ASHRM PATIENT SAFETY TIP SHEET

Second and Third Victims

AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

SITUATION: Adverse events in health care can have widespread effects beyond the impact to the patient or their support system (often called the first victim). In recent years, there has been increased attention to the impact of adverse events on the professionals caring for those patients (second victim) and the patient safety professionals investigating those events (third victim). The effects on second and third victims can be the result of actual physical harm, psychological harm, psychosocial harm, stress, and adverse outcomes from the investigatory/legal/regulatory process.

BACKGROUND: The second victim of adverse events has been described as the health care workers or other staff members who were involved in an event (Holden & Card, 2019). In addition to harm from the incident itself, second victims may also experience harm related to stress from legal proceedings, root cause analysis (RCA) investigations, or action by licensing boards (Ibid).

Third victims are those who were not directly involved in the event but who perform the investigation of the event, such as the risk manager or quality improvement personnel. Whistle-blowers and other staff members who speak up are also seen as the third victim (Ibid).

ASSESSMENT: A systematic review of 18 studies recognized the following symptoms of second victim syndrome: troubling memories, anxiety/concern, anger toward themselves, regret/remorse, distress, fear of future errors, embarrassment, guilt, and sleeping difficulties (Busch et al., 2020). Stress associated with the acute and long-term investigation of incidents, emotional labor (investigating events, disclosing events, and implementing action plans), abusive supervision and bullying, and competing loyalties and duties were identified as causes of harm for third victims (Holden & Card, 2019).

RECOMMENDATIONS:

- Proactively develop and maintain a program that educates staff to identify and support victims of adverse events at every level.
- Promote a culture of psychological safety. This includes the adoption of a peer support structure, with consideration of a hospital chaplain or mental health professional to provide guidance after adverse events.
- Embrace a just culture that views adverse unintentional events as learning opportunities to improve the system's safety, rather than simply blaming individuals for errors.
- Develop metrics (turnover data, exit interviews, culture of safety survey, psychological safety survey) to assist in the identification of specific sources of harm (Sachs & Wheaton, 2023).

Resources: [1] Sachs C and Watson N. Second Victim Syndrome - StatPearls - NCBI Bookshelf (nih.gov). 2023 Treasure Island Publishing. Accessed at https://www.ncbi.nlm.nih.gov/books/NBK572094/. [2] Holden J and Card A. Patient safety professionals as the third victims of adverse events (betsylehmancenterma.gov). Journal of Patient Safety and Risk Management. 2019;24(4):166-175. DOI:10.1177/25 16043519850914 [3] Busch et al. Psychological and Psychosomatic Symptoms of Second Victims of Adverse Events: A Systematic Review and Meta-Analysis: Erratum. J Patient Saf. 2020 Sep;16(3):e211.