Second Victim Syndrome: The Emotions Related to Complications and Perfectionism in Medicine

By Michael Baron, MD, MPH, DFASAM, FAPA

The practice of medicine is a profession, an art, and personal to both the physician and patient. Nowhere is that more evident than when there is an adverse event or patient complication.

“It’s not personal… it’s strictly business,” is a famous line from the movie, *The Godfather*, commonly used to indicate that an action is based on practical or financial considerations rather than emotion. In reality, devaluing the practice of medicine to “strictly business” can

be seen as a defensive posture against the complex challenges of patient care. Physicians are not robots, we have emotions. When a patient complication occurs, those emotions emerge and the situation becomes personal for all parties involved.

Patient complications challenge the physician's perfectionism and erodes their confidence. We are taught and programmed to exceed excellence and be perfect. This unachievable feat further handicaps the physician. Psychiatrist Glen Gabbard famously described perfectionism as a malady among colleagues, stating, "Society's meat is the physician's poison."[1] While demanded by patients and sought by clinicians, perfectionism is not a human condition, and therefore it is not attainable.

The only thing worse than a patient complication is a malpractice lawsuit stemming from a patient complication. Reading about ourselves in a legal document that uses terms like negligence, failure to diagnose, failure to treat, causation, duty of care, breach of duty, and punitive damages makes us cringe. This is very much like pouring salt into an open wound.

When a patient suffers a complication, an adverse event, or an untimely death, everyone involved is affected, including the patient, their family, and their health care providers. The patient and their family are the first victims; the physician becomes the "Second Victim." The healthcare organization will provide support for the patient and their family, while the physician or Second Victim is often left alone to struggle.

The term "Second Victim" was coined in 2000 by Dr. Albert Wu, a professor of Health Policy and Management at the Johns Hopkins School of Public Health. A widely accepted definition describes a Second Victim as "any health care worker, directly or indirectly involved in an unanticipated adverse patient event, unintentional healthcare error, or patient injury, and who becomes victimized in the sense that they are also negatively impacted."

Second Victim Syndrome (SVS) is a psychological phenomenon experienced by physicians and other healthcare providers who are involved in a patient complication, medical error, or patient injury, and who subsequently suffer emotional trauma as a result. The term highlights the often-overlooked impact that these events have on the physician. This emotional trauma caused by the SVS is almost identical to the emotions that occur when involved in a medical malpractice lawsuit. This looks like, feels like, and is experienced like trauma.

It is estimated that nearly half of physicians experience SVS at least once in their career.[2] A 2014 survey of 1,755 physicians found most physicians had been involved in a serious safety event and most admitted to experiencing symptoms consistent with SVS.[3]

Physicians affected by SVS frequently suffer intense feelings of guilt, shame, and personal responsibility for the outcome, often believing they have failed their patient. They do not or cannot accept a force majeure or unavoidable event. Anxiety, depression, and intrusive memories of the event can persist for months or even years. Many symptoms of SVS overlap with PTSD, including intrusive memories (flashbacks and nightmares), avoidance,

anger outbursts, insomnia, hypervigilance, and difficulty concentrating.[4] After the complication, the physician may practice more defensively as there is also fear of litigation and job loss.

In severe cases of SVS, physician burnout syndrome, depression, and even suicide may develop if the physician does not get treatment. These emotional burdens can compromise not only the well-being of the physician, but also patient safety, as impaired judgment and ongoing distress may affect clinical performance.

SVS follows a predictable trajectory after an adverse event. *Chaos and Accident Response* occur first, with immediate focus on stabilizing the patient while managing shock and confusion. *Intrusive Reflections* follow, with persistent rumination and replaying of the incident over and over, often interfering with daily life. *Fear of Rejection vs. Seeking Confirmation* brings intensive worry about colleagues' perceptions and seeking reassurance that the outcome was not solely the physician's fault. The next phase is *Enduring the Inquisition,* which involves facing administrative, medical-legal, or peer review investigations, often perceived by the physician as questioning their competence. *Emotional First Aid* often overlaps with the *Inquisition* and includes seeking support from peers, mentors, or mental health professionals. The *Final Disposition* has many potential endings that include the physician *Leaving* the profession or *Surviving* but not fully recovering or *Thriving,* which is growing from the experience and contributing to system improvements.

The severity of SVS is influenced by several variables, including the physician's personal connection to the patient. The closer the relationship the physician has with the patient and the more severe the complication, the more the physician will struggle with SVS symptoms. In contrast, physicians with greater support from colleagues and their institutions are less prone to experiencing severe SVS symptoms.

Effective peer support groups are essential for mitigating the impact of SVS. Leadership engagement and a culture that encourages open discussion of errors without blame are essential to minimize SVS and decrease the chance of the complication reoccurring. Typical resources available to physicians after an adverse event occurs can include the hospital or organization's clergy, psychiatric department, wellness committee or employee assistance program (EAP). In most states, the Physician Health Program is well equipped to provide support and counseling for the physician. Unfortunately, there are numerous barriers that prevent physicians from seeking out these resources, including time away from work, fears about confidentiality, stigma, negative judgments by colleagues, ineffective support, and the lack of expertise or awareness of how to support a physician with SVS.

A viable resource is the Tennessee Medical Foundation (TMF). The TMF is a confidential resource with the expertise and resources to help a physician with SVS. Visit e-tmf.org to learn more about the TMF's mission, program, and services.

Conclusion:
Second Victim Syndrome is a profound, often invisible consequence which physicians can experience following a patient complication or an adverse event – frequently resulting from the expectation of perfection. By acknowledging the existence of SVS and accepting robust, stigma-free support, physicians can recover, learn, and continue to deliver safe and compassionate care to their patients.

1. The role of compulsiveness in the normal physician. JAMA. Nov 22/29, 1985-Vol 254, No. 20.

2. Seys D, et al. Health care professionals as second victims after adverse events: A systematic review. Evaluation & The Health Professions. 2012;36(2):135-162.

3. Stewart K, et al. Supporting “second victims” is a system-wide responsibility.
4.

British Medical Journal. 2015;350:h2341.

4. Institute for Safe Medication Practices. Too many abandon the “second victims” of medical ISMP Medication. Safety Alert! July 14, 2011.