Chapter 8
The Second Victim Phenomenon: The Way Out

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ABSTRACT

Medical error happens when an action within the medical field is not fulfilled as planned, or the plan is performed incorrectly. Patient and family are the first victim of an adverse event. The damage in a patient's health, leads in a distressing situation not only for the patient, but also for the clinician who is responsible for this outcome. The term "second victim" refers to the trauma that a health professional sustains due to a serious adverse event in the healthcare system. After a medical error the caregivers are experiencing the aftermath in their personal and professional life. They feel isolated and abandoned, and some of them are coming up against the law with penal and disciplinary ramifications as a consequence of the blame culture in the health care system. Some health professionals experienced the consequences of an unfortunate incident even if it did not lead in harm to the patient's health.

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INTRODUCTION

Cost containment and the quality of a healthcare system are substantial elements contributing to patient safety. The "second victim phenomenon" negatively impacts healthcare quality and cost. A culture of blame exists in a majority of healthcare organizations and impacts the doctor-patient relationship. In addition, patient safety is under intense scrutiny. It is essential that a solution is found to restore the trust between a doctor and a patient. An adverse event is a potential "threat" for this relationship and can be the cause of victimization for both patient and clinician. Literature quests after solutions that can result in restoration of the relationship between patient and clinician and lead to reduction of the unfavorable implications this mistrust provoke in the health system.

BACKGROUND

According to several publications, roots of the second victim phenomenon extend beyond the healthcare profession. The phenomenon has its causes in the latent systemic factors in health care system that literally push health professional to err. Health professional victimization factors include: exhaustion of a health professional due to the understaffing of an organization; a professional's burnout or depression; and blame culture in organizations. This situation is intensified by the current systems of patient compensation including possible litigation on behalf of the patient. This puts both the professional and patient in an ongoing venture. In turn, the situation can lead to low quality of the healthcare services and high healthcare expenses. Literature suggests several ways to confront the phenomenon. These include: establishing teams to help the wounded professionals; changing the blame culture; and redefining the compensation systems.

MAIN FOCUS OF THE CHAPTER

The main issue resulting from the second victim phenomenon is the need for a structured peer or institutional support for the clinician. A poorly-structured or non-existent support system may result in a professional becoming a second victim following an adverse event (Ullstrom, Sachs, Hansson, Ovretveit, & Brommels, 2014). The support system should include guidelines and educational programming to practice disclosing skills (Wu, Boyle, Wallace, & Mazor, 2013).