

Impact of health care adversity on providers: Lessons learned from a staff support program

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Background: Health care providers often experience traumatic events and adversity that can have negative emotional impacts on the profession and on patients. These impacts are typically multifaceted and can result from many different events, such as unanticipated outcomes, licensing board complaints, claims, and litigation. Because health care providers are exposed to diverse situations, they require adequate and timely support, imperative for provider resilience and patient safety. This study evaluated the success of an institution's second victim health care support program and best practices in responding to these traumatic experiences effectively.

Methods: Twenty faculty and medical residents who utilized the support program at a large hospital system located in Central Texas from 2001 to 2012 participated in 1 of 6 focus groups. Qualitative data were collected from these groups to describe program requirements for the adequate delivery of health care adversity support and necessary program improvements. Responses were first transcribed verbatim. Each research team member analyzed data using a thematic framework approach. This approach helped to characterize traumatic experiences and to design a support system.

Results: The results revealed that (1) provider experiences are traumatic, (2) it is necessary to communicate an adverse event in a confidential and timely manner, preferably with a peer, (3) preemptions education regarding risk management and the legal process is helpful, and (4) there is a need for further support of the specific experience of a board complaint.

Conclusions: Focus group data indicated the complexity of the emotional impact of traumatic experiences. Specific program components are needed to create best practices for providers affected by health care adversity, including support when providers face board complaints. The program's unique combination of support and education allowed us to expand upon leading national health care adversity programs.

INTRODUCTION

The term *second victim* was coined to describe the negative emotional effects of medical errors on health care professionals.¹ In 2007, a survey of over 3000 physicians reported that when involved in medical errors, emotional distress was prevalent and support was needed but was largely unaddressed.² Eighty-eight percent of anesthesiologists surveyed post perioperative catastrophe reported they needed time to recover emotionally, and 19% acknowledged they never recovered.³ Furthermore, in a systematic review, Lineman et al found that physicians are twice as likely to commit suicide as the general population.⁴ A recent study of second victim programs reported that an institution's rapid intervention to provide support to clinicians may offer sufficient help to health care providers involved in adverse events. However, the grinding, drawn-out repercussions of prolonged litigation matters frequently require support on a regular basis for the duration of the matter.⁵ Additional reports have demonstrated that by age 65, 75% of physicians in low-risk specialties had faced a malpractice claim, compared with 99% of physicians in high-risk specialties.⁶ As a result of this reality, experts consider litigation stress syndrome a real phenomenon that has a significant impact on physician quality of life.⁷ In addition, health care providers must also deal with complaints submitted to their respective licensing boards, which frequently accompany adverse outcomes, claims, and litigation. Specifically, as it relates to the Texas Medical Board, enforcement cases against physicians and other health care professionals in the state increased 76% between 2004 and 2013 as more patients turned to the board instead of the courts in the aftermath of tort reform.⁸

Scott & White Healthcare (SWH), a member of Baylor Scott & White Health (BSWH), is a health system located in Central Texas (CTX) and 5 surrounding regions. In response to provider suffering due to adverse outcomes, SWH Risk Management (RM) staff and senior staff provided informal staff support from 2001 to 2012. The SWH RM approach to managing risk incorporates multiple patient and staff safety components including programs such as patient relations, potentially compensatory events investigation, root cause analysis and process improvement, regulatory support, multiple risk prevention educational programs, in-house legal team for claims and litigation, support for board complaints through Legal Nurse Consultants, and 24-hour coaching available for difficult disclosures. Due to the comprehensiveness of the division, SWH RM is uniquely positioned to provide staff support and early intervention in the aftermath of second victim scenarios.

In 2011, SWH system committed to deliver second victim staff support to providers experiencing health care adversity. An internal grant was obtained to formalize the program. Leadership named the program "Swaddle." To assist in program formalization, the program manager

and 2 key program stakeholders attended the Medically Induced Trauma Support Services (MITSS) conference in Boston, where the 3 leading national second victim programs (Brigham and Women's Hospital Center for Professionalism & Peer Support; University of Missouri Health System; and Johns Hopkins School of Public Health) were presented. As a result, the Swaddle program was designed, incorporating previous experience with informal provider support, empirically supported crisis intervention training, the MITSS program development tool kit (<http://mitss.org>), peer support methodologies, and the Scott Three-Tiered Staff Support Model.⁵ Swaddle was also designed to be supervised by an executive team of experienced supporters who previously provided peer support for staff suffering the second victim experience, claims and litigation, and licensing board complaints and disciplinary action. These multidisciplinary volunteers are trained throughout the five CTX division regions to provide 1:1 ongoing peer support.⁹ Swaddle also trains high-risk areas in psychological first aid and after action response for immediate support subsequent to an unanticipated outcome. Additionally, because of the known potential risks of suicide among providers, a licensed behavioral health clinician was hired to assess escalating psychological crises and fast-track referrals for psychiatric care. In collaboration with Chaplains and the Human Resources Employee Assistance Program, Swaddle aids in providing a safety net of support options for staff members post disaster response. Swaddle provides prevention education for compassion fatigue, secondary traumatic stress, and burnout. The program funds compassion enrichment through Schwartz Rounds (www.theschwartzcenter.org), and victim response training for frontline departments through the National Organization of Victim Assistance (www.trynova.org). As a result, we have also further defined the second victim experience to consist of "health care adversity" which we describe as difficult disclosures, depositions, claims, lawsuits, and licensing board/agency complaints.

The objectives of this qualitative study were to evaluate health care providers' traumatic experiences on second victim and health care adversity scenarios, the impact of those experiences on providers' lives, the components of the support model that were helpful, and additional support options that would be beneficial to include. The results of this study are significant in that they provide further insight into the multifaceted effect of second victim experiences on providers and what risk management teams can do to further support them.

METHODS

Study design

A qualitative study design with focus group interviews was utilized. The study was granted exempt status by the Scott & White Memorial Hospital Institutional Review Board.

Participants

E-mail invitations for focus group participation were sent to 50 staff physicians and medical residents who utilized health care adversity support from RM between 2001 and 2012.

Data collection

Qualitative data were collected during 6 separate focus groups over a 6-month period. Two research team members (MT, KW) moderated each focus group. At the beginning of each session, participants completed a demographic data form and signed acknowledgment of informed consent. Eight questions were asked to gather information about the individual and general experience of health care adversity (Table 1). Questions were designed to be nonbiased and not misleading. A licensed professional counselor attended each focus group and was prepared to provide psychological first aid, support, and referrals, if necessary. The sessions were audio recorded. Narrative data were transcribed verbatim and individual names were replaced with fictitious ones.

Data analysis

Qualitative analysis utilizing deidentified focus group narratives was conducted by the research team members: a psychiatrist (DW), a registered nurse (KW), a behavioral health counselor (MT), a research development specialist (WH), and an educational researcher with expertise in qualitative research (HWJ). Analysis bias was mitigated by the diverse backgrounds of the team members. Research team members first completed independent content analysis of the transcribed data to identify broad themes and subthemes, then met 4 times as a group and reached consensus on final themes and subthemes. Descriptive statistics were utilized to analyze demographic data.

Table 1: Focus group questions

1. What are your thoughts about traumatic experiences in health care?
2. What kind of negative events have you experienced while working in health care? Describe your personal experience(s).
3. What impact did these experiences have on your life?
4. What has been most beneficial for your recovery from these events?
5. What kinds of risk management support did you receive as a result of negative events?
6. How was the risk management support you received helpful or not helpful?
7. What else could Scott & White do to be helpful in adverse event situations?
8. Do you have anything else to add?

RESULTS

A total of 6 focus groups with 20 total participants over a 6-month period were held (Temple-4, Waco-1, and College Station-1; Table 2 indicates the demographics of the focus group participants). The sample included 12 (60%) women and 8 (40%) men; and 95% ($N = 19$) of the participants had been in health care for greater than 10 years. Participants encompassed a variety of specialties including Family Medicine ($N = 4$), Anesthesiology ($N = 2$), Emergency Medicine ($N = 2$), Gastroenterology ($N = 2$), Obstetrics and Gynecology ($N = 2$), and 1 participant from each of the following: Diagnostic Radiology, Internal Medicine, Orthopedic Surgery, Postanesthesia Care Unit (PACU), Pediatric Surgery, Pediatrics, Physician Management, and Plastic Surgery.

Content analysis of the narrative data identified a total of 4 main themes and 18 subthemes. Table 3 reflects the themes and subthemes with the number of coded exemplars for each.

Table 2: Demographics of focus group participants

Variable	Percent (Count)
Gender	
Male	40 (8)
Female	60 (12)
Age	
No response	5 (1)
30–39	5 (1)
40–49	40 (8)
50–59	35 (7)
60–69	15 (3)
Ethnicity	
African American	5 (1)
White	95 (19)
Years in HC	
5–10	5 (1)
> 10	95 (19)
# Patient Care Hours/Week	
None	5 (1)
< 30	20 (4)
30–39	5 (1)
40–49	35 (7)
50–59	5 (1)
60–69	25 (5)
70+	5 (1)

Table 3: Themes and Subthemes

1. Traumatic Experience (outcomes are) Multifaceted on Providers Lives (118)
 - a. Emotional impact (47)
 - b. Disruption of daily systems of care processes (18)
 - c. Effects on personal life/relationships (19)
 - d. Perceived change of state (18)
 - e. The meaning of the traumatic experience is personalized and different per individual (15)
2. Design of the Support System Important for Impact (74)
 - a. Peer-to-peer support (15)
 - b. Confidential and personalized support in a protected environment (18)
 - c. Proactive education regarding the process and role (26)
 - d. Timely response and support (6)
3. Characteristics of Traumatic Experience (diversity) (72)
 - a. Dichotomy between provider intent and complainant motive (16)
 - b. Potential threat of licensing board disciplinary action (13)
 - c. Unexpected health care events (14)
 - d. Inescapable trajectory of events (29)
4. Significance of Communication (61)
 - a. Process for coping with event (18)
 - b. Effects of restricted communication (14)
 - c. Gender specific impact (2)
 - d. Seeking an outlet to communicate (14)
 - e. Value of leadership support (10)

Note: Numbers reflect the number of exemplars associated with the theme/subtheme.

Theme 1: Traumatic experience (outcomes are) multifaceted in providers' lives

This theme and its subthemes represent the majority of exemplars from the focus group and describe the pervasive effects of traumatic experiences on providers' lives.

Providers report the traumatic experiences of second victim/health care adversity had significant and multifaceted impact and outcomes in their lives:

- “You can't eat, you can't sleep.”
- “It will make you call into question your own abilities, unfortunately.”
- “You can't even enjoy your family.”

The disruption of daily systems of care processes:

- “Even now when I see a patient that is similar to the one that this happened with, I have flashbacks to the day and that was in 2002.”
- “It is something that gets in between the physician/patient relationship. You can't even trust your patients or that they can come back and get you in some way.”

Providers described the effect of the traumatic experience on their personal life/relationships:

- “I went through months not feeling like I could enjoy my family, not feeling any of the joy in my life. ... There I was with a newborn baby ... that assault on your personal life, you can't get that back, I can't get that time back.”

Providers reported feeling that they had been changed by the traumatic experience:

- “You are never the same after you have been through one of these. You walk a little differently after a truck runs over you, don't you?”

The meaning of the traumatic experience being personalized but different per individual:

- “We still have those same human reactions, but how we cope with them and manage them is different.”

Theme 2: Design of the support system important for impact

How health care systems can best support providers who have been impacted by second victim/health care adversity is paramount in the creation of support programs.

Providers reported support by a peer was important for impact. Peer-to-peer support with specific history of training/specialty matched is preferred:

- “Specialty is important because like we are both physicians, but she is a __ doctor and I am a __ physician and we don't do the same things. I can listen, but it isn't the same.”
- “It completely helps to have someone who has your training to talk to.”

Confidential and personalized support in a protected environment:

- “Having someone that says, look if you need anything, I would be happy to be available to talk with you, but on a personal basis.”
- “It kind of needs to be within the walls of where we are.”

Providers' recommendations were to incorporate proactive education for health care professionals, particularly in legal processes, and the role of providers into a second victim/health care adversity support program:

- “I think there needs to be more of a focus on outreach ... more information about what to expect.”
- “It would have been nice for me to know that there had been other people who had been faced with litigation, you know, ahead of time.”
- “Whenever this comes about, it would be nice to have a link on Insite [the SWH intranet] and maybe a way for staff members to get the help they need and definitions of legal terms.”

A support program that is designed to provide a timely response and support is important for impact:

- “I think it needs to be a rapid response.”
- “Risk Management needs to tell the person, ‘OK, you have gotten this letter; we are going to have a volunteer contact you tomorrow.’ It would be even better if you could have the advocate at the RM meeting so they could say, ‘Here is Dr. __. He is here to support you, talk with you.’”

Theme 3: Characteristics of traumatic event (diversity)

Traumatic experience is subjective and personal and encompasses a wide spectrum of potential causes in health care. What is pervasive is the sense of helplessness providers feel in the face of traumatic events.

Providers reported diverse characteristics of the traumatic experience of second victim/health care adversity and the dichotomy between provider intent and complainant motive in litigation:

- “It was so frustrating that I would be sued when I was trying to help and I did everything right and there was nothing ethically or medically I did wrong.”
- “... understand that you are not being sued because you are guilty; sometimes you are being sued because somebody wants something.”
- “You gotta remember they don’t just want your soul, they want your cash.”

The potential threat of licensing board disciplinary action:

- “It wasn’t even that I had done anything wrong, but I still had the fear, ‘They are going to take away my license, they are going to restrict my practice, I am not going to be able to do what I love to do.’”
- “This is how I see it in a malpractice trial or deposition. In one sense it is about money no matter what the truth is; state board is about your soul, they are about your soul. That is just like we got you by the scrotum and we are just going to squeeze it and turn it if we feel like it, and what are you going to do?”

The traumatic experience of unexpected health care events:

- “Unexpected sudden death. It is not like trauma patients, because there are some things you just can’t fix, but when it is a routine thing and you have to walk out of the OR and say we got a problem.”

Focus group participants reported feeling as if they had been caught up in an inescapable trajectory of events during the traumatic experience of second victim/health care adversity:

- “But I think it doesn’t matter if I do everything right, the right indication, the right procedure. If something is going to happen, it is going to happen. In the end you are vindicated because you did the right thing, but for a year of your life you feel like a total failure.”
- “I think dealing with that side of it, knowing that I did nothing wrong, to me was just as heartbreaking as the patient outcome. In fact, it lasted longer and took more years off my life.”
- “It is that helpless sensation for me; to know that can happen to me any day.”
- “Like everyone else said, I had no control over what started it and it involved more helplessness because I had no influence on the outcome.”
- “By the time the lawyers get involved you kind of feel like you are getting drug behind a horse. You are intimately involved and you have no control whatsoever. You are just along for the ride at that point.”

Theme 4: Significance of communication

Laws to protect confidentiality and the inherent communication restrictions throughout the litigation process create communication challenges.

Focus group participants reported communication as a significant component in the traumatic experience of second victim/health care adversity:

- And they tell you not to talk about it, so you don’t feel at liberty to talk about it, not even to your boss. And my friends became the litigation people up here, the people I could talk to.”

Providers described communication as a needed process for coping with the event:

- “The willingness of your team to listen to me was so important because I had no other avenues to tell.”
- “It is better to talk about it.”
- “Having more venues for whoever is involved in litigation to just be able to talk through. ...”

The impact of restricted communication:

- “I felt like I needed to tell everybody, but you can’t tell anybody that you are being accused, and it is so wrong and it is so frustrating. . . .”

A gender-specific need to communicate:

- “Women like to talk about their issues and their worries and it was like you can’t talk about this to anybody unless the lawyer is in the room. That was a total hassle because women talk through their issues when distressed and frustrated.”

Providers reported seeking an outlet to communicate:

- “You don’t want anyone to solve it; you just want somebody to listen.”

Finally, providers reported the importance of leadership communicating support for staff:

- “If leadership isn’t supportive and compassionate for your staff, if we don’t have empathy for them, how can they have empathy for the patient and take care of them? It is not OK just to say you need to grow some skin and get over it.”

DISCUSSION

When evaluating the traumatic experience of second victim/health care adversity and the effect on providers’ lives, we found that the traumatic impact outcomes are multifaceted. Emotional impact of the traumatic experience exhibited the greatest effect on providers. Guilt and shame typically are the primary feelings that should be recognized and addressed¹⁰, which are supported in the exemplar, “For me there was always a shade of shame or embarrassment.” Embedded in most liability litigation is a bad outcome, which, with or without actual medical error, profoundly affects physicians.¹⁰ Evaluation of the focus group data verified the acute stress response post unanticipated outcome/error, claim, or litigation^{11–13} with a resulting pervasively negative impact on providers’ lives both at home and professionally. Even with prior training in how best to support patients after unanticipated outcomes,¹⁴ providers reported a profound sense of having been changed by the experience.

The outcomes of the study suggest that implementing the Scott Three-Tiered Interventional Model of Support⁵ ensures that a health care system has support mechanisms for providers with multiple components and is valuable in handling second victim/health care adversity. Further, leadership communicating support during second victim/health care adversity is an important component for continued compassionate patient care. “Great leaders go to bat for their caregivers. They develop strategies, tactics, outcomes, and structures that enhance the ability to learn from catastrophic events to protect future patients and the rights of staff.”¹⁵ Communication being highly confi-

dential and protected¹⁶ through this type of program was reflected by the participants as well.

Second victim,^{1,5,11,16–21} medical error,^{2,11,22–29} and litigation stress^{6,7,12,26,9,30,31} are well documented in the literature. However, there is a gap in the literature regarding the specific trauma of a licensing board complaint. There is a significant impact on providers when a board complaint is filed and how that impact is different from unexpected outcome, claims, and litigation. One focus group member suggested a suicide screen following board complaint notification was warranted. There is a lack of research into the specific experience of providers facing board complaints, particularly in those states that have had tort reform and, as a result, have seen a sharp increase in number of regulatory board complaints.⁸ Furthermore, these data report a strong sense of having been caught up in an inescapable trajectory of events while experiencing health care adversities. Further research into the helplessness that providers feel and the relationship to burn-out and attrition of health care providers is warranted. Additionally, comparison of providers’ experience with board complaints to the second victim stages of recovery²³ and malpractice stress¹³ would be informative. The impact of comprehensive programs that support second victim, claims, litigation, and board complaints organized through risk management needs further investigation.

The psychological first aid provided by Swaddle peer support team members potentially decreases the risk of medical error in the provider’s medical practice through nervous system reregulation after an unanticipated event. The ongoing peer support provides a confidential means of verbally processing the event and its effects, thus reengaging providers’ inherent resilience. Peer support during board complaint, claims, and litigation is unique to the Swaddle program and is a foundational component in mediating the additional stress of these processes on providers. Limitations of this study are (1) a lack of diversity in the demographics of focus group participants, (2) the small number of focus group participants, and (3) the focus group participants experienced risk management staff support prior to the formalization of the program. As previously discussed, further investigation into the impact of similar programs that support second victims, claims, litigation, and board complaints organized through risk management is warranted.

Multidimensional program changes have been made as a result of the findings of this study. The Swaddle program has posted videos of physicians talking about deposition and second victim/health care adversity on their intranet web page. Up-to-date BSWH System information regarding risk management/legal coverage for claims, litigation, and board complaint is now available on the web page. Risk management team members who work with providers experiencing board complaint are encouraged to strongly suggest and further facilitate a peer support connection. To further support providers, a staff support counselor

is available for screening and referral purposes related to psychological crisis due to a board complaint. Paralegals and attorneys provide peer support program information at all initial meetings. Leadership groups from each of the 5 CTX regions have been briefed on psychological first aid and the importance of leadership response and provided “badge buddies” for ease of support referral.

The prevention, early intervention, and peer support focus of this program has been integrated successfully within 2 North Texas (NTX) test sites since the BSWH merger and is now being implemented at BSWH system-wide. Referrals to the program have broadened and include legal risk management team, self-referral, coworker referral, and leadership referral. Currently, there are 118 trained Swaddle peer support volunteers at BSWH comprising 6 teams in the CTX division and 3 teams in the NTX division.

Since the groundbreaking “second victim” article by Wu¹ in 2000, we have learned a great deal about the second victim response and are seeing growth in the number of health care systems building programs to support first victims (patients) and second victims (providers). How providers respond to litigation and its resulting stress is well documented.^{5,11,16} There has been great improvement in how health care systems can both prevent and respond to clinical error.³² The outcomes from this study are important as other health care systems continue to improve patient safety initiatives, assess the need for staff support programs, consider their options for building programming, and examine options for program expansion to include emotional support for providers during claims, litigation, and board complaint processes. Risk management teams should consider the benefits of building staff support program components and create best practices for providers affected by second victim/health care adversity.

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