Why clinicians involved with adverse events need much better support

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Abstract
Purpose – The purpose of this paper is to draw attention to the problem of second victims involved in adverse events and their need for adequate support.

Design/methodology/approach – The impact on second victims involved in adverse events and implications for organisational support were determined from previous studies and relevant publications about this problem.

Findings – The impact of adverse events on health professionals who are involved in them can be profound. These second victims can suffer extreme emotional distress, anxiety regarding perceptions of their competence and professional isolation, and may endure long-term professional and personal consequences. Some of the more severe outcomes include leaving the profession, symptoms of post-traumatic stress disorder and suicide. Many studies report a substantial lack of organisational support for second victims. Key strategies have been recommended for organisations to implement to support second victims.

Originality/value – The authors note that recently published studies continue to report that organisational support is inadequate for second victims. Improved mechanisms of support would prevent the loss of second victims from the workforce, and ameliorate the severity and duration of the impact on second victims.

Keywords Clinical governance, Patient safety, Organizational learning, Clinical leadership and culture, Health professions, Adverse events or outcomes

Paper type Viewpoint

Adverse events and the impact on patients have been a major issue of concern for health professionals, and patients and their families, and have received significant media attention over the last three decades. An extensive amount of research has been conducted in the USA, the UK, Australia, New Zealand, Japan, Singapore, Denmark and by the World Health Organisation in developing countries that has confirmed that this is a global problem with an overall rate of about 10 per cent (Hamilton et al., 2014; Brennan et al., 1991; Wilson et al., 1995; Vincent et al., 1999). Consequently, many organisations and programs have been established to address the quality and safety of health care delivery and to prevent the occurrence of adverse events (Spigelman and Rendalls, 2015).

However, the issue of the impact of adverse events on health professionals has received less attention (Edrees et al., 2011) and has been predominantly focused on doctors (Wu, 2000; Aaraas et al., 2004; Aasland and Forde, 2005; Schwappach and Boluarte, 2008; Manser, 2011), and to a lesser extent nurses (Scott et al., 2008; Treiber and Jones, 2010; Kable et al., 2018; Quillivan et al., 2016; Burlison et al., 2016) and health professionals (Scott et al., 2009; Edrees et al., 2011; Ullstrom et al., 2014; Harrison et al., 2015). Health professionals who are involved in adverse events are recognised as “second victims” (Wu, 2000; Scott et al., 2009; Sirriyeh et al., 2010; Denham, 2007; Santomauro et al., 2014; Edrees et al., 2011; Mira et al., 2015; Quillivan et al., 2016; Burlison et al., 2016; Ullstrom et al., 2014; Seys et al., 2013; Dekker, 2013).
Many of them suffer profound professional and personal effects associated with these events (Santomau et al., 2014), and in some instances the outcomes have been significantly negative including their loss of employment or decision to leave the profession, fear (Treiber and Jones, 2010), long-term depression and emotional trauma (Sirriyeh et al., 2010; Kable et al., 2018; Ullstrom et al., 2014) and tragically suicide (Santomau et al., 2014).

Many initiatives related to responding to adverse events in the last 20 years have focused on establishing national safety and quality safety standards, improved reporting of events, thorough investigation and root cause analyses, and the adoption of a just or “no-blame” culture (Hamilton et al., 2014; Walton, 2004; Denham, 2007). However, these initiatives may not always be adequate in terms of providing support to health professionals at the time events occur, or during the subsequent investigation processes. It is important to make a distinction between being involved in an adverse event as a result of a series of circumstances leading up to the event (Reason’s Swiss cheese model) (Reason, 2000) resulting in an inadvertent error, which requires support for clinicians and a constructive approach to sustaining them in the workforce; and professional misconduct which is concerned with the individual breaching recognised standards and demonstrating poor professional accountability. Several studies have reported that second victims felt isolated from their colleagues, and were concerned that their clinical competence was perceived to be inadequate and that the team dynamics were substantially altered after an adverse event occurred.

Previous studies have identified the importance of collegial and organisational support for clinicians involved in adverse events. They have reported that these second victims need to know that they are still respected by their colleagues, that their clinical competence is not being questioned and that they are still a valued member of the team (Scott et al., 2008; Kable et al., 2018; Edrees et al., 2011).

In addition, studies have described the importance of organisations supporting health professionals after an event by giving them time off, debriefing, maintaining communication and providing professional support during an investigation, keeping them informed about processes and expectations, avoiding isolating them, providing access to professional support such as EAP programs, and involving them in designing prevention strategies and safer health delivery processes (Scott et al., 2008; Kable et al., 2018; Edrees et al., 2011; Ullstrom et al., 2014; Harrison et al., 2015). A recent study of nurses (n = 155) reported that organisational support fully mediated distress-turnover intentions and distress-absenteeism relationships (p < 0.05) (Burlison et al., 2016). Denham (2007) described five rights for the second victim using the acronym TRUST: treatment that is just, respect, understanding and compassion, supportive care and transparency and the opportunity to contribute. These rights constitute fundamental principles for responding to second victims and sustaining and retaining them in the workforce.

Despite these findings, it appears that health professionals may still not be receiving the kind of support that will adequately sustain them to remain in the workforce after they have been involved in an adverse event, and it has been reported that only one in four, or less, receives organisational support resulting in extended duration of the impact of the event (Santomau et al., 2014; Ullstrom et al., 2014; Mira et al., 2015; Manser, 2011). Recently published studies continue to report significant long-term professional and personal outcomes for second victims, and their negative experiences associated with collegial and organisational responses after an adverse event (Kable et al., 2018; Quillivan et al., 2016).

It is a sad reflection to note that while health professionals are committed to taking care of their patient’s welfare, this commitment may not extend to their colleagues who are experiencing distress and trauma associated with their involvement in adverse events and subsequent investigations. It would be timely for the multiple clinical excellence/patient safety/investigative organisations established around the globe consequent to local reviews of significant serious adverse events to address this hitherto largely neglected issue.
References


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