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Confronting the inevitable: When a urologist feels like a second victim

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Abstract

There are many opportunities for urologists to be emotionally impacted, and possibly injured, in the regular course of their work. In particular, urologists are vulnerable to become Second Victims as a result of errors, adverse events, and distressing clinical events. This article reviews best practices that individuals, training programs, hospitals, and healthcare systems can implement to intentionally and programmatically mitigate the short and long-term effects on healthcare professionals.

Keywords: Patient safety; Adverse event; Second victim; Peer support; Resilience; Wellbeing

1. Case

A urologist has been working with a 62-year old patient for several years to monitor his benign prostatic hypertrophy. The symptoms have been progressive and increasingly troublesome, and after much observation and counseling, the decision is made to remove the patient's prostate. He undergoes a transurethral resection of the prostate. The service is short staffed, and an intraoperative dose of antibiotics is ordered but not administered. On postoperative day 2, the patient begins to show signs of infection, which progresses rapidly to urosepsis.

He is hospitalized, and transferred to the intensive care unit, where he is intubated for 10 days. He ultimately recovers and is discharged to home without serious sequelae. However, while the patient is in the ICU, the urologist visits, and assesses the patient every day. And every day the patient's partner berates the surgeon. She questions the urologist's skill, ability, knowledge, purpose, and intention.

Because of the unanticipated infection, this case undergoes an investigation which reveals the antibiotic was not administered. The urologist participates in the investigative meetings which further exacerbates his feelings of failure.

On later reflection with a colleague, the urologist says, "For the first 2 or 3 days, I could understand why she was upset, but I knew this complication could not have been foreseen. But then, after a few days of enduring the verbal and emotional abuse, I started to question if I had done the right thing. I wondered if the surgery was necessary in the first place. I questioned my own skill. And then, by the tenth day, I wondered if I needed to transition out of practice because maybe I was a danger to patients."

2. The Second Victim Syndrome

The case describes the urologist as a second victim, in the sense that he was injured psychologically by the same incident that harmed the patient [1]. One definition is "a health care provider involved in an unanticipated adverse patient event, medical error and/or a patient related-injury

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who become victimized in the sense that the provider is traumatized by the event" [2].

Unfortunately, it is not uncommon for patients to encounter system flaws and failures. Because patient safety has become a priority in healthcare, we encourage reporting of these events so that we can learn from them, implement interventions, and prevent them from recurring. However, the organization must create an environment where staff feel empowered and safe to report, and that they will not be punished in response. In this example, both the patient and the urologist were victims of the same flaws and failures that led to the infection.

In this case, the patient and their loved ones experienced discomfort and distress, prolonged hospitalization, and increased out of pocket costs. They suffered everything from short-term inconvenience to long-term injury. Although the urologist was not personally to blame, he experienced the emotional impact of feeling responsible for what happened to the patient. This is in part because our modern healthcare system tends to assign the bulk of responsibility, directly or by implication, on the physician.

The second victim syndrome has been well-described. It can include short term symptoms, which may include an acute stress reaction.

This includes an initial dazed state, with tunnel vision, inability to comprehend stimuli, and disorientation. This may be followed by withdrawal and detachment, or alternatively by agitation and hyperactivity. There may be confusion, dissociation, or amnesia. This may be accompanied by anxiety and depression. In extreme cases it may include emotional collapse.

There can also be persistent effects including psychological and somatic symptoms. Psychological consequences include troubling memories, worry, anger and blame directed towards self and others, remorse, emotional distress, fear of recurrence, shame, guilt, and difficulty concentrating. Somatic symptoms include sleep difficulties, changes in appetite, fatigue, increase in respiratory rate and blood pressure, and muscle tension [3,4].

Health care workers can have specific worries for the patient and for themselves. They have specific concerns about the well-being of the patient and family. They may also be worried they will be fired, lose their license, or be sued. They may be worried for their reputation: what will my colleagues think of me? They question their own competence.

A small percentage may develop post-traumatic stress disorder (PTSD) with persistent re-experiencing of the original trauma through flashbacks, nightmares; avoidance of stimuli associated with the trauma; and increased arousal with disturbed sleep or hypervigilance.

It is also valuable to acknowledge the other ways a provider might be emotionally injured or affected in the course of doing their work. In recent years, an increasing number of cases of workplace violence involving patients or family members has been noted [5,6]. Healthcare workers who provide direct patient care have the experience of being verbally and emotionally attacked by a patient or their family even when there were no errors or adverse events involved. Even when things go according to plan, providers can be emotionally and/or psychologically impacted. This impact can be both short and long-term.

The work of a urologist is important and necessary. No matter how far the field has advanced, it is still an inherently risky venture when well-intentioned providers provide their best effort to remediate disease and injury in patients. Errors, adverse events, and severe unexpected outcomes will always be a part of the practice.

Urologists are, themselves, regularly vulnerable to being emotionally impacted by their work. Virtually every practicing urologist can recall a situation in which she or he felt like a second victim. All of this points to the need for this special issue.

3. Mitigating the Second Victim Experience

Having acknowledged all these realities, what steps can we take to prevent, and, more importantly, mitigate the impact of the second victim experience?

Just like we endeavor to prevent patient harm when there are known vulnerabilities, it is important to work to protect our providers and teams from the emotional and/or psychological impact of this harm we know exists.

To protect medical professionals from these known possible harms, both institutions and individuals have responsibility. All these efforts require intention, attention, and resources.

4. Providing Support After an Event

When there is a known error, adverse event, or other emotional impact, there is an opportunity to reach out directly to those impacted and give them a chance to process their experience. For example, while a system's standard investigation processes follow their necessary pathways, it is also important to give an affected individual an opportunity to process how they are feeling in relationship to the event. This might be accomplished in the form of an organized and intentional program that provides that person with a peer who reaches out to provide nonjudgmental support.

A challenge baked into the culture of medicine is that urologists are historically resistant to seeking and accepting help. The cultural attribution of a surgeon as an emotion-free independent agent has only done harm to the role. The hidden curriculum tells them that it is a sign of weakness to ask for help, and the clinical regime makes it seem difficult to take the time for self-care. The social stigma against finding the psychological or emotional support one might need damages the urologist, and by fiat, his or her future patients.

5. Individual and Organizational Resilience

The incidence of stressful patient events, most of them unrelated to medical errors, is so great that all health care workers should know how to provide support to their

colleagues. It is the responsibility of health care institutions and professional societies to accept and embrace that this is an inevitable part of practice.

The first step is to increase awareness of the factors that impact the health and wellbeing of our healthcare workers, understand natural human reactions to stress, and to create an environment that makes it easy for providers to find the help they need [7]. The return on investment is not just individual health and wellbeing, but a resilient organization. There is also likely to be a financial benefit to providing support [8–10].

Organizational resilience is the foundation that acknowledges we work in a challenging and dynamic environment that includes risk, anticipates failure and prepares for a response. Organizational resilience relies on the culture of the organization which is influenced by many factors such as management style (e.g., Just Culture), engagement, training, and support all of which are based upon the concept of psychological safety [11].

A resilient organization strives to prepare both urologists in training and in practice to accept the inevitability of failure, cope with it when it happens, and do what is needed to mitigate the impact, including providing resources and tools for them to access during, and outside of, their time at work.

Because of the outsized influence of organizational culture it is essential that top leaders and educators in institutions emphasize the importance of training, available resources and normalize utilization by integrating support into everyday work [10]. In turn, urologists may better understand the expectation to avail themselves of help when they need it. Seeking support is a strength, not a weakness.

6. The Johns Hopkins Experience

For more than a decade at Johns Hopkins School of Medicine has offered training to undergraduates, in the second year of medical school, near the end of the basic science curriculum and just before students begin their clinical rotations [12]. As part of this course, every student is required to complete 1.5 hour of training in handling adverse events including disclosure to patients and families, and providing support to one another.

In the past 5 years, we have begun to offer modified peer support training to surgical residents at the start of their clinical introduction. This past year the surgical residency director allocated 2 full hours of training during orientation week. The training is adapted from the Resilience In Stressful Events (RISE) program and includes awareness of second victim experience, impact of work stress, value and benefit of support as well as an introduction to the support skills that they can use with each other [13,14]. This training empowers the next generation of providers to acknowledge their feelings and fosters willingness to receive support. As a result of these trainings, positive perceptions of organizational support have also been reported after just learning about the RISE program. Surgeons in training appreciate the close attention the program pays to the unique needs of our healthcare workforce and how it contributes to organizational resilience.

The Johns Hopkins Medicine RISE Program is designed to provide individuals and groups of health workers with support that feels psychologically safe. It is entirely confidential, with no links or notification of other entities like risk management or patient safety, no reporting back to managers or human relations, and no notification or investigation. RISE provides 24/7 on-call support via an electronic pager system, with the goal of responding to a call within 30 minutes. One-to-one or group support is provided by peers in the form of psychological first aid and emotional support. The RISE intervention offers a sense of relief, eliminates feelings of aloneness, and fosters resilience within from those who received support.

In 2015, Johns Hopkins began a collaboration with the Maryland Patient Safety Center to develop a curriculum that other health care organizations can use to implement their own RISE program. Since that time, RISE has been established in over 140 hospitals and other institutions in the US and internationally.

7. Summary

Virtually every clinical urologist can expect to have experience the second victim syndrome at least once in their career, and more likely multiple times.

It is the duty of health care institutions and professional societies to embrace the inevitability of this experience. Then they can set up systems that enable a psychologically safe culture that works to prepare help clinicians cope with experiences, support one another, and create and utilize structures/resources to minimize the impact.

Ultimately, organizations have the opportunity to create a resilient culture that emphasizes the importance, value and benefit of support. A key success factor is that leaders integrate and model elements that foster a healthy culture and supportive environment. The answer to high quality, safe care is the health and wellbeing of our healthcare workers.

Declaration of competing interest

On behalf of myself and my coauthors, Matt Norvell and Cheryl Connors, none of us have any conflicts of interest to declare related to our Introduction to the SUO Special Issue on the Second Victim.

CRediT authorship contribution statement

Matt Norvell: Writing – review & editing, Writing – original draft, Conceptualization. **Cheryl A. Connors:** Writing – review & editing, Writing – original draft, Conceptualization. **Albert W. Wu:** Writing – review & editing, Writing – original draft, Supervision, Conceptualization.

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