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# Reducing the Second Victim Phenomenon: Healing Our Healers With Caritas Coaching

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Reducing the Second Victim Phenomenon:

Healing Our Healers with Caritas Coaching

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**Abstract**

**Background:** The second victim phenomenon is one in which nurses and other healthcare providers use dysfunctional mechanisms, such as anger, projection of blame, or drugs and/or alcohol to cope with serious mistakes in the absence of a healthier means for healing (Wu, 2000). This phenomenon can lead to healthcare professional absenteeism, leaving the job or leaving the profession altogether (Burlison, Quillivan, Scott, Johnson, & Hoffman, 2018). Following the release of an editorial by Dr. Wu (2000), organizational peer support programs have been developed to reduce this phenomenon. These types of peer support programs have been found to counter absenteeism and intentions to turnover (Burlison et al., 2018). Unfortunately, many health care professionals do not have access to these prevention programs due to a paucity of evidence supporting them. **Purpose:** The second victim phenomenon is not well known among many leaders in healthcare organizations. Further information on how to support the holistic well-being of nurses and other healthcare professionals is essential in increasingly complex health care systems. The main purpose of this manuscript is to provide evidence that supports the need for caring organizational support systems following serious adverse clinical events. **Design:** Relevant literature about the second victim phenomenon and transpersonal caring were compiled and reviewed. **Findings:** Recommendations are provided on key elements of programs to prevent the prevalence, symptoms, and impact of the second victim phenomenon on our healthcare professionals, our patients, and our healthcare system. **Conclusion:** To improve the holistic well-being of health care professionals following a serious adverse event, health care organizations must provide programs to promote their healing.

**Keywords:** *second victim phenomenon; secondary traumatic stress, Caritas, transpersonal caring*

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### Reducing the Second Victim Phenomenon: Healing Our Healers with Caritas Coaching

#### **Background**

There is a silent epidemic growing in our healthcare organizations. The National Academy of Medicine or NAM (2000) began a movement to bring this epidemic to light in their report: *To Err is Human: Building a Safer Health System*. Their report postulated that 44,000 to 98,000 patients die in hospitals each year due to preventable diagnostic, treatment, preventative, and “other” errors. In that same year, Wu (2000) cited the lack of organizational systems for aiding in the grieving process of physicians who make mistakes. In the absence of such systems, physicians who make errors can respond with anger, projection of blame, and scolding of staff and patients (Wu, 2000). Such behaviors reveal the deep wounds caused by these errors which may lead to burnout and/or drug or alcohol overuse (NAM, 2018). Work by the National Academy of Medicine’s *Action Collaborative on Clinician Well-Being and Resilience* has shown that these behaviors are not isolated to physicians alone, but also occur among nurses and other healthcare professionals (NAM, 2018). Albert Wu (2000) was the first person to use the term *Second Victim* to describe this phenomenon and it has slowly gained momentum as healthcare providers and researchers attempt to understand and create systems and processes to alleviate it in our healthcare system.

The data NAM (2018) gathered revealed alarming statistics about rates of depression, post-traumatic stress, and emotional exhaustion among health care providers. Findings revealed 400 physician deaths by suicide each year and 39% of physicians experiencing depression. NAM’s (2018) campaign also provided statistics demonstrating that nurses are similarly affected. Their report noted that 24% of ICU nurses tested positive for symptoms of post-traumatic stress disorder, and the prevalence of emotional exhaustion among primary care nurses was 23-31%

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(NAM, 2018). Included in the report by NAM (2018) was the financial cost of healthcare professional burnout. This includes the cost of nurse turnover being \$82,000 to \$88,000 per nurse and the cost of replacing one physician is roughly \$1 million. Given these staggering effects the second victim phenomenon can have on our healthcare system, we can no longer ignore this phenomenon. Cabilan and Kynoch (2017) point out that there is minimal published evidence on the second victim phenomenon in nursing. This lack of knowledge and understanding is of grave concern given the impact the second victim phenomenon can have on the nursing professional.

This manuscript will provide an overview of the second victim phenomenon; review the prevalence, symptoms, and impact of the second victim phenomenon; and present a theoretical framework encompassing transpersonal caring strategies for nurses and healthcare professionals to use to address the second victim phenomenon.

### **Literature Review**

The second victim phenomenon consists of a group of symptoms experienced by healthcare professionals following an adverse traumatic clinical event. These events can cause physical and psychological symptoms including the impairment of medical judgment, flashbacks of the event, insomnia, fatigue, emotional outbursts, guilt, anxiety, depression, and thoughts of suicide (The Joint Commission, 2018; Caliban & Kynoch, 2017). Many healthcare researchers and organizations have implemented programs to care for these professionals following an adverse traumatic clinical event and many medical and nursing researchers have begun studying this phenomenon that impacts the human capital, along with the patient and financial outcomes of our care delivery systems.

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We often hear about the five rights of safe medication administration but we rarely, if ever, hear about the five rights of the second victim. These rights were first proposed by Denham (2007) using the TRUST acronym. He offered that clinicians involved in a preventable event that harmed a patient due to systems failures and/or unintentional human error are entitled to rights that are not routinely offered in our healthcare system (Denham, 2007). These include:

- **Treatment that is just:** Denham (2007) proposes that the presumption of guilt cannot be assigned solely to the clinician involved in the error. Instead, a “Just Culture” must be adopted with nonpunitive approaches that can lead to improving the system to prevent similar future errors (Denham, 2007).
- **Respect:** Denham (2007) proposes that nurses, pharmacists, and all members within the healthcare system are susceptible to error and the fallout which can include blaming and withholding respect for the clinician involved in the error. Leaders must encourage respect for the clinician involved in the error and encourage the use of “the golden rule” by treating the clinician with the same respect we would expect if in their shoes (Denham, 2007).
- **Understanding and Compassion:** Denham (2007) proposes that when an unanticipated error occurs, the clinician involved becomes akin to a patient and needs time to grieve following the serious adverse event, using the strategies first proposed by Ku'bler-Ross: denial, anger, bargaining, depression, and acceptance. Leaders must reach out to the clinician involved in the error and offer them the same compassion and understanding they would offer their patients (Denham, 2007).

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- **Supportive Care:** Denham (2007) proposes that clinicians are entitled to psychological and supportive services due to their day-to-day encounters with trauma, loss, and unintentional errors which can make them the second victim of these events. Healthcare systems must deliver supportive care to its clinicians in the same way it would give this care to patients (Denham, 2007).
- **Transparency and the Opportunity to Contribute:** Denham (2007) proposes that patient safety depends on healthcare clinicians' and leaders' ability to be more transparent about unintentional mistakes to patients, colleagues, and themselves. Denham (2007) points out that the current system of writing an error report, saving the information in silos and suppressing discussions about the error out of fear of lawsuits does no justice to the patient, the clinician involved in the error, or the system. Instead, healthcare leaders must use the error to learn and make changes within the system. This provides an opportunity for those involved in the error, including the clinician, to heal (Denham, 2007)

These five rights of the second victim were also proposed by Cabilan and Kynoch (2017) who note that in the absence of these rights, organizations risk cultivating a culture of non-disclosure and underreporting, putting patient safety at risk.

There have been several definitions of the “second victim” in the literature. Each of the articles reviewed for this manuscript gave one or more definitions with an in-depth description. The most widely used definition of the second victim, developed by Scott, Hirschinger, Cox, McCoig, Brandt, and Hall (2009), defines the second victim as:

Second victims are health care providers who are involved in an unanticipated adverse patient event, in a medical error and/or a patient-related injury and become victimized in

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the sense that the provider is traumatized by the event. Frequently, these individuals feel personally responsible for the patient outcome. Many feel as though they have failed the patient, second-guessing their clinical skills and knowledge base. (p. 326)

### **Prevalence, Symptoms, and Impact of the Second Victim Phenomenon**

**Prevalence.** The prevalence of the second victim phenomenon is a growing problem in our increasingly complex healthcare system. Prevalence rates from this review of evidence range from 2.5% to 43.3% and “high” (Lewis et al., 2015; Cabilan & Kynoch, 2017; Seys et al., 2012).

**Symptoms.** The symptoms found in healthcare professionals who are second victims include guilt, incompetence, self-doubt, humiliation, embarrassment, self-blame, frustration, loss of confidence, detachment, burnout, symptoms of depersonalization, anger, psychological distress, and fear (Burlison, Scott, Browne, Thompson, & Hoffman, 2017; Cabilan & Kynoch, 2017; Lewis et al., 2015; Seys et al., 2012). These symptoms are similar to ones found in burnout syndrome however, there is currently no internationally agreed upon definition of burnout (Kaschka, Korczak, and Broich, 2011).

**Outcomes.** Errors that occur within healthcare systems that are not followed-up with organizational support can lead to the second victim phenomenon and over time can lead to increased absenteeism, decisions to leave the organization, or even more severe decisions to leave the profession (Burlison et al., 2018). The National Academy of Medicine (2018) recognizes healthcare professional burnout as a threat to safe, high-quality care. Given that the symptoms of burnout are becoming more defined through research and an agreed upon definition of the second victim phenomenon, these two findings highlight the importance of supporting our healthcare professionals in their times of need.



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**Relationship Between Errors and the Second Victim Phenomenon.** In a Patient Safety Network question and answer session, Dr. Robert Watcher (2011) questioned Dr. Wu about the second victim phenomenon. Dr. Wu voiced that healthcare professionals feel a sense of responsibility when errors are made in the care of patients and in some instances, this can leave the nurse, physician, or other healthcare professional emotionally traumatized, making them the second victim in an error. It is essential to point out that Wu (2000), in his original editorial on the second victim phenomenon, states:

Nurses, pharmacists, and other members of the healthcare team are also susceptible to error and vulnerable to its fallout. Given the hospital hierarchy, they have less latitude to deal with their mistakes: they often bear silent witness to mistakes and agonize over conflicting loyalties to patient, institution, and team. They too are victims. (p. 727)

### **Strategies to Improve the Impact of the Second Victim Phenomenon**

Cabilan and Kynoch (2017) stress the importance of support for the RN following an event and the use of the error as a foundation to make improvements in the practice setting. The disclosure standards following an adverse event, such as providing facts about the event to patients, has been embraced by the National Quality Forum as a strategy that can reduce the impact of the second victim phenomenon (Lewis, et al., 2015). Disclosure was found by Cabilan and Kynoch (2017) to be a means to bring closure to the nurse following an adverse event.

Edrees et al. (2016) conducted a comprehensive study at Johns Hopkins Hospital. They used the RISE (Resilience in Stressful Events) peer support programme which was developed to provide support to employees following adverse events. Edrees et al. (2016) reported the importance of support systems within healthcare organizations to help healthcare professionals handle and deal with traumatic medical and nursing events. They also reported that most second

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victims prefer individual peer support a couple of days after the event occurred rather than immediately after the event, hours after the event, or a week after the event.

Findings by Edrees et al. (2016) were similar to those reported by Seys et al. (2012). Both studies stressed the importance of supportive interventions for healthcare professionals following an adverse event and the need for national and local quality improvement initiatives regarding the second victim phenomenon. An important finding reported by Seys et al. (2012) was in the absence of organizations developing support systems for healthcare professionals following adverse events, the healthcare organization itself can become the third victim through the financial costs of the error, losing staff who become second victims, and an increase of future errors in health care.

The link between peer support programs to reduce the second victim phenomenon and transpersonal caring are evident in the literature. Wiljen (2017) points out that using a Caring Science framework to counter moral distress in new graduate nurses allows these clinicians to replenish what has been drained to aid them in returning to a place of authenticity. This *Caritas* approach involves practices that cultivate mindfulness, reflection, personal growth, and self-development (Wiljen, 2017).

Lowe (2013) notes that Watson's theory fosters nurse well-being through the use of her *Caritas* processes. While Watson's human caring theory and *Caritas* processes were initially developed to facilitate a healing relationship between nurse and patient, Lowe (2013) points out that the theory and its concepts provide an important foundation to build and develop a caring, healing environment for nurses and the healthcare team.

McElligott (2010) highlights that the transpersonal caring process is not only a journey between the patient and the nurse. She notes its importance for nurse self-care and self-

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awareness as a means of healing (McElligott, 2010). These three articles offer essential knowledge about how transpersonal caring and Caritas can heal nurses and our other healthcare professionals.

### **Theoretical Framework**

Dr. Watson's (2018a) theory of transpersonal caring and the Scott three-tier interventional model of second victim support (Scott et al., 2010) provide a theoretical framework to support clinicians following a serious adverse clinical event.

Dr. Jean Watson (2018) notes the importance of healing our nurses and healthcare professionals through transpersonal human caring moments and connections. Her following statement is an important call for not only the loving care of patients and their families, but also for ourselves and each other as nurses and healthcare professionals, and sets the foundation for this manuscript:

As we reenter nursing and its evolving maturity, we are uniting with over 20 million nurses and midwives on the planet and more than 7 billion people—all crying out for healing in some way, to be embraced with love and knowledgeable human caring connections. (p.xix)

***Transpersonal Caring Science.*** Jean Watson's theory of transpersonal caring science and her work in Caritas is a model that continues to evolve as she builds upon her original work of understanding what it means to be human, to be a nurse, to be ill, to be healed, and to give and receive human care (Watson, 2018a). The meaning of *Caritas* comes from the Latin word meaning to cherish, to appreciate, to give special, if not loving, attention to (Watson, 2008). Five core aspects of Dr. Watson's original theory provide a framework for healing our healthcare professionals. These included: (a) relational caring for self and others as an ethical-moral-

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philosophical values-guided foundation, (b) use of the caring core or the ten carative factors/carative processes to guide the process of putting the theory into action, (c) The transpersonal *caring moment-caring field* which is guided by an evolving *Caritas Consciousness* or one's moral, ethical commitment and intentionality with each person, (d) caring as consciousness – energy-intentionality-human presence and (e) caring-healing modalities (Watson, 2008a; Watson, 2008b).

***Scott's three-tier interventional model of second victim support.*** The Scott et al. (2010) three-tier interventional model of second victim support guides how to support second victims within three different tiers, each of which identifies the type of support and who will be provided it. Tier-one support is offered immediately following an adverse clinical event by unit leaders and peers to reduce possible second victim responses following an event. Tier-two support is provided by trained peer supporters who provide one-on-one crisis intervention, peer support mentoring, team debriefings, and support for clinicians who are showing signs and symptoms of the second victim response. Tier-three support is provided within an organizational established referral network which can include an employee assistance program, chaplain, social worker, or clinical psychologist to support the second victim when their emotional stress response escalates to a point outside the expertise of the peer support team (Scott et al., 2010).

Together, Watson's theory and Scott's model, create a theoretical framework to support the second victim by providing caring strategies to reduce and even prevent the potential signs and symptoms of this phenomenon and ensure that healthcare professionals do not suffer in silence.

### **Healing Through Caritas**

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Errors made by nurses and other healthcare professionals can lead them to lose the sense of connectedness they once deeply and meaningfully desired to be in. Errors can lead to clinicians feeling as though they have failed their patient and their team leading them to second-guess their knowledge and skills (Scott, Hirschinger, Cox, McCoig, Brandt, Hall, 2009).

One solution is to use the work of Watson to help the second victim and prevent the second victim phenomenon. Dr. Watson (2003) proposes human-to-human acts of caring within a caring moment unite us and the cosmic energy of love, as one. She also notes the act of turning away from facing our own humanity or turning away from our colleagues in crisis, can be an act of cruelty (Watson, 2003). She emphasizes the importance of supporting, instead of turning away from, our colleagues and other healthcare professionals in their time of need.

Consider the possibility that when a healthcare professional is involved in a serious adverse clinical event, they be given freedom and the opportunity to reflect on the deeper meaning of being a clinician. Given time to be present and process their mistake encourages health care professionals to embrace their emotions of fear and guilt, and to use the mistake to venture home to the roots of connectedness to their profession of caring, helping, and healing (Watson, 2003; Watson, 2018a).

### **The Caritas Coach**

Caritas Coaching is a form of advanced education developed by Jean Watson (2008c). This form of coaching is transpersonal in nature and brings the coach into the personal frame of reference of the person being coached. This type of coaching helps others face and work through their negative habits and ways of thinking to find their inner strength and gifts (Watson, 2008c). It is a holistic form of coaching that promotes transformative alignment of thoughts, feelings, actions, and intentions which are the foundation for expanded consciousness, health, and well-

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being (Anderson, 2018). The Watson Caring Science Institute (2019) defines the Caritas Coach as:

a knowledgeable, experienced, reflective health care professional, who is prepared and committed to personally and professionally practice and model intelligent heart-centered approaches to health care by translating and sustaining the ethic, philosophy, theory, and practice of the Science of Human Caring into our systems and society (pg. 1)

The Caritas Coach embraces the healing, transformative evolution of the spirit and soul of each person (Anderson, 2018). The caritas philosophy and the transformative journey it leads one to deeper questions many may ask themselves as second victims. These include: a) Who am I? b) Why am I here? c) What is my purpose? d) How can I make a difference? e) What is health and healing? f) How do I effect care and healing for those in my care? and g) How can I change this experience (Anderson, 2018). However, the guilt and fear a clinician experiences following a serious adverse event may lead them, as a second victim, to ask these questions critically instead of with positive healing energies. This is where the skills and knowledge of a Caritas Coach are necessary.

Many clinicians who become Caritas Coaches do so because they recognize the need in their own lives (Horton-Deutsch, 2018). Many enter the Caritas Coach Education Program® after experiencing some of the same feelings many second victims encounter. These may include contemplating leaving their profession or feeling depleted of the ability to care or give (Horton-Deutsch, 2018). These similarities between the second victim phenomenon and the transpersonal caring skills of Caritas Coaches bring a new outlook for the care and healing of second victims.

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The Caritas Coach can become the healing catalyst for change in our complex healthcare systems. Through their advanced skills in loving, caring and compassionate coaching, they become advocates for patients, clinicians, colleagues, themselves, and the healthcare system (Horton-Deutsch, 2018). These simple acts of loving, caring, and compassionate coaching of clinicians following a serious adverse event, leading to transpersonal, biogenic relationships proposed by Watson (2008b) as the “transpersonal caring moment” or the evolution toward *Caritas Consciousness and Processes*, is the foundation for an authentic caring-healing relationship. These authentic caring-healing relationships are something clinicians, patients and our complex healthcare systems need now more than ever.

### **Implications for Nursing Practice, Education, and Research**

Jean Watson’s work on Caritas and Caritas Coaching was something this author was not aware of until she began researching the second victim phenomenon and was introduced to a fellow student who is a Caritas Coach. The result of this connection led this author down the path to become a Caritas Coach as part of a passion to help and support other healthcare professionals. Since becoming certified as a Caritas Coach, this author has come to find that many working on the front-line of healthcare are unaware of the second victim phenomenon or the need to support their colleagues in times of crisis. Health care professionals and systems must have an awareness through research and education of the devastating effects the second victim phenomenon can have on our health care professionals and the healthcare system. It is evident that they must unify in identifying and implementing transpersonal caring practices to support second victims.

Caritas Coaching and the advanced education provided in becoming a Caritas Coach gives the Caritas Coach a skill set needed to form authentic caring relationships with others and

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to aid them in finding healthy solutions and strategies to overcome their self-identified issues and needs (Watson, 2008c). Consider the possibility of having a Caritas Coach to assist clinicians following a serious adverse event. Is it possible that the Caritas Coach could fill the need in our healthcare organizations to assist our clinicians following a serious adverse event, leading to healthier clinicians, safer care for our patients and their families, and a reduction in the prevalence of the second victim phenomenon? More research and evidence-based projects need to be done to evaluate this promising intervention.



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