancy, labour and delivery are always physiological, deaths should be "never events" and that error is the only cause of adverse events in maternity care [7]. There is a perception that the general public have an "*expectation that childbirth was a jubilant event and to suggest any possible harm to the mother was met with incredulity*" [8]. Healthcare professionals are conditioned to function at a high level of proficiency with the emphasis on perfection [9][9] Society too tends to expect of clinicians an image of perfection, which can lead to the clinician having to suffer the consequences of a mistake in silence and isolation [10].

In the same year as Kohn estimated the rate of medical error, Albert Wu coined the term "second victim". Wu described medicine as an imperfect science, as "*many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster*" [11], despite the expectation of near perfection by patients, clinicians and administrators. While acknowledging the crucial importance that the patient must always come first –"*although patients are the first and obvious victims of medical mistakes*"- he also acknowledged the effect of error on clinicians, who "*are wounded by the same errors: they are the second victims*".

The definition was further refined nine years later, with the second victim being described as '*A health care provider involved in an unanticipated adverse patient event, medical error, and/or a patient related–injury who become victimized in the sense that the provider is traumatized by the event. Frequently second victims feel personally responsible for the unexpected patient outcomes and feel as though they have failed their patient, second guessing their clinical skills and knowledge base*' [12].

An "*intolerable paradox*" has been described of the clinician who makes a mistake -"*we see the horror of our own mistakes, yet, we are given no permission to deal with their enormous emotional impact . . . . the medical profession simply has no place for its mistakes*" [13]. The effect of an error can have an enormous emotional, professional and personal drain [11], whether this involves personal or local review, litigation, coroners' inquest, court, or increasingly commonly, trial by media or criminal prosecution. The effects of these "hits" can increase the impact for the second victim of an adverse event or outcome [12–15] though some positive outcomes have also been identified [16]. (Table 1). In one study, the clear majority (80%) described a determination to improve because of an adverse event [17].

More recently the Institute for Healthcare Improvement [18] published a white paper on "Respectful management of serious clinical adverse events." Three priorities were described – the first being to care for the patient and their families, who are the direct victims of the event or error. The second was to deal with the healthcare victims – the frontline victims. A third priority is to deal with the needs of the organization that can also become victims of the event – the third victim. We have chosen to call this the "Domino effect" [19] More recently an alternative "Domino effect" has been proposed in opinion pieces [20,21], where the proposed third victims are clinicians' friends and families and the proposed fourth victims are future patients.

This article aims to be a narrative review of the evidence base for the second victim, focusing on the second victim in maternity healthcare. Extensive and systematic searching of multiple sources was performed by the three authors. Sources included databases (MEDLINE, EMBASE, CINAHL), hand searching journals, guidelines, conference proceedings, opinion articles and literature reviews. Searching was performed in January 2016 and again in January 2017. Databases were searched using the PICO framework (participants, interventions, comparison and outcome) as appropriate. No language restrictions were applied.

Prevalence and Risk Factors

The phenomenon of the second victim is common, with a prevalence of anything between 10% [22], to 72.6% [14,15,23] of all healthcare practitioners, depending on the group sampled. It should be noted that as systematic sample was not performed in these papers that true prevalence is unknown and it is unfair to perform direct comparisons. As such the following comments are made lightly without inference to the specialties reported.

The highest rate reported were hospital staff in Spain, with nearly three quarters of staff reporting that they had experienced the second victim experience either directly or via a colleague within the previous five years [14]. Fellows and members of the Royal College of Physicians self-reported a rate of 63%, the first large-scale UK survey to describe the experiences of physicians in relation to adverse patient events [15]. The lowest reported rate of emotional reactions to errors or events was within otolaryngologists in the US[22].

Reactions are influenced by both the outcome of the error and the degree of personal responsibility the clinician felt [24–27] (Table 2). Stress may be higher if the incidents involve young, healthy people and multiple lives [25]–a perfect analogy to the labour ward.

Table 1
Reported Experiences of Second Victim.

Common	
Guilt	Improved professional relationships
Anxiety	Improved communication
Fatigue	Determination to further improve
Frustration	
Anger	
Difficulty concentrating	
Self- Doubt	
Less Common	
Reliving event/post-traumatic stress disorder (PTSD)	
Avoidance of patient care	
Severe anxiety about return to work	
Depression	
Suicidal Ideation	

Download English Version:

https://daneshyari.com/en/article/5693464

Download Persian Version:

https://daneshyari.com/article/5693464

Daneshyari.com