Annotated Facilitator Guide

Adverse Events and Peer Support

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Learning Goals:

1. Discuss the concept of the second victim phenomena including triggering events, expected personal reactions, and widespread implications.
2. Discuss potential support mechanisms for second victims of adverse events, both personally and institutionally.
3. Discuss components of a peer support system and practice reflective listening as a peer supporter.

Case Stem:

Samuel is a junior pediatric anesthesiology attending in his first year of practice. He excelled as a fellow in a clinically robust fellowship and has transitioned into the role of attending with ease. Although working at a busy academic hospital and juggling the pressures of providing clinical care efficiently and teaching can be challenging, Samuel has begun to feel more comfortable in his role as an attending.

Working with a junior resident, he is assigned a 3-week-old patient for pyloromyotomy. On rapid sequence induction, the junior resident struggles to intubate the patient and the patient desaturates. Samuel quickly intervenes, bag mask ventilates without success and similarly struggles to obtain the patient's airway. Ultimately, the patient's condition worsens to a hypoxemic cardiac arrest. After several rounds of PALS resuscitation, ROSC is achieved. A senior colleague who responded to the code easily intubates the patient and the patient is transported to the ICU.

Following the event, Samuel has difficulty focusing on his next patient – he continues to replay the events of the code and questions every step of his medical decision making. He feels ashamed and wonders why he himself wasn't able to intubate the patient and questions his own skills. Is he capable of taking care of patients? He also feels immense guilt and worries about the patient's neurological outcome. These thoughts persist for weeks following the event.

Who are the victims in this scenario?

- First victim – patient
- Second victim – clinician directly involved, other members of the immediate team
- Other victims:
  - "Third Victim" – traditionally, thought of as the future patients which the physician will care for directly after the event. [1] Their care may be affected as the anesthesiologist is unable to provide the typical level of clinical care due to distraction, lack of confidence in medical decision making, or changes in his/her practice following the prior adverse clinical event.
  - Colleagues/coworkers who hear about the event
  - Family/friends who support the second victim

Describe the second victim phenomena. What constellation of emotional responses can the physician experience? What types of adverse events can trigger this type of response?

- Second victims are healthcare providers who are involved in an unanticipated adverse patient event and become victimized in the sense that they are traumatized by the event" [2,3]
- Responses may include [3]
  - Emotional: Guilt, anxiety, fear, anger, sadness, depression, frustration, remorse
  - Physical: Sleep difficulty, fatigue, rapid heart rate, increased blood pressure, rapid breathing, pain, muscle tension, abdominal pain, gastrointestinal distress.
  - Psychological: Impaired concentration, impaired decision making, flashbacks, repetitive intrusive thoughts
  - Work Related: Decreased job satisfaction, return to work anxiety, second guessing career, avoidance of patient care area.
  - Symptoms may mirror both grief and post-traumatic stress disorder
  - Specifically in anesthesiology, a 2012 study by Gazoni et al [4] documented the following:
    - >70% experienced guilt, anxiety, and reliving of the event.
    - 88% required time to recover emotionally from the event.
    - 19% endorsed never fully recovering.
    - 12% considered a career change.
    - 5% endorsed substance abuse following the event.
    - 67% believed that their ability to provide patient care was compromised in the first 4 hours subsequent to the event, but only 7% were given time off.
    - 27% believed their ability to provide safe patient care was still compromised one week following the event with 16% that felt this compromise lasted an even longer period

What types of adverse events can trigger this type of response?

- Any event can lead to the second victim phenomena based on the provider's experience of the event and psychological response after.

- The same event will affect different individuals in different ways.
- Potential common triggering events:
    - Death or near death of a patient, especially when sudden or unexpected.
    - Event affecting a patient known to the provider (colleague, family member, friend, etc).
    - Harm to a patient following a medical error.

How common are adverse events during anesthesia?

- Despite advances in patient safety, it is highly likely that every anesthesiologist will experience a significant adverse event during their career.
- 84% of anesthesiologists surveyed had been involved in at least one unanticipated death or serious injury over his/her career. [3]

Does Samuel's experience resonate with you? How? Why?

Consider the time when you were involved in an adverse event or imagine yourself in Samuel's shoes. What resources did/do you need to help you heal from this event? What kinds of resources did you wish you had? What elements could institutions use to support their staff?

- Immediate relief from clinical duties
- Time to reflect/debrief
- Peer support program
- Employer provider psychological support
- Chaplain/Religious support
- Patient safety experts
- Risk management/legal experts

What resources specific to your institution that are available to assist physicians after adverse events? What gaps exist in support at your institution?

What is the purpose of Peer-to-Peer Support?

- Goals
    - To foster a culture of support and well-being
    - To create an opportunity for sharing thoughts and emotions related to an event
    - To connect with others who have had similar experiences
    - To support the process of healing after an adverse event
- Concept:
    - A trained clinician (peer supporter) is available to offer support to their colleague (peer) [5]
    - Having the availability of peers is important as physicians rarely utilize support from mental health providers after adverse events. [5]

    - Support may occur in 1:1 conversations (as physicians in general are reluctant to share emotional distress in group settings) or in a group setting (especially if a full team is involved).
- What Peer Support is not
    - Not an investigation of the facts (e.g. M&M, QI/Safety/RCA, legal inquiry, "expert opinion")
    - Not formal therapy

What elements should be part of a Peer-to-Peer support conversation?
- Confidentiality
- Ask:
    - Use open ended questions
    - Invite them to talk
    - Show you are interested and care
    - Normalize that this is a difficult situation
    - Validate what they are feeling (no matter what it is, this is absolutely normal)
- Listen:
    - Actively listen to their story
    - Validate their story
    - Remind them they are a good doctor (many times hearing from someone that they would have behaved in the same exact way can be helpful, of course depending on the situation)
- Connect:
    - Remind them that you are there for them, will continue to be there for them, check in with them.
    - Offer more validation/normalization and make them aware of resources that are available around your campus including formal support

Reflective Listening Exercise
- Break off group into pairs.
- Provide a copy of the **Peer Support Best Practices Document** (below, also included as a separate document in the *For Facilitators* section) for pairs to have as a reference.
- Instructions for participants:
    - We are now going to practice participating in peer support both as someone who has been involved in an adverse event and someone who is a neutral peer supporter.
    - Take a few moments to review the Peer Support Best Practices Document for helpful suggestions on how to approach a conversation as a peer supporter. Remember, the purpose is to create space for sharing of the experience of being part of an adverse event, not for simply recounting facts or discussing medical decision making.
    - Using the event you reflected on during your pre-work journaling exercise, you will take turns assuming both roles:

    - Peer - Discuss the experience of being part of an adverse event
    - Peer Supporter – Ask, listen, validate, and connect.
  - Each participant should take 5-10 minutes in each role and 5 minutes to debrief about the experience with their partner.
    - What did that feel like as the peer?
    - What did that feel like as the peer supporter?
- Following the exercise, groups should share their insights about this experience with the group.

Closing: Ask each participant to share one thing they learned by participating in this session.

Peer Support Best Practices-Tips Sheet

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- Goals:
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  - To create an opportunity for sharing thoughts and emotions related to an event
  - To connect with others who have had similar experiences
  - To support the process of healing after an adverse event

- Elements needed for a peer support conversation:
  - Confidentiality
  - Validation of experience
  - Space and time for sharing
  - Closure with a plan

- How to Be a Good Peer Supporter:
  - Tone of voice: Warm, inviting, curious
  - Body language: Open, lean in, eye contact, active listening
  - Typical conversations: can be impromptu or formal

- Important Elements of the Conversation:
  - Encourage sharing
    - Begin with open-ended questions
      - “Can you tell me a little about what is going on?”
      - “How are you feeling now?”
    - Validate experience, including thoughts, emotions, unanswered questions
      - Examples
        - Repeat statement
          - “So you are saying that you are feeling…”
          - “It seems like you feel….”
        - Validate the emotion, not the facts
          - “I can imagine how difficult it is.”
          - “That’s quite a heavy load to carry.”

        - Name the emotion/normalize
            - "I can imagine that could make you feel…"
    - Provide Support
        - Acknowledge shared humanity
        - Allow for silence and time for reflection
        - Elicit coping strategies
        - Stress importance of self-care
        - Share local and national resources

- What Peer Support is not:
    - Not meant to be an investigation of the facts
        - M&M
        - Formal QI/Safety investigation
        - Legal inquiry
    - Not meant to be formal therapy
    - Not meant to be "expert opinion"

- Pitfalls/ things to Avoid
    - Statements that discourage sharing:
        - "Don't be so hard on yourself."
        - "Don't feel that way! You are such a good doctor."
        - "It wasn't your fault."
    - Judgement:
        - Both in body language and word choice
    - Over-sharing:
        - Too many questions
        - Inserting personal experiences
    - Making assumptions about:
        - Emotions
        - Experiences
        - Level of Impact
    - Taking notes about the peer's experience
        - No documentation of the content of the peer conversation should be taken
        - This is important from a risk mitigation standpoint

References:

1. Martin TW, Roy RC. Cause for pause after a perioperative catastrophe: one, two, or three victims? Anesth Analg. 2012 Mar;114(3):485-7. doi: 10.1213/ANE.0b013e318214f923. PMID: 22358047.
2. Wu AW. Medical error: the second victim. The doctor who makes the mistake needs help too. BMJ. 2000 Mar 18;320(7237):726-7. doi: 10.1136/bmj.320.7237.726. PMID: 10720336; PMCID: PMC1117748.
3. Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall LW. The natural history of recovery for the healthcare provider "second victim" after adverse patient events. Qual Saf Health Care. 2009 Oct;18(5):325-30.
4. Gazoni FM, Amato PE, Malik ZM, Durieux ME. The impact of perioperative catastrophes on anesthesiologists: results of a national survey. Anesth Analg. 2012 Mar;114(3):596-603. doi: 10.1213/ANE.0b013e318227524e. Epub 2011 Jul 7. PMID: 21737706.
5. Shapiro, Jo MD; Galowitz, Pamela. Peer Support for Clinicians: A Programmatic Approach. Academic Medicine 91(9):p 1200-1204, September 2016.