



Peer support in anesthesia: turning war stories into wellness

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Purpose of review

Peer support, a method of providing for the well being of healthcare providers following adverse or stressful events, is garnering increased attention in light of the increased prevalence and awareness of burnout, depression and suicidality in physicians. In this review, we will summarize the evolution of the 'second victim,' explore methods of support and examine how new regulatory requirements are changing the peer support landscape.

Recent findings

As peer support and the second victim are investigated more, themes are emerging regarding the natural history of recovery. As these are delineated, more targeted peer support models are being developed. One major change in 2017 is the institution of new Accreditation Council for Graduate Medical Education's Common Program Requirements, now including topics targeted on well being.

Summary

Effective and accessible peer support is developing in many departments nationwide and can only be expected to continue, given new regulatory requirements. As these programs develop, and research on their effect continues, best practices will likely emerge.

Keywords

medically induced trauma, peer support, second victim, self-compassion, well being/wellness

INTRODUCTION

It has been said that the difference between a fairy tale and a war story is that fairy tales begin: 'a long time ago in a land far, far away' and war stories begin: 'no kidding, there I was!' Without minimizing the trauma experienced by those experiencing actual military conflict, this reflection highlights the narrative power of the first person – the importance of recounting one's own experience to another person who inherently understands. It seems universal that whenever those in roles of great stress (e.g. medical, military, humanitarian) gather together, stories often flow, often even when far away from those sources of stress. Stories are powerful, and how they are received may encourage growth and healing [1].

A 'peer' is defined as 'one that is of equal standing with another.' 'Support' is more complex. 'Support' is a transitive verb and has several component definitions including a wide range of valuable actions. A supporter bears burdens, advocates, assists, corroborates, maintains, and comforts [2] (Table 1). A peer supporter is one who does all these things, while having a first-hand understanding of the difficult situation. In an era of mounting

physician burnout, peer support is enjoying increased research and interventional interest.

In this review, we will summarize the advances and innovations in peer support over the past 2 years. Specifically, we will review the evolution of the concept of the second victim, explore specific models and methods of deploying peer support, and examine the potential impact of more recent regulatory attempts to mandate wellness interventions, including peer support.

EVOLUTION OF THE 'SECOND VICTIM'

No productive discussion on peer support can be endeavored without first addressing the concept of

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Curr Opin Anesthesiol 2018, 31:000–000

DOI:10.1097/ACO.0000000000000591

KEY POINTS

- Peer support is an active measure taken to provide for the well being of second victims (healthcare providers who are personally impacted by adverse clinical outcomes).
- Regulatory requirements related to well being (including peer support) were released in 2017 impacting all departments with ACGME-accredited trainees.
- Innovative models of peer support are being deployed and investigated in a range of settings. As research continues, best practices are likely to emerge.
- Examining and delineating the 'natural history' of recovery for second victims is occurring and may yield guidance for more effective peer support models.

the second victim. This term was first used by Wu [3] in a 2000 editorial, wherein he defines the 'second victims' as those healthcare professionals (HCP) who are 'wounded by the same errors' as the patients who are harmed. The prevalence of second victims is between 10.4 and 43.3% [4].

In 2016, Scott *et al.* reported 9 years of experience addressing the second victim phenomenon through the University of Missouri Healthcare's forYOU program. Despite individual differences, they describe the following universal 'stages' of recovery following an adverse event: 'Chaos and accident response,' 'Intrusive reflections,' 'Restoring personal integrity,' 'Enduring the inquisition,' 'Obtaining emotional first aid,' and 'Moving on,' at which point clinicians will either drop out of practice, thrive, or merely survive [5[■]] (Table 2)

Table 1. Definitions of peer and support

| |
|--|
| Definition of peer |
| Noun |
| 1: one that is of equal standing with another: equal |
| Definition of support |
| Transitive verb |
| 1: to endure bravely or quietly: bear |
| 2a (1): to promote the interests or cause of |
| (2): to uphold or defend as valid or right: advocate |
| b (1): assist, help |
| c: to provide with substantiation: corroborate |
| 3a: to pay the costs of: maintain |
| b: to provide a basis for the existence or subsistence of |
| 4a: to hold up or serve as a foundation or prop for |
| 5: to keep from fainting, yielding, or losing courage: comfort |
| 6: to keep (something) going |

Data from [2].

Van Gerven *et al.* sought to clarify which HCPs, situations, and organizational factors are more likely to elicit a second victim response. They found stronger responses with more severe events, whenever one felt personal responsibility and amongst female HCPs. Those HCPs who demonstrate greater optimism experienced less negative impact. The impact was reduced by a 'support culture' and 'rendered support' and worsened in a 'blame culture.' They did not find an association with personal resilience or with having a second victim support team [6[■]].

Vinson *et al.* [7[■]] in a study of interest in wellness topics amongst academic anesthesiology department chairs, found that, of 22 wellness related topics, 'support after adverse events' ranked second and 'peer support' ranked sixth in interest. In fact, the topic is of such great import, that one institution has developed a tool for organizations to use to determine the strength of peer support available after adverse events: Second Victim Experience and Support Tool (SVEST). They found that, after adverse events, the resource most desired by a second victim was 'A respected peer to discuss the details of what happened' [8[■]]. Coughlan *et al.* [9[■]] similarly looked at the institutional response to adverse events and, in a review, determined that a supportive culture and a culture of learning allowed for enhanced disclosure of and recovery from medical errors and adverse events.

Despite interventions, the toll remains demonstrably high. In a study of Boston area surgeons, following an intraoperative adverse event, 84% of respondents described an array of negative emotional responses, including anxiety, guilt and sadness. Notably, the most helpful support system cited was peer support in the form of colleagues [10[■]].

As the concept of the second victim has evolved, so has the proposed terminology. In 2017, Wu and colleagues published a discussion exploring the terminology for the clinicians involved in adverse event as well as the positives and negatives for the more prevalent terms. The term most widely used is 'second victim,' but this has met with resistance from patient advocacy groups out of a concern for deemphasizing the pain and experience of the patient and family. There is also concern that it is a passive term and may stigmatize involved clinicians. However, the impact of the clinician's experience is real and documented and use of 'second victim' is now widely recognized and may denote an urgency needed for an advocacy and legislative agenda. Other terms, such as 'medically induced trauma,' are likely more precise, but may lack the gravitas required to affect change [11[■]].

Table 2. Second victim recovery stages

| Stage | Impact realization (individual may experience one or more of these stages simultaneously) | | | | Moving on (individual migrates toward one of three paths) | | | |
|-------------------------------------|---|---|---|--|---|--|--|--|
| | Chaos and accident response | Intrusive reflections | Restoring personal integrity | Enduring the inquisition | Obtaining emotional first aid | Dropping out | Surviving | Thriving |
| Stage descriptors | Point of impact is equal to event recognized/error realized | Evaluate clinical events that have transpired | Fears rejection among work/social structure | Realization of event severity | Identify who is safe to confide in | Feelings of inadequacy and failure | Coping with what has transpired | Does not base practice/work on one event |
| | Stabilize offering immediate supportive care for patient | Self-isolation to reflect on the case and care delivered | Fear of the unknown (next steps) is prevalent | Reiterate scenario | Attempting personal/professional support | Leave current role by transferring to different facility or unit | Persistent sadness prevails | Minimal adverse effect from event |
| | May or may not be able to continue providing care for this patient | Haunted reenactments of event and feelings of self-doubt | Struggling to get back to 'baseline' level of professional skill confidence | Interact with event responders (many strangers) | May 'hint and hope' for support from various sources | Consider quitting profession altogether | Trying to learn from event | Advocates for patient safety initiatives |
| | Clinician commonly distracted | Shock and denial | | | | | Assist in defense of legal action | Advocates for patient safety initiatives |
| | | | | | | | | Tries to make a difference for the next patient or clinician |
| Second victim's personal goals | Recognize event occurred | Conceptualize and understand what has transpired | Restore personal/professional credibility among peers and supervisors | Provide effective accounts of the event | Identify a safe zone to communicate feelings regarding the event | Determine future professional role | Identify ways to cope from impact of the event | Identify ways to process the event and make a positive impact on future events |
| Institutional supportive objectives | Identify potential second victims | Identify key individuals involved in the event | Provide oversight of event and manage overall response including gossip control | Start to collect all details of what happened from key event participants | Ensure that optimal emotional support is offered | Provide ongoing support of the second-victim | Provide ongoing support of the second victim | Provide ongoing support of the second victim |
| | Assess staff (s)' ability to continue shift | Formalize a second victim response plan | Evaluate if a team debrief would be beneficial | Develop understanding of what happened and begin formulating the 'why' did it happen and could it be prevented | Assure risk management and patient safety resources are available as needed | Dialogue | Support second victim in how to make a difference for future events | Support second victim in how to make a difference for future events |
| | Determine if second victim support is needed | Observe staff for lingering physical or psychological symptoms | | Document event investigation according to institution policies | | If needed, assist the second victim in search for alternative employment options | including mentoring others in similar situations | including mentoring others in similar situations |
| Risk management interventions | Gather information and start preclaim file | Talk to staff involved and allow venting of concerns | Contact with the staff discussing event and status of investigation | Discuss case details with staff to preserve information for risk management/legal use | Answer questions about investigations or litigation process, what to expect, and assistance available | Supporting and working with staff on the defense of the legal action | Supporting and working with staff on the defense of the legal action | Supporting and working with staff on the defense of the legal action |
| | | Encouraging staff not to allow event to change good practice techniques | Provide information to legal counsel and insurance | Assurance to patient/family, work with billing issues as needed | Discuss personal and family counseling options inside and outside the organization | Working with internal and/or external attorneys | Working with internal and/or external attorneys | Working with internal and/or external attorneys |
| | | | | Assurance to staff of support during all phases of investigation and anxiety | | | | |

Reproduced from [5].

METHODS AND MODELS OF SUPPORT

Social support is key for posttraumatic growth

In 2001, to address the adverse effect of war-time experiences on soldiers' psychological health, the Operational Stress Injury (OSI) Social Support program was created. Research on this innovative program confirmed the effectiveness of peer support. Typically, 25% of soldiers with posttraumatic stress would not seek help. Yet, with peer support, it has decreased the social stigma of seeking help and shortens the time for obtaining mental health. This intervention enhances return of soldiers to duty and saves money in training new personnel: however, most importantly, enhances the dignity and respect of the soldier [12].

Organized peer support models and lessons learned

In 1992, the Norwegian Medical Association established a peer support program that offers empathy, support, advice and counseling for doctors. This is a service initiated by a doctor 'under strain from professional or personal issues.' An appointment is provided within 48 h and the doctor may have up to three sessions. Following years of such service, this article examines the various counseling roles – both formal and informal – and highlights the need for balance between the two [13].

In 1999, following a life-threatening adverse event herself, a patient created an organization called Medically Induced Trauma Support Services (MITTS) for physicians, patients and their families. The goal is to increase awareness and provide a toolkit for shortening the recovery and healing process from the impact of an adverse medical event. Core beliefs are that errors will occur and will impact those involved (HCPs, patients and families) dramatically [14,15].

In an effort to establish the severity of the second victim phenomenon, Edrees and Wu used semistructured interviews to query patient safety representatives at acute care hospitals in Maryland. With an 83% response rate, they all felt that organizational support should be offered. They also noted that, in root cause analysis, they discovered stigma remained a barrier to speaking up and seeking help [16].

Recent innovations in peer support

At the University of Missouri Healthcare, members of the Risk management and the Patient Safety committee partnered, researched and developed a structured formal peer support program. First

published in 2010, their peer support rapid response team was at the vanguard and they report their experience spanning several subsequent years. They identify and intervene according to one of the six stages, the second victim is experiencing. Their goal is to intervene and offer 'just-in-time' support and promote healthy recovery [5,17].

More recently, Johns Hopkins Hospital developed the Resilience in Stressful Events (RISE) program to support HCPs following adverse patient events. In this mixed method study, they demonstrated that most staff had experienced adverse events and were amenable to peer support. The authors described the evolution of the program, including overcoming barriers of awareness and the introduction of group support [16,18].

A small pilot study of residents at Columbia University demonstrated in initial data (published as an editorial) that utilizing the READ-SG (Reflect, Empathize, Analyze and Discuss in Small Groups) protocol showed promise in reducing resident burnout [19]. At the University of Saskatchewan, in response to the growing importance of wellness in combatting burnout, depression and suicide, an Anesthesiology Residency Wellness Program curriculum was developed and published for the edification of other departments. The curriculum contains four components: 'modular curriculum, peer support curriculum, self-directed learning activities, [and] department wellness program' [20].

Another interesting approach has been improving awareness of the issue of the second victim. In Spain, researchers developed an online program: 'Mitigating Impact in Second Victims' (MISE), which underwent rigorous accreditation and evaluation as a healthcare website and achieved high-quality marks by objective reviewers. They demonstrated improved knowledge of end users on 'patient safety terminology, prevalence and impact of adverse events and clinical errors, second-victim support models, and recommended actions following a severe adverse event [21].'

One highly publicized and creative innovation has been the 'code lavender,' which seeks to 'increase acts of kindness after stressful workplace events' in an attempt to cultivate and preserve empathy and decrease burnout. Following stressful events, HCPs can activate a 'code lavender' and be provided with a kit including 'words of comfort, chocolate, lavender essential oil, and employee health referral information.' In their pilot, all of those activating a code lavender felt it was helpful and most (84%) would recommend it. Although they did not show improvements in Professional Quality of Life Scales, the participants did statistically feel cared for [22].

Practices for the peer and peer supporter

Contemplative practice is a form of training the brain that cultivates self-awareness, self-regulation and or self-inquiry to enact a process of shifting from distress to eustress. These practices essentially down-regulate our sympathetic system while activating the parasympathetic system. Different modes of contemplative practice target different psychological processes, such as, enhanced attention, cultivated equanimity, compassion, self-understanding and insight, and meta-awareness [23[¶]].

It is important to have self-compassion for oneself in order to extend it to others. High self-compassion is associated with psychological well being and adaptability. It is a capacity that can be cultivated; however, it involves recognizing and balancing three interactive forces. They are:

- (1) Self-judgment versus self-kindness
- (2) Isolation versus recognizing our common humanity
- (3) Over-identifying with the situation versus mindfulness

Neff and Germer [24] demonstrated with a randomized controlled trial of the Mindful Self-Compassion 8 week program that well being, mindfulness and self-compassion was maintained at 6 months and 1-year follow-ups.

REGULATORY IMPACT ON PEER SUPPORT

Self-effacement is a common and commended trait of physicians and most enter medicine, at least partially, with altruistic intentions. These two traits provide the context for a physician who will place the needs of others ahead of their own, which is generally appropriate. However, there exist situations, such as perioperative catastrophes, wherever emotional trauma can create a state of impairment for the second victim clinician. In 2009, Scott *et al.* [25] described the ‘natural history’ of recovery following a major adverse event, which encompasses a wide range of physical and emotional sequelae.

Although not engaging in clinical care while impaired seems a basic professional tenant, many continue to work following emotional trauma, even whenever relief is available. One of the reasons, regulations are important in the realm of wellness and support is that they impart care for the vulnerable clinician, even when self-care is not actively sought.

In July 2017, the Accreditation Council for Graduate Medical Education (ACGME) revised their Common Program Requirements (the regulations

applicable to all ACGME-approved training programs, regardless of specialty). Of particular note, is a new section (VI.C.) pertaining to ‘Well Being,’ which is in response to a growing knowledge of the impact and prevalence of burnout and depression and in recognition of the notable stressors of the physician profession. Particularly, section VI.C.1.(e).(3) states ‘The program, in partnership with its Sponsoring Institution must provide access to confidential, affordable mental health assessment, counseling and treatment, including access to urgent and emergent care 24 h a day, 7 days a week.’ In addition to giving well being parity with other competencies, the policy acknowledges that ‘self care is an important component of professionalism’ and that it is a skill that can be taught and fostered [26^{¶¶}].

In an effort to characterize the current status of peer support in medicine, White *et al.* [27] queried US members of the American Society for Healthcare Risk Managers and, in addition to describing many of the programs cited in this article, reinforced the responsibility of hospitals to provide peer support following adverse outcomes because of the often-profound negative experiences of second victims. In their article ‘Well being in graduate medical education: A call for action,’ Ripp *et al.* argue that it is the responsibility of the hospital to provide peer support for residents after adverse events and emotionally charged situations. They also argue that providing such peer support as part of an evidence-based ‘menu’ of interventions promotes positive culture change at the organizational level [28[¶]].

CONCLUSION

Peer support models have been proven effective in improving care and support of second victims. Novel approaches have evolved to meet the specific situations and resource availability of individual departments and groups. With the advent of more stringent ACGME requirements for attending to the well being of not only trainees, but staff, these initiatives will at first be compelled, and then expected of graduates. As these new graduates generationally replace the work force, peer support will become the norm – this is inevitable. The challenge at hand is accelerating this process to help the clinicians of today meet the demands of the present.

Acknowledgements

I (AEV) would like to thank Dr. Robert Holzman for the thought provoking conversations comparing fairy tales and war stories that are referenced in the opening of this article.

Financial support and sponsorship

This work was supported in the form of academic time by the Department of Anesthesiology, Critical Care and Pain Medicine, Harvard Medical School & Boston Children's Hospital (Boston, Massachusetts) and the Department of Anesthesiology, Northwestern University (Chicago, Illinois).

Conflicts of interest

There are no conflicts of interest.

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- of outstanding interest

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