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Psychosocial Hazards for Healthcare Workers: Supporting the Second Victim Also Helps the Primary Victims

Sarah Michael

Sydney Local Health District, Sydney, New South Wales, Australia

Correspondence: Sarah Michael (sarah.michael1@health.nsw.gov.au)

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ABSTRACT

The psychosocial hazards of healthcare are well-recognized and are now subject to new legislation in Australia. Missing from this discussion has been the recognition of the second victim phenomenon—the distress experienced by healthcare workers involved in an adverse event, medical error or unexpected patient outcome—which appears to meet criteria for a psychosocial hazard. Organizations should ensure support for second victims by building a restorative and just culture, including ensuring all staff are educated on the second victim phenomenon and can support their colleagues, implementing a staff peer-support programme and ensuring that specialist mental health supports, such as an employee assistance programme, are geared towards supporting the second victim.

JEL Classification: Health services administration, Occupational diseases, Ethics and law, Mental disorders

1 | Introduction to Psychosocial Hazards for Healthcare Workers

There is a reasonably large body of international literature discussing psychosocial hazards in healthcare, including excessive work demands (workloads, long hours, shift work and staffing shortages); regular exposure to violence and aggression; organizational issues, including poorly managed change or culture; poor leadership styles; bullying, harassment and interpersonal issues within teams; emotional demands; and low autonomy or control in work decisions [1–3].

While the discussion around the legal implications in Australia is in its infancy, what is missing from even the broader international literature is the concept of the second victim, defined as a healthcare worker 'involved in an unanticipated adverse patient event, in a medical error and/or a patient related injury and... [who] is traumatized by the event' [4].

It is important to keep the concept of 'unanticipated adverse patient event' as something broad. Yes, some of these events will inexcusably be from negligence and malpractice. But there will also be near-misses, human error and many examples (including unexpected deaths, suicides or patient aggression) where a healthcare worker may have met all their obligations, yet still the patient outcome is poor or an investigation process is triggered.

The problems with the term 'second victim' are obvious. Some postulate that it can suggest a lack of responsibility or effort to prevent adverse events, or that it takes away from the undoubtable experience of the patient and family as the primary victims [5]. The intention of this article is not to do any of these things, and to acknowledge the harm of patients and their families in adverse events.

But it does not have to be an 'either/or' equation. Rather than stoke controversy, this article hopes to contribute to the existing discussion on psychosocial hazards with the urgency it deserves [6]. The consequences of psychosocial hazards are significant, with healthcare workers experiencing high rates of psychological distress, burnout, substance use, depression, other mental illness and suicide [1, 3, 7, 8]. Several data points in the past

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two decades indicate that healthcare workers in Australia have some of the highest rates of stress risk factors, poor psychological health and more workers compensation claims for mental health compared to non-healthcare workers [3, 9]. These psychological symptoms also have patient and organizational impacts, with increased rates of medical errors, decreased patient satisfaction, increased staff turnover, loss of productivity and increased costs [1, 8]. Ultimately, mitigating psychosocial hazards to healthcare workers reduces several harms in the broader healthcare system.

2 | New Psychosocial Hazards Legislation

In July 2022, Safe Work Australia included psychosocial hazards as part of their model work health and safety laws [10], after multiple calls from experts, researchers and a commissioned review to make these risks more explicit [11–13]. Psychosocial hazards at work are defined as hazards arising from the design, management of work, the work environment or workplace interactions or behaviours which, through causing stress, may cause psychological or physical harm. Psychological harm or injuries can include anxiety, depression, post-traumatic stress disorder and sleep disorders, among other conditions [14].

Under the model laws, which have been adopted by all jurisdictions except Victoria, it is the responsibility of a person conducting a business or undertaking to eliminate, or where not able, minimize all risks as far as reasonably practicable, or face penalties [15]. Such legislation allows the regulator to investigate, make recommendations and lay charges against employers if psychological hazards are not adequately managed.

At the time of writing, the adapted legislation has a limited body of publicly available decided case law, although early recommendations and enforcement activity have occurred, and more cases are underway. Convictions have been made for cases involving the death of workers by suicide, where this has been linked to psychosocial hazards in the workplace [16, 17]. This is an early indication that the psychological harm experienced from adverse events, which can in severe cases lead to suicide, is a risk worth considering. Based on publicly available sources, we did not identify notices or prosecutions explicitly concerning 'second victim' phenomena within Australian healthcare settings, and note that jurisprudence around clinical governance and investigative processes in the workplace continues to evolve.

3 | The Second Victim Phenomenon as a Psychosocial Hazard

Even before the legislation was introduced, leading authors in workplace stress noted that it is the responsibility of management to balance not just productivity concerns, but also the psychological health of workers, through their philosophy, values and actions [3]. Management who demonstrate commitment, prioritization, communication and engagement in psychological health and safety have better staff engagement, lower absenteeism and better outcomes for accidents, absences and patient incidents [18]. Unsurprisingly, this is consistent with research on the importance of frontline leadership on clinician well-being [19].

With such evidence and the new legislation, there are calls for healthcare managers to address job stressors, such as bullying, intimidation and harassment, excessive work demands and inadequate resourcing, as well as ensuring duty-hour limitations, safer work conditions, engagement of healthcare workers in psychosocial safety programmes and providing a supportive work environment with autonomy [18].

Missing from these calls is consideration of the impact on staff after adverse events. Given that 6.4% of the 7.1 million hospital separations (when a patient leaves a hospital due to discharge, transfer to another facility or death) in Australia in 2022–2023 were associated with an adverse event [20], this is almost half a million adverse events each year. Almost half of workers involved in these events, if not more, will experience distress and the second victim phenomenon [21, 22], meaning there are potentially tens or even hundreds of thousands of healthcare workers in Australia impacted every year, largely unacknowledged.

Healthcare workers involved in adverse events may experience shock, helplessness, guilt, inadequacy, self-criticism, embarrassment, worry, depression, grief, anger, impaired concentration, intrusive thoughts, nightmares, sleep disturbance, physical symptoms, social withdrawal, fear and doubts about competence. Investigations may cause further harm, prompting worry about repercussions to reputation, job security and registration. A subset of second victims may experience severe and persistent effects similar to post-traumatic stress disorder, depression, anxiety, burnout, impaired relationships, reduced quality of life, workforce exit or suicide [4, 21–26]. These psychological symptoms and their sequelae, often linked to feeling both personally responsible for the patient outcome and that the healthcare worker has failed the patient and their family [4], makes being a 'second victim' a psychosocial hazard.

Although management of healthcare worker well-being is a sufficient impetus for change, there is evidence of increased rates of additional adverse events after the initial event, as well as increased absenteeism and staff turnover, with significant costs to organizations [26–29]. It is in everyone's interest to address this psychological hazard.

Under the WHS Act, organizations must ensure, as far as reasonably practicable, the health and safety of workers. Given that the rate of hospital admissions associated with adverse events has not changed significantly over recent years [20], elimination of such incidents may not be immediately feasible. Instead, senior managers must recognize the second victim phenomenon and act.

For an organizational approach, there is emerging evidence for adopting a restorative and just culture (RJC), which aims to avoid punitive impacts and instead foster restorative processes [30]. An RJC considers the needs of all those harmed—including healthcare workers, patients, families and communities—and works to collaboratively address these harms to provide healing. Accountability is maintained through dialogue and learning, in contrast to retribution and blame [30]. An RJC reduces second victim distress and mediates outcomes, such as absenteeism and turnover via open communication, collaborative problem solving and a non-blaming climate [31, 32].

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An RJC begins with leadership and staff co-developing a culture imbued with psychological safety, care and support. All meetings, including morbidity and mortality meetings, should reflect this ethos, and leadership must be custodians of this culture. Serious incident reviews should ensure deep exploration of contributing issues, allow staff to speak openly without fear and foster learning and improvement [31, 32]. Support should be provided to staff involved in incidents, including follow-up [30]. Scott and colleagues emphasize the role of education in their three-tiered model, with the first tier being that supervisors and colleagues should receive basic awareness training so all staff can offer early support after an adverse event [33].

The second tier from Scott and colleagues work [33] is provision of trained peer supporters. Increasingly, organizations have peer-support programmes for staff impacted by adverse events [33–38], reflecting evidence that this type of support is valued by second victims [4, 21]. Peer-support programmes operationalize the care of colleagues, with trusted and trained peers providing immediate emotional first aid and facilitating access to professional services [35]. Evidence shows improved psychological outcomes among users of these services [36, 37]. Such programmes require ongoing resources to remain sustainable [34, 38].

The third tier is access to professional support when needed [33], including employee assistance programmes, chaplains and external mental health resources. Employee assistance programmes may be customized to support second victims through education on expected reactions, guidance for supervisors and integration with peer support.

RJC paradigms are emerging in Australian and international contexts. Early evidence shows improvements in organizational trust and support [39], the quality of investigations and recommendations [39], other workforce outcomes [26] and meeting justice needs of patients, families and involved staff [26]. Further evaluation is needed to determine whether greater learning and behavioural change occur as predicted [26].

For too long healthcare workers have silently suffered as second victims of adverse events, and through investigations rooted in blame rather than learning and humanity. Legislation will hopefully provide impetus to change, and RJC offers a framework to support healthcare workers while also addressing justice needs of patients and families, who remain the primary victims. Ultimately, caring for healthcare workers is inseparable from caring for the patients they serve.

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