Annotated bibliography: Peer support literature 2015-2021

Compiled by the Betsy Lehman Center for Patient Safety

2016

Epstein, and Privitera. **"Doing Something about Physician Burnout**." The Lancet, vol. 388, no. 10057, 2016, pp. 2216–2217.

Abstract: *Burnout affects more than half of practising physicians and is on the rise. When burnout was seen as a crisis of wellbeing—affecting physicians' personal lives and work satisfaction—it garnered little public sympathy and could be dismissed as the whining of a privileged class. Now that evidence suggests that burnout negatively affects physicians' effectiveness and availability to patients, as well as patient safety, physicians, health-care organisations, and the public are justifiably worried about quality of patient care and the health of health-care institutions.*

DOI: 10.1016/S0140-6736(16)31332-0

Van Gerven, Eva, Vander Elst, Tinne, Vandenbroeck, Sofie, Dierickx, Sigrid, Euwema, Martin, Sermeus, Walter, De Witte, Hans, Godderis, Lode, & Vanhaecht, Kris. (2016). **Increased Risk of Burnout for Physicians and Nurses Involved in a Patient Safety Incident**. Medical Care, 54(10), 937–943.

Abstract: *Human errors occur everywhere, including in health care. Not only the patient, but also the involved health professional is affected (ie, the "second victim").To investigate the prevalence of health care professionals being personally involved in a patient safety incident (PSI), as well as the relationship of involvement and degree of harm with problematic medication use, excessive alcohol consumption, risk of burnout, work-home interference (WHI), and turnover intentions. Multilevel path analyses were conducted to analyze cross-sectional survey data from 37 Belgian hospitals. A total of 5788 nurses (79.4%) and physicians (20.6%) in 26 acute and 11 psychiatric hospitals were included. "Involvement in a patient safety incident during the prior 6 months," "degree of harm," and 5 outcomes were measured using self-report scales. Second victims experience significant negative outcomes in the aftermath of a PSI. An appropriate organizational response should be provided to mitigate the negative effects.*

DOI: https://doi.org/10.1097/MLR.0000000000000582

Van Gerven, Eva, Bruyneel, Luk, Panella, Massimiliano, Euwema, Martin, Sermeus, Walter, & Vanhaecht, Kris. (2016**). Psychological impact and recovery after involvement in a patient safety incident: a repeated measures analysis**. BMJ Open, 6(8), e011403–e011403.

Abstract: *To examine individual, situational and organisational aspects that influence psychological impact and recovery of a patient safety incident on physicians, nurses and midwives. Design: Cross-sectional, retrospective surveys of physicians, midwives and nurses. Setting: 33 Belgian hospitals. Participants: 913 clinicians (186 physicians, 682 nurses, 45 midwives) involved in a patient safety incident. The Impact of Event Scale was used to retrospectively measure psychological impact of the safety incident at the time of the event and compare it with psychological impact at the time of the survey. Individual, situational as well as organisational aspects influenced psychological impact and recovery of a patient safety incident. Psychological impact is higher when the degree of harm for the patient is more severe, when healthcare professionals feel responsible for the incident and among female healthcare professionals. Impact of degree*

of harm differed across clinicians. Psychological impact is lower among more optimistic professionals. Overall, impact decreased significantly over time. This effect was more pronounced for women and for those who feel responsible for the incident. The longer ago the incident took place, the stronger impact had decreased. Also, higher psychological impact is related with the use of a more active coping and planning coping strategy, and is unrelated to support seeking coping strategies. Rendered support and a support culture reduce psychological impact, whereas a blame culture increases psychological impact. No associations were found with job experience and resilience of the health professional, the presence of a second victim support team or guideline and working in a learning culture. Healthcare organisations should anticipate on providing their staff appropriate and timely support structures that are tailored to the healthcare professional involved in the incident and to the specific situation of the incident.

DOI: https://doi.org/10.1136/bmjopen-2016-011403

Hall, Louise H., et al. **"Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review."** Vol. 11, no. 7, 2016, p. e0159015.

Abstract: *To determine whether there is an association between healthcare professionals' wellbeing and burnout, with patient safety. Systematic research review. Quantitative, empirical studies that included i) either a measure of wellbeing or burnout, and ii) patient safety, in healthcare staff populations. Forty-six studies were identified. Sixteen out of the 27 studies that measured wellbeing found a significant correlation between poor wellbeing and worse patient safety, with six additional studies finding an association with some but not all scales used, and one study finding a significant association but in the opposite direction to the majority of studies. Twenty-one out of the 30 studies that measured burnout found a significant association between burnout and patient safety, whilst a further four studies found an association between one or more (but not all) subscales of the burnout measures employed, and patient safety. Poor wellbeing and moderate to high levels of burnout are associated, in the majority of studies reviewed, with poor patient safety outcomes such as medical errors, however the lack of prospective studies reduces the ability to determine causality. Further prospective studies, research in primary care, conducted within the UK, and a clearer definition of healthcare staff wellbeing are needed.*

DOI: 10.1371/journal.pone.0159015

Martens, J., Van Gerven, E., Lannoy, K., Panella, M., Euwema, M., Sermeus, W., De Hert, M., & Vanhaecht, K. (2016**). Serious reportable events within the inpatient mental health care: Impact on physicians and nurses**. Revista de calidad asistencial : organo de la Sociedad Espanola de Calidad Asistencial, 31 Suppl 2, 26–33.

Abstract: *To investigate the prevalence of physicians and nurses involved in an adverse event within mental health. A quantitative, cross-sectional study was performed. Six Flemish psychiatric hospitals (Belgium) participated in this exploratory cross-sectional study. All psychiatrists and nurses working in these hospitals were invited to complete an online questionnaire in March 2013. 28 psychiatrists and 252 nurses completed the survey. 205 (73%) of the 280 respondents were personally involved at least once in an adverse event within their entire career. Respondents reported that the adverse event with the greatest impact was related to suicide in almost 64% of the cases. About one in eight respondents considered quitting their job because of it. Almost 18% declared that due to the impact of the event, they believed that the quality of the administered care was affected for longer than one month. Respondents stated that they received much support of colleagues (95%), the chief nurse (86%) and the partner (71%). Colleagues seemed to be most supportive in the recovery process. Physicians and nurses working in inpatient mental health care may be at high risk to being confronted with an adverse event at some point in their career. The influence on health professionals involved in an adverse event on their work is particularly important in the first 4–24 h.*

Professionals at those moments had higher likelihood to be involved in another adverse event. Institutions should seriously consider giving support almost at that time.

DOI: https://doi.org/10.1016/j.cali.2016.04.004

Shapiro, Jo, and Pamela Galowitz. **"Peer Support for Clinicians: A Programmatic Approach."** Academic Medicine, vol. 91, no. 9, 2016, pp. 1200–1204.

Abstract: *Burnout is plaguing the culture of medicine and is linked to several primary causes including long work hours, increasingly burdensome documentation, and resource constraints. Beyond these, additional emotional stressors for physicians are involvement in an adverse event, especially one that involves a medical error, and malpractice litigation. The authors argue that it is imperative that health care institutions devote resources to programs that support physician well-being and resilience. Doing so after adverse and other emotionally stressful events, such as the death of a colleague or caring for victims of a mass trauma, is crucial as clinicians are often at their most vulnerable during such times. To this end, the Center for Professionalism and Peer Support at Brigham and Women's Hospital redesigned the peer support program in 2009 to provide one-on-one peer support. The peer support program was one of the first of its kind; over 25 national and international programs have been modeled off of it. This Perspective describes the origin, structure, and basic workings of the peer support program, including important components for the peer support conversation (outreach call, invitation/opening, listening, reflecting, reframing, sense-making, coping, closing, and resources/referrals). The authors argue that creating a peer support program is one way forward, away from a culture of invulnerability, isolation, and shame and toward a culture that truly values a sense of shared organizational responsibility for clinician well-being and patient safety.*

DOI: 10.1097/ACM.0000000000001297

Lambert, B. L., Centomani, N. M., Smith, K. M., Helmchen, L. A., Bhaumik, D. K., Jalundhwala, Y. J., & McDonald, T. B. (2016). **The "Seven Pillars" Response to Patient Safety Incidents: Effects on Medical Liability Processes and Outcomes**. Health services research, 51 Suppl 3(Suppl Suppl 3), 2491-2515.

Abstract: *Although acknowledged to be an ethical imperative for providers, disclosure following patient safety incidents remains the exception. The appropriate response to a patient safety incident and the disclosure of medical errors are neither easy nor obvious. An inadequate response to patient harm or an inappropriate disclosure may frustrate practitioners, dent their professional reputation, and alienate patients. The authors have presented a descriptive study on the comprehensive process for responding to patient safety incidents, including the disclosure of medical errors adopted at a large, urban tertiary care centre in the United States. In the first two years post-implementation, the "seven pillars" process has led to more than 2,000 incident reports annually, prompted more than 100 investigations with root cause analysis, translated into close to 200 system improvements and served as the foundation of almost 106 disclosure conversations and 20 full disclosures of inappropriate or unreasonable care causing harm to patients. Adopting a policy of transparency represents a major shift in organisational focus and may take several years to implement. In our experience, the ability to rapidly learn from, respond to, and modify practices based on investigation to improve the safety and quality of patient care is grounded in transparency.*

DOI: 10.1136/qshc.2008.031633

2017

Decaporale-Ryan, et al. "**The Undiagnosed Pandemic: Burnout and Depression within the Surgical Community**." Current Problems in Surgery, vol. 54, no. 9, 2017, pp. 453–502.

Abstract: *In order for an institution to support physicians and other health care team members to deliver high-quality care, the organization must be a learning organization and promote a culture of psychological safety where we are not afraid to ask questions or raise concerns. In a learning organization, we can improve patient safety and quality by analyzing and learning from our errors and near misses. Importantly, reporting must be seen as a shared responsibility and events investigated to identify errors, choices, system contributors as well as personal performance factors. At BWH we are using the Just Culture framework that recognizes that as humans we are fallible and will inevitably make mistakes. Our individual and institutional responsibility is to learn from these events and to work toward preventing such events from happening in the future and causing patient harm. We were part of a study showing that for physicians in the aftermath of a medical error, learning from the event and working toward future safety improvements was correlated with growth and resilience. This learning cannot occur in a shame and blame environment. Shame has a serious negative impact on clinician wellness in addition to silencing others from reporting their own errors or near misses. To promote well-being, our programs are designed to create relational trust within the organization, with a particular focus on large-scale projects promoting teamwork, respectful interpersonal communication, and peer support. Parker Palmer writes that: "Relational trust is built on movements of the human heart such as empathy, commitment, compassion, patience, and the capacity to forgive." It is precisely this idea of relational trust that underpins our institutional programs to support well-being.*
DOI: 10.1067/j.cpsurg.2017.07.001

Panella, M., Rinaldi, C., Leigheb, F., Knesse, S., Donnarumma, C., Kul, S., Vanhaecht, K., & Di Stanislao, F. (2017). **Prevalence and costs of defensive medicine: a national survey of Italian physicians**. Journal of health services research & policy, 22(4), 211–217.

Abstract: *To identify the prevalence of the practice of defensive medicine among Italian hospital physicians, its costs and the reasons for practising defensive medicine and possible solutions to reduce the practice of defensive medicine. Number of physicians reporting having engaged in any defensive medicine behaviour in the previous year. A total of 1313 physicians completed the survey. Ninety-five per cent believed that defensive medicine would increase in the near future. The practice of defensive medicine accounted for approximately 10% of total annual Italian national health expenditure. Defensive medicine is a significant factor in health care costs without adding any benefit to patients. The economic burden of defensive medicine on health care systems should provide a substantial stimulus for a prompt review of this situation in a time of economic crisis. Malpractice reform, together with a systematic use of evidence-based clinical guidelines, is likely to be the most effective way to reduce defensive medicine.*

DOI: https://doi.org/10.1177/1355819617707224

Vandenbroeck, S., Van Gerven, E., De Witte, H., Vanhaecht, K., & Godderis, L. (2017). **Burnout in Belgian physicians and nurses**. Occupational medicine (Oxford, England), 67(7), 546–554.

Abstract: *Burnout in healthcare is a worldwide problem. However, most studies focus narrowly on work-related factors and outcomes in one health profession or speciality. To investigate the prevalence of burnout and its association with job demands, job resources, individual well-being, work-related attitudes and behaviour in physicians and nurses across different specialties. 1169 physicians and 4531 nurses participated; response rate 26%. High scores (>75th percentile in reference group of Dutch health care workers) were seen in 6% of the sample on three burnout dimensions (i.e. emotional exhaustion, depersonalization and personal competence) and in 13% for at least two dimensions. In contrast to the other dimensions, emotional exhaustion strongly related to almost all variables examined in the model. Positive associations were seen with workload, role conflicts, emotional burden and work–home interference and negative associations with learning and development opportunities and co-worker support.*

Emotional exhaustion correlated negatively with well-being, turnover intention, being prepared and able to work until retirement age, medication use, absenteeism and presenteeism. Work-related factors were critical correlates of emotional exhaustion, which strongly related to poor health and turnover intention. Randomized controlled trials are suggested to underpin the effectiveness of interventions tackling job stressors and promoting job resources.

DOI: https://doi.org/10.1093/occmed/kqx126

Shanafelt, Tait, and John Noseworthy. "**Executive Leadership and Physician Well-Being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout**." Mayo Clinic Proceedings, vol. 92, no. 1, 2017, pp. 129–146.

Abstract: *These are challenging times for health care executives. The health care field is experiencing unprecedented changes that threaten the survival of many health care organizations. To successfully navigate these challenges, health care executives need committed and productive physicians working in collaboration with organization leaders. Unfortunately, national studies suggest that at least 50% of US physicians are experiencing professional burnout, indicating that most executives face this challenge with a disillusioned physician workforce. Burnout is a syndrome characterized by exhaustion, cynicism, and reduced effectiveness. Physician burnout has been shown to influence quality of care, patient safety, physician turnover, and patient satisfaction. Although burnout is a system issue, most institutions operate under the erroneous framework that burnout and professional satisfaction are solely the responsibility of the individual physician. Engagement is the positive antithesis of burnout and is characterized by vigor, dedication, and absorption in work. There is a strong business case for organizations to invest in efforts to reduce physician burnout and promote engagement. Herein, we summarize 9 organizational strategies to promote physician engagement and describe how we have operationalized some of these approaches at Mayo Clinic. Our experience demonstrates that deliberate, sustained, and comprehensive efforts by the organization to reduce burnout and promote engagement can make a difference. Many effective interventions are relatively inexpensive, and small investments can have a large impact. Leadership and sustained attention from the highest level of the organization are the keys to making progress.*

DOI: 10.1016/j.mayocp.2016.10.004

2018

Carugno, and Winkel. "**Surgical Catastrophe. Supporting the Gynecologic Surgeon after an Adverse Event**." The Journal of Minimally Invasive Gynecology, 2018, pp.

Abstract: *Medical errors and adverse events (AEs) are unavoidable, and the effect of adverse outcomes on providers can be devastating. An intraoperative AE is often directly attributable to surgeon technical error or suboptimal intraoperative judgment. To prevent the potential devastating psychological consequences that cases with adverse outcome pose to surgeons involved, it is essential to provide adequate support to the individuals involved in cases with intraoperative AEs. Common reactions to AEs and individual and organizational strategies to support clinicians through the aftermath are reviewed. The goal of this commentary is to create awareness of the mental health impact and to describe options to help physicians involved in intraoperative AEs to recover from their experience related to bad surgical outcomes.*

DOI: 10.1016/j.jmig.2018.05.012

Robertson, and Long. "**Suffering in Silence: Medical Error and Its Impact on Health Care Providers**." Journal of Emergency Medicine, vol. 54, no. 4, 2018, pp. 402–409.

Abstract: *Physicians and other providers may feel a variety of adverse emotions after medical error, including guilt, shame, anxiety, fear, and depression. It is thought that the pervasive culture of perfectionism and individual blame in medicine plays a considerable role toward these negative effects. In addition, studies have found that despite physicians' desire for support after medical error, many physicians feel a lack of personal and administrative support. This may further contribute to poor emotional well-being. Potential solutions in the literature are proposed, including provider counseling, learning from mistakes without fear of punishment, discussing mistakes with others, focusing on the system versus the individual, and emphasizing provider wellness. Much of the reviewed literature is limited in terms of an emergency medicine focus or even regarding physicians in general. In addition, most studies are survey- or interview-based, which limits objectivity. While additional, more objective research is needed in terms of mitigating the effects of error on physicians, this review may help provide insight and support for those who feel alone in their attempt to heal after being involved in an adverse medical event.*

DOI: 10.1016/j.jemermed.2017.12.001

Schiess, C., Schwappach, D., Schwendimann, R., Vanhaecht, K., Burgstaller, M., & Senn, B. (2018). **A Transactional "Second-Victim" Model-Experiences of Affected Healthcare Professionals in Acute-Somatic Inpatient Settings: A Qualitative Metasynthesis**. Journal of patient safety, 10.1097/PTS.0000000000000461. Advance online publication.

Abstract: *"Second victims" are healthcare professionals traumatized by involvement in significant adverse events. Associated burdens, e.g., guilt, can impair professional performance, thereby endangering patient safety. To date, however, a model of second victims' experiences toward a deeper understanding of qualitative studies is missing. Therefore, we aimed to identify, describe, and interpret these experiences in acute-somatic inpatient settings. Based on 19 qualitative studies (explorative-descriptive: n = 13; grounded theory: n = 3; phenomenology: n = 3), a model of second-victim experience was drafted. This depicts a multistage developmental process: in appraising their situation, second victims focus on their involvement in an adverse event, and they become traumatized. To restore their integrity, they attempt to understand the event and to act accordingly; however, their reactions are commonly emotional and issue focused. Outcomes include leaving the profession, surviving, or thriving. This development process is alternately modulated by safety culture and healthcare professionals. For the first time, this model works systematically from the second-victim perspective based on qualitative studies. Based on our findings, we recommend integrating second victims' experiences into safety culture and root-cause analyses. Our transactional model of second-victim experience provides a foundation for strategies to maintain and improve patient safety.*

DOI: https://doi.org/10.1097/PTS.0000000000000461

Winning, Adrien M, et al. "**The Emotional Impact of Errors or Adverse Events on Healthcare Providers in the NICU: The Protective Role of Coworker Support**." Journal of Advanced Nursing, vol. 74, no. 1, 2018, pp. 172–180.

Abstract: *To examine the impact of errors or adverse events on emotional distress and professional quality of life in healthcare providers in the neonatal intensive care unit, and the moderating role of coworker support. Compared with those who did not experience an error or adverse event (58%), healthcare providers who observed (23%) or were involved (19%) in an incident reported higher levels of anxiety and secondary traumatic stress. Those who were involved in an event reported higher levels of depression and burnout. Differences between the three groups (no event, observation and involvement) for compassion satisfaction were non-significant. Perceived coworker support moderated the association between experiencing an event and both anxiety and depression. Specifically, experiencing an event was associated with higher levels of anxiety and depression when coworkers were perceived as low in supportiveness, but not when they were*

viewed as highly supportive. Findings suggest that errors or adverse events can have a harmful impact on healthcare providers and that coworker support may reduce emotional distress.

DOI: 10.1111/jan.13403

Carugno, and Winkel. "**Surgical Catastrophe. Supporting the Gynecologic Surgeon after an Adverse Event**." The Journal of Minimally Invasive Gynecology, 2018, pp.

Abstract: *Medical errors and adverse events (AEs) are unavoidable, and the effect of adverse outcomes on providers can be devastating. An intraoperative AE is often directly attributable to surgeon technical error or suboptimal intraoperative judgment. To prevent the potential devastating psychological consequences that cases with adverse outcome pose to surgeons involved, it is essential to provide adequate support to the individuals involved in cases with intraoperative AEs. Common reactions to AEs and individual and organizational strategies to support clinicians through the aftermath are reviewed. The goal of this commentary is to create awareness of the mental health impact and to describe options to help physicians involved in intraoperative AEs to recover from their experience related to bad surgical outcomes.*

DOI: 10.1016/j.jmig.2018.05.012

Mokhtari, Zahra, Hosseini, Mohammad Ali, Khankeh, Hamid Reza, Fallahi-Khoshknab, Masoud, & Nasrabadi, Alireza Nikbakht. (2018). **Barriers to support nurses as second victim of medical errors: A qualitative study**. Australasian Medical Journal, 11(12), 556–560.

Abstract: *Given the inevitability of medical errors and their impact on health workers, providing support to those who suffer is vital for their physical and mental recovery. Identifying the barriers to obtaining support is imperative in this regard. The current study was conducted to identify the barriers regarding supporting nurses as second victims of nursing errors in clinical settings in Iran. According to the results, mismanagement, cultural barriers, inadequate information, and legal barriers were the main barriers to supporting nurses. Training nurses about the second victim phenomenon is recommended as well as the methods to manage the effects of this phenomenon, the supportive resources, and legal issues.*

DOI: https://doi.org/10.21767/AMJ.2018.3515

Lane, Michael A, Newman, Brianne M, Taylor, Mary Z, O'Neill, Meg, Ghetti, Chiara, Woltman, Robin M, & Waterman, Amy D. (2018). **Supporting Clinicians After Adverse Events: Development of a Clinician Peer Support Program**. Journal of Patient Safety, 14(3), e56–e60.

Abstract: *Many healthcare organizations have developed processes for supporting the emotional needs of patients and their families after medical errors or adverse events. However, the clinicians involved in such events may become "second victims" and frequently experience emotional harm that impacts their personal and professional lives. Many "second victims," particularly physicians, do not receive adequate support by their organizations. We describe the multiple steps necessary to create a successful PSP focused on physicians and midlevel providers. There is an unmet need to provide support to this group of healthcare providers after medical errors and adverse events.*

DOI: https://doi.org/10.1097/PTS.0000000000000508

Wright, Alexi A., and Ingrid T. Katz. "**Beyond Burnout — Redesigning Care to Restore Meaning and Sanity for Physicians**." The New England Journal of Medicine, vol. 378, no. 4, 2018, pp. 309–311.

Abstract: *High burnout rates among physicians are taking a high financial and human toll. Burnout can undermine a physician's sense of purpose and altruism and lead to substance use, depression, and suicidality. Some medical organizations are starting to tackle the challenge.*

DOI: 10.1056/NEJMp1716845

2019

Rinaldi, C., D'Alleva, A., Leigheb, F., Vanhaecht, K., Knesse, S., Di Stanislao, F., & Panella, M. (2019). **Defensive practices among non-medical health professionals: An overview of the scientific literature**. Journal of healthcare quality research, 34(2), 97–108.

Abstract: *Defensive medicine (DM) is used when a doctor deviates from good practices to prevent complaints from patients or caregivers. This is a structured phenomenon that may not only affect the physician, but all healthcare personnel. The aim of this review was to determine whether DM is also performed by Non-Medical Health Professionals (NMHP), and the reasons, features, and effects of NMHP-DM. NMHP-DM is quite similar to DM practiced by doctors, and is mainly caused by fear of litigation. Midwives and nursing personnel practiced both active and passive DM, such as over-investigation, over-treatment, and avoidance of high-risk patients. NMHP-DM could increase risks for patient health, costs, risk of burnout for healthcare employees. Further studies are needed to better understand prevalence and features of NMHP-DM in all health professional fields, in order to apply appropriate preventive strategies to contrast DM among health care personnel.*

DOI: https://doi.org/10.1016/j.jhqr.2018.12.005

Elizabeth Marran, Jayne. (2019). **Supporting staff who are second victims after adverse healthcare events.** Nursing Management (Harrow, London, England), 26(6), 36–43.

Abstract: *Healthcare delivery is challenging and complex, At some point, most healthcare professionals, including nurses, will be directly or indirectly involved in adverse events, such as medication errors, patient safety incidents, witnessing adverse events and near misses. While the patient is considered the first and most important 'victim' of such events, the healthcare professional involved is often considered the 'second victim'. Second victims often experience negative psychological effects due to the event, may feel they have failed the patient and can doubt their clinical skills and knowledge base. This may lead to absenteeism and their leaving their profession. This article explores the concept of healthcare professionals as second victims, as well as the effects of adverse events on these individuals, their managers and healthcare organisations. It also details the investigation process, the healthcare professional's legal and professional responsibilities after an adverse event, and the resources and services available to support second victims.*

DOI: https://doi.org/10.7748/nm.2019.e1872

Johnson, Jennifer, Ford, Eric, Yu, James, Buckey, Courtney, Fogh, Shannon, & Evans, Suzanne B. (2019). **Peer support: A needs assessment for social support from trained peers in response to stress among medical physicists.** Journal of Applied Clinical Medical Physics, 20(9), 157–162.

Abstract: *Burnout affects more than half of practising physicians and is on the rise. When burnout was seen as a crisis of wellbeing—affecting physicians' personal lives and work satisfaction—it garnered little public sympathy and could be dismissed as the whining of a privileged class. Now that evidence suggests that burnout negatively affects physicians' effectiveness and availability to patients, as well as patient safety, physicians, health-care organisations, and the public are justifiably worried about quality of patient care and the health of health-care institutions.*

DOI: 10.1016/S0140-6736(16)31332-0

2020

Busch, I, Moretti, F, Purgato, M, Barbui, C, Wu, A, & Rimondini, M. (2020). 170 - **Are second victims real victims? Evidence and reflections on the traumatic impact of adverse events in the medical setting**. Journal of Psychosomatic Research, 133.

Abstract: *The term "second victim" (SV) has recently been criticized as downplaying patient harm and reinforcing passive role-taking by the involved healthcare provider. However, the literature suggests a strong psychological burden of this experience, which in some cases might be even considered a trauma. Aim of this study is to identify symptoms and behaviors that emphasize the traumatic character of the adverse event and might reflect the presence of posttraumatic stress disorder (PTSD). Our data confirm that adverse events can be of traumatic nature which may lead to avoidance behaviors, thus negatively affecting SVs' personal and professional well-being, the therapeutic alliance, and the quality of care delivered by the healthcare system.*

DOI: https://doi.org/10.1016/j.jpsychores.2020.110033

Kruper, Abbey, Domeyer-Klenske, Amy, Treat, Robert, Pilarski, Alicia, & Kaljo, Kristina. (2020). **Secondary Traumatic Stress in Ob-Gyn: A Mixed Methods Analysis Assessing Physician Impact and Needs.** Journal of Surgical Education.

Abstract: *This study aims to evaluate the incidence of secondary traumatic stress in Obstetrics and Gynecology physicians including symptoms, impact, and programmatic needs for support. Obstetrics and Gynecology providers are likely to experience symptoms of secondary traumatic stress following adverse patient events similar to other medical specialties. Comprehensive programs to address emotional well-being of physicians are important to promote collegiality and reduce symptoms of secondary traumatic stress. Safety and transparency with opportunities for group processing are identified as essentials for positive institutional culture, as well as peer support programs.*

DOI: https://doi.org/10.1016/j.jsurg.2020.08.038

Margulies, Samantha L, Benham, Joshua, Liebermann, Joan, Amdur, Richard, Gaba, Nancy, & Keller, Jennifer. (2020). **Adverse Events in Obstetrics: Impacts on Providers and Staff of Maternity Care**. Curēus (Palo Alto, CA), 12(1), e6732–e6732.

Abstract: *This is a single-institution observational study evaluating the impact of adverse perinatal/ neonatal and maternal events on obstetrical/maternal providers and staff. This appears to be the only study that focuses specifically on obstetrical adverse events. To determine the frequency of maternity health employee experiences with maternal and perinatal/neonatal adverse outcomes and gain a deeper understanding of how these experiences impact the providers. Non-physicians, those using substances, those considering career change, and those seeking mental health treatment are more likely to experience anxiety/depression and post-traumatic stress symptoms after a maternal or perinatal/neonatal loss. These individuals should be identified and offered additional support.*

DOI: https://doi.org/10.7759/cureus.6732

Stone, Misty. (2020). **Second Victim Support: Nurses' Perspectives of Organizational Support After an Adverse Event**. The Journal of Nursing Administration, 50(10), 521–525.

Abstract: *The purpose of this study was to describe hospital nurses' experiences with organizational support after an adverse event (AE). Most hospital staff nurses will experience an AE, being left and feeling traumatized. Data collection and analysis followed a qualitative descriptive approach. Nurses yearn to feel valued and to receive timely support from nurse executives after an AE. To help lessen the suffering of the nurse after an AE, healthcare organizations and nurse executives must support the nurse in the aftermath.*

DOI: https://doi.org/10.1097/NNA.0000000000000928

Fisher, Edwin B, Miller, Suzanne M, Evans, Megan, Luu, Samantha L, Tang, Patrick Y, Dreyer Valovcin, Dawn, & Castellano, Cherie. (2020). **COVID-19, stress, trauma, and peer support—observations from the field.** Translational Behavioral Medicine, 10(3), 503–505.

Abstract: *One might imagine that the value of nonprofessionals providing "ancillary" assistance would be reduced amidst pressing needs for clinical services and hospital beds and the immense economic, social, and logistic needs brought about by the pandemic. Just the opposite, the role of peer support has increased and become more complicated amidst the pressing demands for food, housing, safety, and economic assistance. For behavioral medicine and public health, these findings make clear that preparedness needs to address not only clinical challenges and services but also the psychological and social needs of people. Stress is not good for resistance to viruses. The fundamental impacts of social connectedness on biology, disease, and well-being [e.g., 15,–17] make clear that social and psychological status are important not only as ends in themselves but also as they facilitate individual and group resistance to threats and as they, themselves, constitute important determinants of health.*

DOI: https://doi.org/10.1093/tbm/ibaa056

Moore, Kendra A, O'Brien, Bridget C, & Thomas, Larissa R. (2020). **"I Wish They Had Asked": a Qualitative Study of Emotional Distress and Peer Support During Internship**. Journal of General Internal Medicine : JGIM, 35(12), 3443–3448.

Abstract: *The investigators identified three themes around emotional distress and two themes around resident peer support. Distress was a pervasive experience among participants, caused by a combination of contextual factors that decreased emotional resilience (e.g., sleep deprivation) and acute triggers (e.g., patient death) that led to an abrupt increase in distress. Participants grappled with identity reconciliation throughout internship. Reaching clinical competency reinforced self-efficacy for participants. With regard to peer support, participants recalled that resident support was ad hoc, primarily involving task support and debriefing traumatic events. Participants reflected that their intern experiences shaped their supervisory support style once they became senior residents; they did not perceive any formalized, systematic approach to supporting interns.*

DOI: https://doi.org/10.1007/s11606-020-05803-4

Wu, A. W., Shapiro, J., Harrison, R., Scott, S. D., Connors, C., Kenney, L., & Vanhaecht, K. (2020). **The Impact of Adverse Events on Clinicians: What's in a Name?**. Journal of patient safety, 16(1), 65–72.

Abstract: *Unanticipated patient adverse events can also have a serious negative impact on clinicians. The term second victim was coined to highlight the experience of health professionals with these events and the need to effectively support them. However, there is some controversy over use of the term second victim. This article explores terminology used to describe the professionals involved in adverse events and services to support them. There is a concern that use of the term victim may connote passivity or stigmatize involved clinicians. Some patient advocates are also offended by the term, believing that it deemphasizes the*

experience of patients and families. Despite this, the term is now coming into widespread use by clinicians and health care managers as well as policy makers. As the importance of emotional support for clinicians continues to gain visibility, the terminology surrounding it will undoubtedly change and evolve. At this time, it may be most appropriate to label this important phenomenon in a way that local leaders are comfortable with—in a way that promotes its recognition and adoption of solutions. For example, for policy makers and health care managers, the term second victim may have value because it is memorable and connotes urgency. For support programs that appeal directly to health care workers, different language may attract more users. Debate concerning the benefits and drawbacks to this terminology will enhance and further drive its evolution, while helping retain our industry's focus on the importance of developing and evaluating programs to support clinicians in need.

DOI: https://doi.org/10.1097/PTS.0000000000000256

Anderson, Gregory S, Di Nota, Paula M, Groll, Dianne, & Carleton, R. Nicholas. (2020). **Peer Support and Crisis-Focused Psychological Interventions Designed to Mitigate Post-Traumatic Stress Injuries among Public Safety and Frontline Healthcare Personnel: A Systematic Review**. International Journal of Environmental Research and Public Health, 17(20), 7645.

Abstract: *Public safety personnel (PSP) and frontline healthcare professionals (FHP) are frequently exposed to potentially psychologically traumatic events (PPTEs), and report increased rates of post-traumatic stress injuries (PTSIs). Despite widespread implementation and repeated calls for research, effectiveness evidence for organizational post-exposure PTSI mitigation services remains lacking. The current systematic review synthesized and appraised recent (2008–December 2019) empirical research from 22 electronic databases following a population–intervention–comparison–outcome framework. Eligible studies investigated the effectiveness of organizational peer support and crisis-focused psychological interventions designed to mitigate PTSIs among PSP, FHP, and other PPTE-exposed workers. The review included 14 eligible studies (n = 18,849 participants) that were synthesized with qualitative narrative analyses. The absence of pre–post-evaluations and the use of inconsistent outcome measures precluded quantitative meta-analysis. Thematic services included diverse programming for critical incident stress debriefing, critical incident stress management, peer support, psychological first aid, and trauma risk management. Designs included randomized control trials, retrospective cohort studies, and cross-sectional studies. Outcome measures included PPTE impacts, absenteeism, substance use, suicide rates, psychiatric symptoms, risk assessments, stigma, and global assessments of functioning. Quality assessment indicated limited strength of evidence and failures to control for pre-existing PTSIs, which would significantly bias program effectiveness evaluations for reducing PTSIs post-PPTE.*

DOI: https://doi.org/10.3390/ijerph17207645

Behrman, Sophie, Baruch, Nina, & Stegen, Gerti. (2020). **Peer support for junior doctors: a positive outcome of the COVID-19 pandemic?** Future Healthcare Journal, 7(3), fhj.2020–0069–e66.

Abstract: *The COVID-19 pandemic has imposed new, intense and, as yet, unquantifiable strain on the wellbeing of healthcare professionals. Similarities are seen internationally with regards to the uptake of psychological support offered to healthcare professionals during a pandemic. Junior doctors are in a unique position to offer and access peer support; this is an evidence-based strategy to promote psychological wellbeing of junior doctors through the COVID-19 pandemic and into the future. The development of peer support networks during the pandemic may lead to reduced physician burnout and improved patient care in the future. We discuss a peer support initiative to support medical trainees during the COVID-19 pandemic, discuss the barriers to the success of such schemes, and reflect on the value of grass-roots peer support initiatives.*

DOI: https://doi.org/10.7861/fhj.2020-0069

Cheng, Pu, Xia, Guohua, Pang, Peng, Wu, Bo, Jiang, Wei, Li, Yong-Tong, Wang, Mei, Ling, Qi, Chang, Xiaoying, Wang, Jinghan, Dai, Xiaocheng, Lin, Xiaojin, & Bi, Xiaoting. (2020). **COVID-19 Epidemic Peer Support and Crisis Intervention Via Social Media**. Community Mental Health Journal, 56(5), 786–792.
Abstract: *This article describes a peer support project developed and carried out by a group of experienced mental health professionals, organized to offer peer psychological support from overseas to healthcare professionals on the frontline of the COVID-19 outbreak in Wuhan, China. This pandemic extremely challenged the existing health care systems and caused severe mental distress to frontline healthcare workers. The authors describe the infrastructure of the team and a novel model of peer support and crisis intervention that utilized a popular social media application on smartphone. Such a model for intervention that can be used elsewhere in the face of current global pandemic, or future disaster response.*

DOI: https://doi.org/10.1007/s10597-020-00624-5

Shapiro, Jo, & McDonald, Timothy B. (2020). **Supporting Clinicians during Covid-19 and Beyond — Learning from Past Failures and Envisioning New Strategies**. The New England Journal of Medicine, 383(27), e142–e142.

Abstract: *We believe there are several important strategies that medical institutions could use to design emotional-support programs that clinicians will embrace. First, institutions can create and provide funding for peer-support programs. Emotional stressors are often occupational hazards rather than mental health problems. Second, institutions can prioritize reaching out to employees who may benefit from receiving help by developing systems for offering support to clinicians rather than relying on self-referral. Third, institutions can provide easily accessible and psychologically safe "reach-in" services for clinicians requesting help. Finally, institutional leadership should be accountable for clinician well-being. Leaders should empower clinicians to speak up about unsafe, highly stressful, or morally challenging workplace conditions and ensure that concerns are listened to and, whenever possible, acted on.*

DOI: https://doi.org/10.1056/NEJMp2024834

Mellins, Claude A, Mayer, Laurel E.S, Glasofer, Deborah R, Devlin, Michael J, Albano, Anne Marie, Nash, Sara Siris, Engle, Erin, Cullen, Colleen, Ng, Warren Y.K, Allmann, Anna E, Fitelson, Elizabeth M, Vieira, Aaron, Remien, Robert H, Malone, Patrice, Wainberg, Milton L, & Baptista-Neto, Lourival. (2020**). Supporting the well-being of health care providers during the COVID-19 pandemic: The CopeColumbia response**. General Hospital Psychiatry, 67, 62–69.

Abstract: *Lessons learned include: (1) there is likely an ongoing need for both well-being programs and linkages to mental health services for HCW, (2) the workforce with proper support, will emerge emotionally resilient, and (3) organizational support for programs like CopeColumbia is critical for sustainability.*

DOI: https://doi.org/10.1016/j.genhosppsych.2020.08.013

Wu, Albert W, Connors, Cheryl, & Everly, Jr, George S. (2020). **COVID-19: Peer Support and Crisis Communication Strategies to Promote Institutional Resilience**. Annals of Internal Medicine, 172(12), 822–823.

Abstract: *We recommend 3 strategic principles that may be of value for other health care institutions responding to the COVID-19 pandemic: First, provide leadership focused on resilience. Effective crisis*

management provides a clear, optimistic vision and realistic plan; takes decisive action; and facilitates open, honest, and frequent communication. Leaders should make extra efforts to thank workers and express gratitude for the extra burden being imposed on them.

DOI: https://doi.org/10.7326/M20-1236

2021

Greenwald, Jeffrey L, Abrams, Annah N, Park, Elyse R, Nguyen, Phuong L, & Jacobsen, Juliet. (2021). **PSST! I Need Help! Development of a Peer Support Program for Clinicians Having Serious Illness Conversations During COVID-19**. Journal of General Internal Medicine : JGIM, 1–4.

Abstract: *Prior to the pandemic, our hospital had trained over 1300 clinicians to conduct serious illness conversations (SIC) that explore patients' values and priorities using Ariadne Labs' Serious Illness Care Program. This program trained non-palliative care providers how to conduct the conversation with the aid of a script.1, 6 However, when the pandemic arose, our providers needed additional support. Since peer support for serious illness conversations has been shown to be valued by clinicians when it is accessible, tailored, and aligned with the clinician's goals,7 we developed the Peer SIC Support Team (PSST), a novel program to offer real-time assistance to frontline clinicians by leveraging trained, non-palliative care providers' communication skills.*

DOI: https://doi.org/10.1007/s11606-020-06565-9

Guille C**. Rate of Suicide Among Women Nurses Compared With Women in the General Population Before the COVID-19 Global Pandemic**. JAMA Psychiatry. Published online April 14, 2021.

Abstract: *In a large retrospective cohort study of 159,372 suicides from 2007 to 2018 in the United States, sex-specific suicide incidence rates among nurses, physicians, and the general population were estimated using data from the National Violent Death Reporting System and workforce data from the United States Bureau of Labor Statistics and Association of American Medical Colleges' State Physician Workforce Data. Findings indicate that suicide rates among nurses exceed those of people in the general population and that female nurses are at twice the risk for suicide compared with women in the general population.*

DOI: doi:10.1001/jamapsychiatry.2021.0141