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Emotional Healing

After a harm event, clinicians need support to move forward.

By Sue Campbell

He replayed the day in his mind, trying to figure out if he could have done anything differently.

For patient Linda Kenney, about to undergo an ankle replacement nearly two decades ago, surgery was nothing new. She was born with bilateral clubfeet and up to that point had faced 20 operations. One more felt almost routine. But the events of that day did not unfold as expected.

When the care team's anesthesiologist, Rick van Pelt, injected bupivacaine to numb her leg below the knee, a rare complication resulted. Kenney suddenly, shockingly, had a seizure and went into cardiac arrest. Chaos and noise erupted as the medical team sprang to action, reacting to the crisis. For ten minutes, they tried to restart Kenney's heart, using CPR and a defibrillator. But Kenney didn't respond, and they wheeled her to the hospital's cardiac suite, where surgeons cracked open her chest and clinicians massaged her heart with their hands until she was hooked to a bypass heart-lung machine, saving her life.

Kenney was, people would later tell her, a miracle. But over the next several months of physical recovery, she didn't feel like one. Instead, she experienced deep sadness. She found herself suppressing her emotions to put on a good face for her family. She eventually began to realize the impact her event had had on her care team.

Nor was van Pelt celebrating having helped bring her back from near death. Instead, he experienced guilt for causing a patient harm. He replayed the day in his mind, trying to figure out if he could have done anything differently. Post-incident, his colleagues shied away from him, and he felt isolated. He sank to "the lowest point I've ever been," he says.

Then one day, he had a flash of insight that brought him peace. He would write Kenney a letter to apologize and express his concern for her. He knew the hospital's risk management team wanted to control communication with the patient, but he knew he was doing the right thing, no matter the consequences.

His letter eventually led to a powerful conversation that changed both Kenney's and van Pelt's lives and gave their work a new focus and purpose. When they spoke, Kenney was the first person who had asked van Pelt how he was doing; that compassion was a salve. When she forgave him, van Pelt says, "It was like an 800-pound gorilla leaped off my back."

At the time, it was unusual for a patient and caregiver to come together and talk about the emotional fallout. Van Pelt felt that he and Kenney recognized what others in the field did not. "It is not just some emotional touchy-feely nice thing to do," he says. "How clinicians are supported is tied to patient safety and quality of care."

That's why van Pelt and Kenney saw the lack of support as a health care crisis, one they set out to confront. Back then, they were pioneers, using their shared story to make change and facing skepticism that they would succeed. While change has come, and research provides a roadmap, there's still more to do.

Haunting events, lasting impact

Research from the University of Missouri Health System (MU) shows that clinicians and care team members have remarkably common reactions to experiencing a harm event. Through interviewing physicians, nurses and other care providers and documenting common themes in their recollections, Sue Scott, PhD, RN, director of nursing for professional practice at MU, along with her colleagues charted the stages they experience after a traumatic event. The data showed a critical juncture where, if people received emotional support, they could move forward, even thrive, after a traumatic clinical event.

"If they had a positive supportive presence from their personal social network at home or from a colleague at work," she says, "they made something positive out of the event. They could make statements like, 'Because of what happened, I'm a better nurse,' or 'I learned from this event how to improve patient safety.'"

Without such help, clinicians and nurses tended to recall the event in a negative, haunting manner. Additional research showed that while most people benefit from talking to colleagues, trained peers or risk managers, 14% "have needs that exceed the capabilities of trained peers," Scott says, and they should be referred to professional support.

Scott also learned that almost every clinician will experience at least one harm event over the course of a career. She herself has been part of several in a 42-year career. But perhaps the

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biggest takeaway from MU's research is that traumatized clinicians can't be expected to simply bounce back and return to work as if nothing happened. As she and her team probed the memories of their subjects, all vividly recalled the events. It was as if, Scott says, they had tucked away the memory, and when they pulled it out, emotions surrounding it remained raw. Many suffered in silence, sometimes for decades.

"They don't really get over it. It takes a lot of time. These events stick with clinicians for the duration of their careers," she says. "Because of our findings, I think it's morally and ethically important for health care facilities to have some form of clinician support in the aftermath of an unexpected clinical event."

Looking to leaders

Health care organizations today focus on patient-centered care in their mission statements, says Laurie Drill-Mellum, MD, chief medical officer at Constellation. She urges broadening that goal to include care for care team members, too—especially after adverse events. But it takes commitment from leadership to transform organizations.

Leaders trying to make change need to follow a series of steps, Dr. Drill-Mellum asserts. They must recognize the need to do things differently, find the motivation to act, and put tools and resources into place to allow cultural change to take root.

"As a first step, leadership needs to recognize that harm events have many ripple effects," Drill-Mellum says. "They obviously impact the patient initially and primarily, and their family, friends and community. At the same time, they have a ripple effect on the people caring for patients. Care teams may have problems with depression, anxiety, substance abuse, lack of engagement, turnover. And that ultimately hits patients, the brand, revenue and cost. It's all very circular."

Leaders can be motivated to change out of a sense of doing the right thing for their teams, and doing the right thing for business. "Caring for one another as peers means better care for patients, fewer adverse events and fewer people leaving the system if something happens," Dr. Drill-Mellum says. When it comes to tools and resources, she argues for enough "upstream" buy-in to allow time for change to happen. Too often, institutions bring in a champion for an idea or cause, but once that person leaves, the push to change fades. "The goal is to weave caring into the culture both for patients and workers," she says.

That's what van Pelt and Kenney embraced 20 years ago, and it's work they continue today—Kenney as director of peer support programs at the Betsy Lehman Center for Patient Safety in Massachusetts, and van Pelt as vice president for clinical practice transformation at the University of Alabama at Birmingham.

"I started advocating for change and clinician support long before it was the thing to do," says Kenney, who founded Medically Induced Trauma Support Services (MITSS) in 2002 as a result of her event. "Doctors used to pat me on the head and say, 'Good work, but we don't really need it…' That was frustrating. I could see what they couldn't see."

Resources

Agency for Healthcare Research and Quality (AHRQ). **Second victims: Support for clinicians involved in errors and adverse events.** bit.ly/302cZEQ Updated January 2019. Accessed July 1, 2019.

Medically Induced Trauma Support Services (MITSS). **Clinician support toolkit.** bit.ly/2MG4P31 Published 2017. Accessed July 1, 2019.

University of Missouri Health System. **Stages of processing a harm event.** bit.ly/2xnmRwL Published 2009. Accessed July 1, 2019.

SUE CAMPBELL

Freelance writer and editor

New backlash to old terminology

The term "second victim" to describe clinicians suffering after adverse events has increasingly come under fire by patients and advocates, most notably in an editorial by the University of Kentucky's Melissa Clarkson and colleagues arguing to abandon the term.[1]

The problem: It implies passivity, that care teams can't prevent harm events because they are "random, caused by bad luck and simply not preventable," Clark writes. The term also can paint horrific events for patients as being about clinicians, says Laurie Drill-Mellum, MD.

Despite objections, the term is embedded in research, literature and the vernacular, so likely won't disappear. "We haven't come up with a better replacement yet," says Sue Scott.

1. Clarkson MD, Haskell H, Hemmelgam, C, Skolnik P. **Abandon the term "second victim."** *BMJ* 2019;364:l1233

Six stages of processing a harm event

Traumatized clinicians experience similar reactions, and University of Missouri Health System researchers organized them into six stages.[1] The first three stages may occur one at a time or all together.

1. Chaos and accident response

2. Intrusive reflections that lead to isolation, shame, rumination

3. Restoring personal integrity, in which both fear and acceptance are common

4. Enduring the inquisition—answering questions for documentation or litigation

5. Obtaining emotional first aid

6. Moving on, which encompasses three trajectories:
   - Dropping out
   - Surviving: coping but still having intrusive thoughts and sadness
   - Thriving: gaining perspective, advocating for patient safety, and continuous learning

1. University of Missouri Health System. **Second victim trajectory.** bit.ly/2xnmRwL Published 2009. Accessed July 1, 2019.