Original Research Article

Second Victim: Health Managers' Perceptions

ABSTRACT

Introduction: The second victims are the healthcare professionals involved in an unexpected adverse event in patient care.
Aims: To apprehend the perception of healthcare managers regarding the assumptions related to the second victim and understand the strategies adopted by healthcare managers for the support and assistance of the second victim.
Study design: This is a qualitative research
Place and Duration of Study: It was conducted in a healthcare institution in the southeastern region of São Paulo, Brazil during two months.
Methodology: The 12 participants were managerial professionals of the institution who responded to a semi-structured interview. The information was analyzed according to Bardin's theoretical framework.
Results: The group of participants consists of managers with different levels of experience, contributing to a diversity of experiences in the field of work, with 83.33% having more than 10 years of professional training. The following categories were apprehended: Safety culture and professional practice, Management and the practice of support, and Healthcare managers and competencies in approaching the second victim. The study highlighted that the second victim management process depends on defining roles and proactive attitudes, involving managers and healthcare professionals, as well as preparing professionals to enhance patient safety and provide appropriate attention to the second victim.
Conclusions: The results suggest, based on the meanings that were apprehended, that the experience of being actors involved in patient safety and adverse events related to the second victim is still in its early stages, and there are paradigms to be shattered and different concepts to be reflected upon.

Keywords: second victim, health managers, adverse event, embracement.

1. INTRODUCTION

In the healthcare environment, there is an increasing concern with patient safety, which is understood as reducing the risk of unnecessary harm during health care to the minimum acceptable [1]. In recent years, several studies on the risks that patients are exposed to during healthcare have been carried out and patient safety has been identified as a public health challenge[2].

Managers working in healthcare institutions are fully aware of the facts that permeate the universe of healthcare errors, patient safety and their consequences, which lead them to understand that adverse events (AE) are inevitable, since human fallibility and the complexity of care are present in any healthcare environment. In this context, an alarming reality comes to light: the frequent occurrence of AEs in hospitals affects not only patients, but also the staff involved in health care.

According to Johnson and Smith (2018)[3], the act of making mistakes is inherent to the human condition and is linked to our ability to learn and evolve. In any case, AEs are a reality in professional practice, due to human nature and the complexity of care. However, the victims of the event go far beyond the patient. When an AE occurs, there is an indirect effect on healthcare professionals, who are considered "second victims" [4].

White (2015)[5] reports that many people are affected when an AE occurs, the patient, their family and the healthcare providers, the latter being the ones directly involved, which we call the "second victim".

This term has been little used, but it refers to the healthcare professional who experiences being involved in an error with harm to the patient and experiences some kind of emotional damage or suffering. In this sense, Quillivan (2016)[6] reiterates that if the second victim does not receive treatment, this experience can damage their emotional and physical health, subsequently compromising patient safety.

Its precursor was Albert Wu, who studied and continues to study the impact of safety problems on patients and healthcare professionals and coined this term in 2000. There is a survey reported with 1755 doctors that the majority had been involved in a serious safety event and admitted to having experienced the effects of being a second victim, effects such as: sadness, depression, insecurity, insomnia and others [7].

The Institute for Safe Medication Practices Canada (ISMP) reports that there is an approach determined by health institutions, which aims to provide care to patients and professionals involved in the critical incident, the second victim who experiences trauma as a result of the incident, an act distinct from intentional misconduct. But, in fact, do healthcare institutions carefully and sensitively observe the legal provisions and make it possible to accommodate the second victim?

The aim of this study was therefore to understand the perception of health managers about the second victim and to understand the strategies adopted by health managers to support and welcome the second victim.

Methods

Comment [A1]: What approach (peer check, extra check,...) has been used to increase the rigor of the study?

This is a descriptive exploratory study with a qualitative approach, which considers that there is a dynamic relationship between the real world and the subject, that is, an inseparable link between the objective world and the subjectivity of the subject that cannot be translated into numbers.

The research was carried out in a highly complex healthcare institution in the southeast of São Paulo, Brazil, with a quality and senior management office team and an active Patient Safety Center. Prior to carrying out the research, the project was submitted to a Research Ethics Committee (CEP), in accordance with

Resolution 466/12 of the National Health Council [8] and only after obtaining a favorable opinion, under No. 59282222.9.0000.5580, were the research data collected.

The participants in this research were chosen for convenience, and were the institution's professional managers: executive director, technical director, clinical director, patient safety centre coordinator, nursing coordinators and supervisors, with a total of 12 professionals, who were personally invited to participate and all accepted. The semi-structured interviews were carried out in the healthcare institution itself, at a time determined by the professionals, who were identified as G1, G2 sequentially, and were audio-recorded and later transcribed, which were returned to the participants for permission and acceptance of the content. During the interviews, which lasted around thirty minutes, the researcher used a field diary to record facts, gestures and meanings. The three stages according to Bardin (2006)[9] were used to analyze the qualitative information.

We emphasize that the study design was guided by the Eight Big Tent Criteria for excellence in qualitative research [10] and also the COREQ qualitative research checklist[11].

RESULTS AND DISCUSSION

Comment [A2]: It is better to use the table to express the category and subcategory.

Of the 12 health managers who took part, five were male and seven female. With regard to length of professional training, two had worked for between six and nine years and 10 had worked for more than 10 years. As for their experience in the job, 11 had worked in the job for between one and five years, and one had worked in the job for between six and nine years.

The data shows that this is a group of participants made up of health managers with varying lengths of experience in the job, so they have different experiences in the field. With regard to the length of professional training, 10 of the participants have been trained for more than 10 years, representing 83.33%, and with regard to the length of time they have worked in the position, 91.66%, 11 of the participants, have between one and five years' experience as a manager.

The analysis of the information followed the stages proposed by Bardin (2011)[9], starting with pre-analysis, considered the first stage to establish contact with the documents to be analyzed and to get to know the text, allowing impressions and orientations to invade, making the target of the reading clearer to the conscience.

At this stage, the importance of starting to articulate with the study's theoretical framework, dialog with the authors in a still reflective way, the pertinence of the expressions, direction in relation to the study's objectives, relevance of the answers obtained and signs of the categories that can be inferred from the text as a whole were observed.

At this stage, the researcher gets to know the text in greater breadth, extracting essences and meanings from what has been investigated, taking into account the research questions: What is the perception of health managers on the subject of the second victim? What is the role of health managers in strategies related to the second victim?

In this sense, the breakdown into categories and subcategories, highlighting the units of record and, from these, the units of meaning is the moment when the researcher moves towards a global apprehension of

the text, always with the question to be unveiled as the driving force. This social encounter contributed to the spontaneous conduction of each manager participant's thinking, acting and being, how they perceive and experience practice in everyday life when faced with professional events during healthcare.

The second stage of the thematic content analysis proposed by Bardin (2011)[9], in which after reading and re-reading the discourses, we began categorization, which means classifying the constituent elements of a set by differentiation and regrouping.

Categorization began by defining the category 'Second victim: Health managers', from which three subcategories were identified:

1- Safety culture and professional practice,

2- Management and practice of reception and health managers and

3- Competencies in the approach to the second victim, which are detailed below.

SUBCATEGORY 1: Safety culture and professional practice.

The subcategory Safety culture and professional practice is broken down into a Meaning Unit called Health professional competence in patient safety. It emerged in the description in which the participants pointed out the lack of knowledge, culture and attention of health professionals in relation to the second victim and patient safety.

When asked about the subject of second victims, the participants described:

> *It's actually quite a complicated issue. It's from the point of view of what it's going to generate, what the circumstances are, what the causes of that event are, what that notification is going to generate, we don't have a culture, it's not our culture, at least here I see it in our region, it's notification, we always end up seeing notification as something that's not to help the process, but sometimes to hinder the process of how it happens. First, we'd have to work on this cultural issue, right, to make professionals understand that when an event is notified, we need to take action to improve it, so that we can make sure that it doesn't happen again [...] (G3).*
>
> *I think it's a bit complex on both sides. Because when there is an error on the employee's side, there are factors that cause these errors to start. For example, nobody makes mistakes because they want to, sometimes they make mistakes because of a lack of knowledge [...] (G2).*

These statements illustrate problems related to the lack of a patient safety culture, emphasizing that professionals need to understand how processes occur, and that factors such as lack of knowledge would be a trigger for errors, demonstrating that the conceptual basis for this subject is still little explored by healthcare professionals and managers.

Matiello (2016)[12] states that the International Classification of Patient Safety (ICPS) categorizes patient safety as the act of improving, avoiding or preventing adverse events or errors as a result of healthcare. Establishing the assumptions of safety in health services on a daily basis is a cultural process, promoting increased awareness among professionals of safety behavior.

Participant G3 emphasizes the importance of professionals understanding that reporting the event promotes improvements and not the exposure of professionals in a negative way, showing that the concept of patient safety and the second victim need to be discussed and reflected on in a broad manner in the short and long term.

In the light of the speeches mentioned above, it is clear that health managers and professionals need to act competently in situations involving patient safety and second victims, and that for this to happen, individuals need to know what needs to be done, how to do it and want to do it. Competence can only be attested to by observing an individual's behavior in a given situation, and the participants' reports highlight the importance of this concept.

SUBCATEGORY 2: Reception Management and Practice

The subcategory 'Management and Practice of Welcoming' emerged from the testimonies, which were broken down into two Meaning Units: Experience in welcoming health professionals allied to management and Essentialities for welcoming.

The Unit of Meaning 'Experience in welcoming health professionals allied to management' was established by individual reflections, in which the participants expressed their meanings and opinions, referring either to the problems faced or to the flaws in the process during the event.

The experience of welcoming health professionals allied to management is referred to as a problem of approximation, and with a view to the human dimension involving ethical aspects, so that health professionals and management are aligned in their role in relation to the event that occurred and to conscious and humanized responsibility, so that all those involved comply with the stages of the processes in a structured and organized manner. The following quote from one of the participants illustrates this situation:

> *[...] I think we have to try to bring their problems closer. To try to solve some of them, trying to see if they have advanced vacation, if the problem is burnout. Family problems, trying to see what's the best way for him to solve these family problems, because we can't go into the merits of his family either, but when it comes to the service, we have to start looking at what's the best way for him, whether it's changing hours or changing shifts. To see what will be easiest to ease this situation he's going through. (G1).*
>
> *With regard to this question, I think we have to look at the more human side, if he is a competent professional, a professional who helps, a professional who is committed. If there has been a slip-up, you also have to look at the emotional side to see what's going on. Suddenly there's a lot going on in his life that he doesn't get out (G12).*

In many cases, health professionals end up being sidelined most of the time by managers who focus only on being able to comply with the processes established for technical purposes, without taking into account the basis of communication synchronized with the context and reality experienced by the second victim, which will have significant consequences for their physical, mental and social well-being.

One of the relevant points to be described in relation to the participant's speech is the need to deal with problems by looking at a broader dimension of the human being, in different aspects of their life.

In this sense, the absence of human dimensions among health professionals and managers means neglecting knowledge of the human sciences, compromising the whole process of building a welcoming environment in health institutions, and specifically in processes related to patient and second victim safety.

In the speeches below we can see the deficit and lack of strategies in the welcoming process, and the preoccupation with the technique of the processes, emanating from a culture in which the importance of the different human aspects is reduced, and which will have an impact on all the parties involved.

> *First of all, we'd have to work on this cultural issue, right, to make professionals understand that when an event is notified, it's so that we can take action to improve, so that we can make sure that it doesn't happen again in the future. I can also tell you personally that I don't feel comfortable, or rather, in relation to notification, I'm from the same culture as most people here in the region, who think it's something more for the purpose of wanting to harm, rather than wanting to help, when in fact that's not really the intention of this notification. (G3).*
>
> *I've noticed that sometimes health professionals and managers can be as much victims as the first victim, which is why we have to raise all the points in order to discover the fault. (G12).*
>
> *Well, I think that the first thing, just like the name, is, as you've already said, welcoming, right, but I think that welcoming should be anticipated. It should be before the event takes place. [...] I think that if we had a work talk with the employee, at least every 3 months, I think it would prevent it, if we had a psychological follow-up of the employee for about 3 months, at least a work talk, simple and objective, but with this talk, I think it would prevent a lot of things. (G2).*

According to the Ministry of Health (2010)[13], welcoming is the act or effect of welcoming and expresses, in its various definitions, an approaching action, a "being with" and a "being close to", in other words, an attitude of inclusion. This attitude implies, in turn, being in a relationship with something or someone. It is precisely in this sense, of "being with" or "being close to", that we want to affirm welcoming as one of the most ethically/aesthetically/politically relevant guidelines of the National Humanization Policy of the SUS.

Considering the speeches of the participants, it is possible to see that the experiences of health managers require different knowledge and strategies in relation to those involved. An attentive look at the human being, ethics and difficulties helps to rescue the good practices of welcoming and the organizational structure of the processes developed by managers.

The 'Essentialities for welcoming' unit of meaning is established from the set of responses to the interviews, and the essentialities pointed out by the participants were: communication, development of strategies and evaluation.

In this sense, we can see that welcoming has fundamental elements that are part of the process of building a new health practice, aiming to find the best way to bring individuals closer together in order to recognize their differences.

The speeches below show some of the elements considered essential by the participants:

> *I first find out what happened to the patient and then to the employee. And with regard to the employee, I take them in, see what happens, if they have any problems, refer them to HR, in short, a good specialized professional. Then, depending on the type of event that happened. (G2).*
>
> *I think the context itself is to listen to the employee and devise strategies so that these events are increasingly minimized. (G4).*
>
> *Encouraging the employee to participate in reporting the error, participating in the solution and listening to what caused the error. (G10).*
>
> *First and foremost, not pointing the finger of blame, welcoming the professionals being assessed and raising the factors in the most humanized way possible. (G12).*

Among the elements covered in the speeches, it can be seen that the essentialities are allied to a set of important skills involving communication, evaluation and performance, so that the professional can provide good quality and effective care.

It can be seen that the essentials for welcoming the second victim reveal the importance of effective communication, so that the processes take place synchronously and involve all management and leadership.

The communication should be thought out and executed in an integrated way between the spheres that make it up, namely institutional communication, marketing communication, internal communication and administrative communication[14].

Like communication, evaluation is part of the elements integrated into the processes taking place within the institution. With communication, there is a reflection on the information transmitted, which will then be evaluated for action planning.

Iin order to understand the measured data and promote a well-founded evaluation, it is necessary to take into account the organizational environment in which communication is inserted. For the author, without a prior environmental analysis, communication managers run the risk of starting from mistaken assumptions, which would consequently result in incoherent evaluations[15].

Strategies must be created and included in the reception of the second victim, there is a need for health managers to be prepared and trained, so that everyone is able to articulate, plan and implement actions in the face of the demands that arise on a daily basis, with a view to articulating actions of reception for the second victim.

SUBCATEGORY 3: Reception Management and Practice

The Unit of Significance Institutional support for the second victim was established by the reflections during the interview, in which the participants expressed their meanings and opinions, referring either to the lack of direction to a specific location, or to institutional support for the second victim during the event.

Institutional support is indispensable and fundamental for supporting the second victim, as the managing professional needs to provide direction for the health professional, which, if not done in a humane and organized manner, will have an impact on their personal and professional lives and processes during the event, both in the short and long term. This is evident in the following speeches, such as the need for a team and a suitable location for this support and approach.

> *Today, in our institution, we don't have a reception area for this professional, for a second victim. (G8).*
>
> *At the moment, our service doesn't have a specific place or professional to do this (G9).*
>
> *Unfortunately, there is no reception flow. The staff justify themselves around the office or call in privately for a chat. (G9)*.

It is essential to recognize the extent to which the phenomenon of the second victim has affected these professionals, psychologically, physically and professionally; generating an organizational awareness of the problem. When offering support to this second victim, it is necessary for the leaders and the organization itself to assess the quality of this support, as well as what they have learned from this experience[16].

In this sense, we can see the importance of the role of institutions for both management and health professionals, who need a well-organized and defined structure during the occurrence of adverse events.

Learning from experience enhances the quality of support for the second victim, but when protocols are poorly defined and emphasize technical processes, there is a repetitive and fragile dismemberment of the event's procedural routine, which is often due to a lack of institutional incentive for managers to support the search for and creation of dynamic and systematized protocols.

In the speeches below, we can see the participants associating corporatism with a lack of safety culture, and the delay in getting institutional feedback on the issues and problems already identified by health professionals.

> *It's the biggest challenge we have here at the institution, we work in a Social Organization and some actions within the OSS that need to be taken corporately, as much as we identify this issue, the importance of talking about second victims, we don't have a consolidated culture of strategies in the unit, in this social organization. (G7).*
>
> *They investigate the incident, but they don't tell us what the outcome of the investigation was. I think it's really important to have this center there. This exclusive outpatient clinic just for employees, not just for this problem, but for other problems they might have in their day-to-day work. (G3).*

Prospectively, institutions have an obligation to invest adequate resources in creating a culture of safety, fundamentally in human resources that ensure the correct development of care processes, without forgetting investments in improving structures and facilities [17]. With hindsight, if damage does occur, a culture of safety means that institutions must handle information correctly and well. This will be transparent and standardized, and will be used not only to repair the damage to the person, but also to provide moral support to

professionals. And, of course, to launch deliberative spaces and processes where the risk is analyzed and safer proposals are made, with the participation of everyone involved.

In the speeches of the participants below, we can clearly see the lack of institutional support for managers and health professionals, in fact supporting that the identification of the roles of each actor in decision-making is vague and ineffective for the continuity of the processes and events involved in patient safety.

> *Yes, it usually is. When an employee is involved in an adverse event, they go to their immediate manager, but that's within the institution. Today we don't have a team with this specific job, of welcoming, listening, treating, and today it's this strategy within the institution. Not yet, we don't have one in the institution (G4, D28).*
>
> *Yes, unfortunately today we have no center, no team that welcomes this type of employee. The first person they go to, when they do, is the nurse, the direct leader, or the supervisor. That's when they're notified, when they're not notified they get scared, apprehensive and end up not saying anything. This isn't good, it's bad for the institution, for the professional and also for the patient (G2).*

Institutional support plays an indispensable role in the emotional, physical and professional structuring of employees as part of the process of implementing a culture of safety in healthcare institutions, in order to minimize the risks and damage generated during and after adverse events when the healthcare professional becomes the second victim.

In one study carried out in Brazil there are no programs that offer support for this situation. The punitive and toxic culture in healthcare organizations is usually validated, as can be seen in the speeches. The manager knows about the problem, but is inert and excludes himself from the situation, leaving the burden to the protocols, to the Organization that maintains the institution, freeing himself from the leadership role and assertive initiative that comes with the management position [18].

Although the group of managers has been in the profession for a long time, there is no evidence that their professional maturity has kept pace with the subject. There is still a certain less human and more administrative look when it comes to the second victim. The discourse is a mixture of practice and theory, unfortunately demonstrating a major step backwards in personnel resource management.

We still have to think about the lack of organizational structure on the subject. Although some - little - knowledge of the subject has been demonstrated, as managers there is no initiative to seek out and build protocols to guide the day-to-day care of the second victim.

conclusion

The results indicate, through the meanings apprehended in the speeches, the experience lived as actors involved in patient safety and adverse events related to the second victim, and that there are paradigms to be overturned and distinct concepts to be reflected on, whether in management or as a health professional.

Welcoming the second victim in the institution requires the interconnection of essentialities and skills, strengthening the links between the employee/institution and management/health professionals. It is essential that employees are fully supported by institutions, which seek the humanized improvement of their staff and the humanized provision of health care.

There are few studies in the literature on the subject of the second victim, especially when it comes to management and institutional support for the professionals involved, and this fact prevented us from delving deeper to provide greater theoretical support. This is a real limitation of this study.

The management of the second victim process is intrinsically linked to understanding the role of managers, requiring strategies that involve training, encouraging dialogues and other dynamic measures that cover different dimensions, such as the human and ethical dimensions.

Considering the complexity of adverse events, where the practice of prevention is actively promoted in healthcare establishments, trauma and damage suffered by the second victim can also be avoided by developing a well-defined "culture of safety" and implementing it early, in compliance with current legislation, even before the events occur.

Reflecting on managers' perceptions of the second victim provides opportunities to explore new paths, break paradigms and involve specific groups in the search for innovative approaches to patient safety.

Within the scope of this study, by analyzing the strategies adopted by healthcare managers in relation to supporting and welcoming the second victim, it was possible to recognize the need to implement such strategies as a way of improving the safety culture and providing support to the professionals involved. However, the lack of strategies is recurrent in the institutions. Among the participants, it was noted that the managers and the institution do not have effective protocols, a place or specific support groups to welcome the second victim.

There was a gap in their knowledge of the subject, which has an impact on their conduct and management practices, because when they are faced with the challenges related to the second victim, they do not feel prepared, and it is only through daily experience that they have tried to deal with these situations.

Professional work in this area certainly involves management. However, propositional reflection needs to be systematically developed, with concepts focused on humanized management, management by results and high-level skills where communication, welcoming, evaluation, pausing in action to think better, reflection on action, problem definition, problem solving, are aspects that should permeate the quality of the duties assigned in "doing" health.

In addition, the institution should prepare its managers and senior management professionals to be welcoming, through continuing education. Not only should the physical structure be able to accommodate the second victim, but all the human and ethical assumptions that support the professional at this time.

The study allowed the participants to express their ideas and experiences, which resulted in discussion about the role of health managers, their potential, weaknesses and need for constant improvement.

In short, this study on the second victim enabled the multiplication of knowledge, the interconnection of daily experiences and helped in the discussion of difficulties, pains, facilities, expectations sand the constant search for professional identity and the role of managers.

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