Fostering a Culture of Wellbeing: Caring For the Caregivers

Illinois Risk Management Services Annual Meeting

Bloomington, IL, 9/18/2025

Albert W. Wu, MD, MPH

Johns Hopkins University

Objectives

- Define the concept “Second Victim”
- Explain the importance of a culture of well-being to worker well-being and patient safety
- Describe how to support health workers without increasing disclosure risk, including for
  - Allegations of sexual misconduct or maltreatment
  - Adverse/unexpected events
- Explain relationship to CMS Patient Safety Structural Measures

How Many

- Clinicians
- Trainees
- Managers
- Leaders
- Risk Managers
- Lawyers

What are the scariest words in medicine?

“Can you stop by my office?”

Your mind instantly leaps to assume

I must be in Trouble

For most people, hearing these words elicits instinctive panic

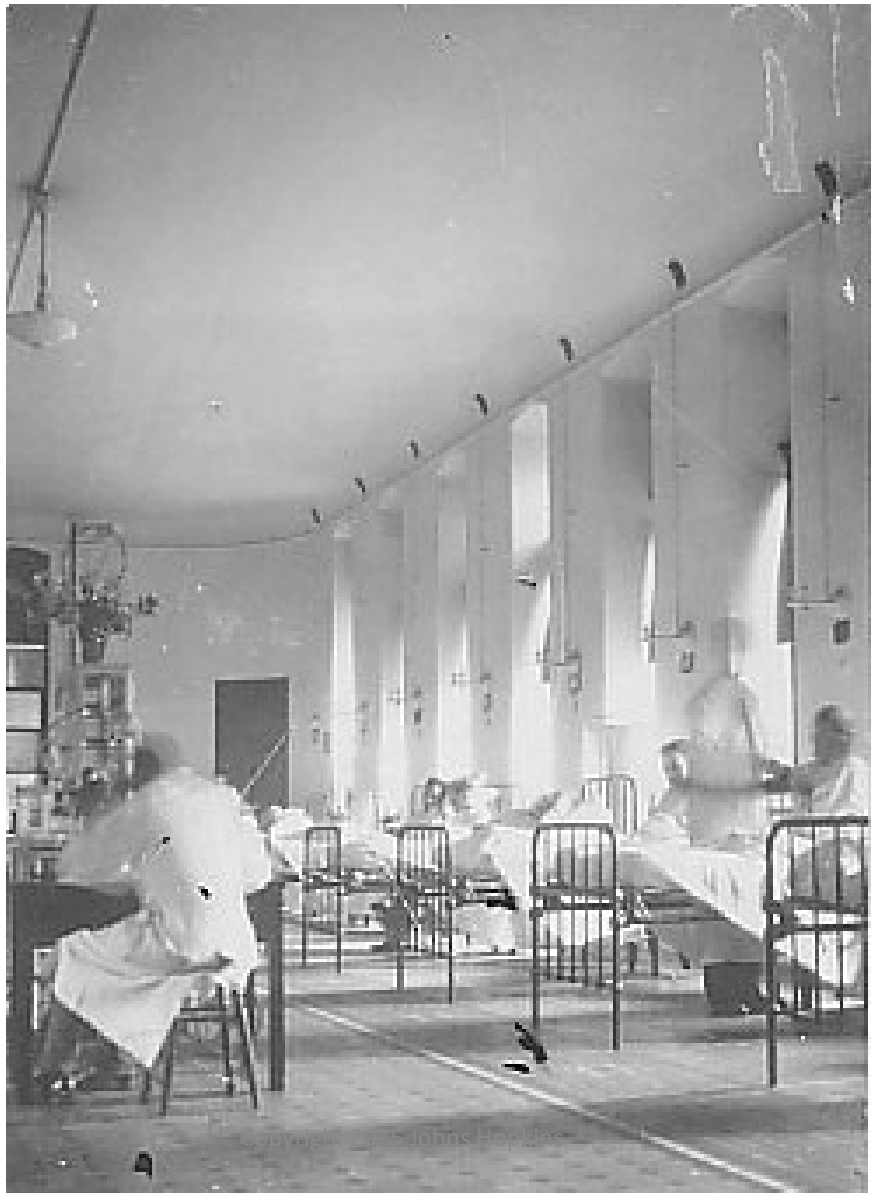
”If you need to talk to Risk Management, it is not a good day”

We know that

Individual workers are not to blame for adverse events

but…

Every Clinician Has a Personal Experience



Case

65 year old woman transferred from Cardiac Intensive Care where she had been admitted for Acute Myocardial Infarction and Congestive Heart Failure

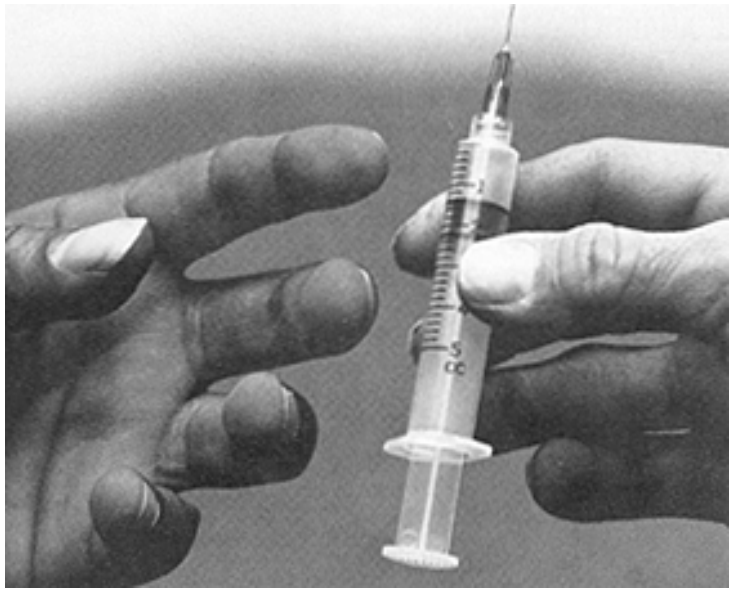
Hospital Course

Rapidly progressive increasing dyspnea

Cardiac team returns, administers 100% O_2 via face mask

Cardiology fellow calls for 2 mg Morphine Sulfate “IV Push”

Or, directs Medical Student to "Push this"

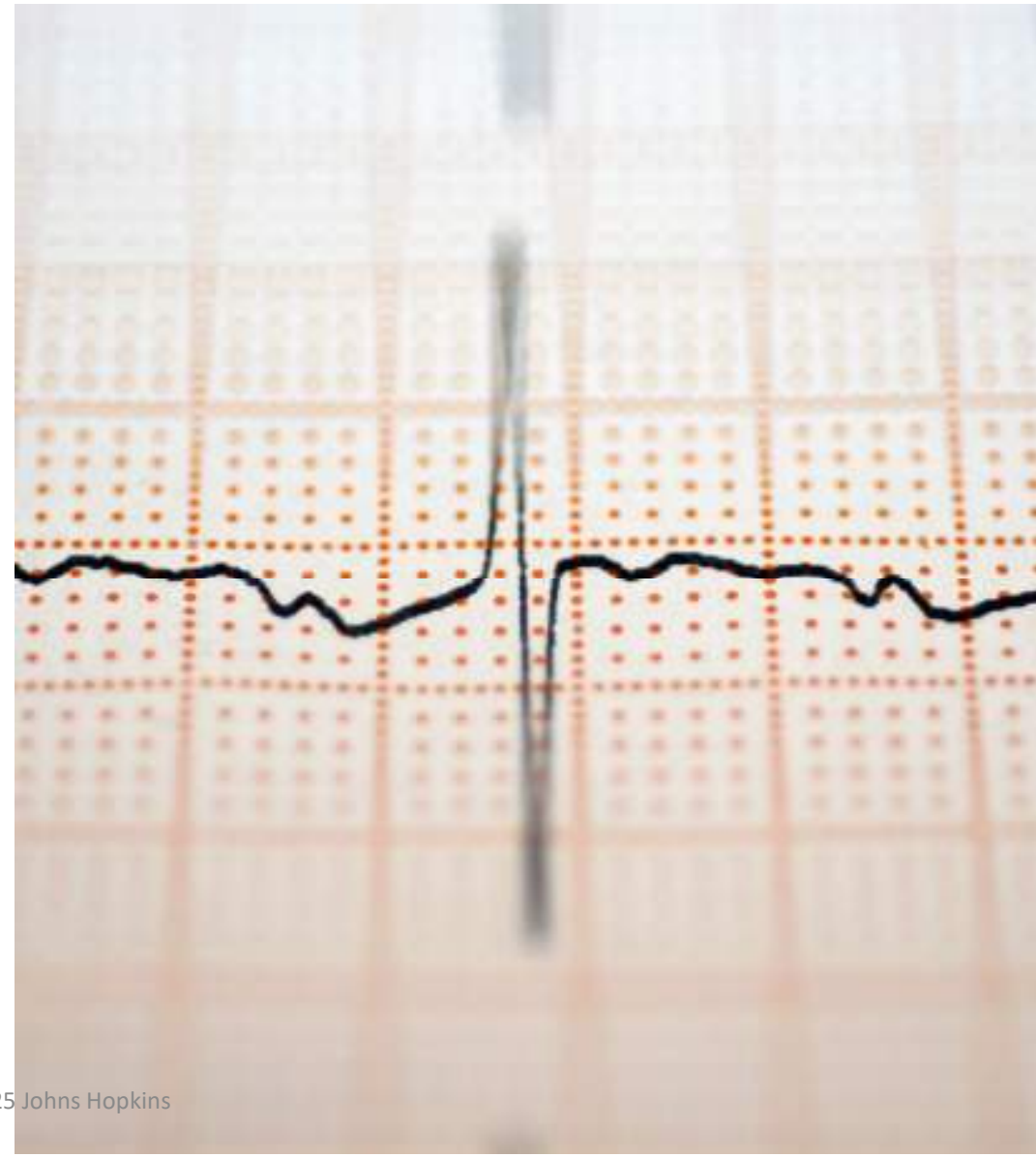


Medical Student administers 10 mg of intravenous Morphine Sulfate

Respiratory rate slows from 32 to 2

Patient intubated

Returns to CCU



Acute Stress Reaction

Initial dazed state: tunnel vision, inability to comprehend stimuli, disorientation – followed by:

- Withdrawal / detachment
- Agitation, hyperactivity
- Anxiety, depression
- Impaired judgment
- Confusion, depersonalization
- Amnesia

Symptoms appear within minutes of the impact of the stressful event, disappear within 2–3 days

Walter Cannon

Debrief

"Did you learn anything today?"

"I don't think anyone needs to hear about this"

Medical error: the second victim

The doctor who makes the mistake needs help too

When I was a house officer another resident failed to identify the electrocardiographic signs of the pericardial tamponade that would rush the patient to the operating room late that night. The news spread rapidly, the case tried repeatedly before an incredulous jury of peers, who returned a summary judgment of incompetence. I was dismayed by the lack of sympathy and wondered secretly if I could have made the same mistake—and, like the hapless resident, become the second victim of the error.

improvements that could decrease errors. Many errors are built into existing routines and devices, setting up the unwitting physician and patient for disaster. And, although patients are the first and obvious victims of medical mistakes, doctors are wounded by the same errors: they are the second victims.

Virtually every practitioner knows the sickening realisation of making a bad mistake. You feel singled out and exposed—seized by the instinct to see if anyone has noticed. You agonise about what to do, whether to

Wu AW. BMJ 2000

The Second Victim Experience

- Adverse events and patient safety are caused by systems of care which contain a multitude of flaws and and latent errors
- Patients and their families are the first and obvious victims of medical mistakes
- Clinicians can be psychologically harmed by the same errors, and can be considered “second victims”
- Clinicians feel responsible, like they have failed, question own competence

Psychological and Psychosomatic Symptoms of Second Victims of Adverse Events: a Systematic Review and Meta-Analysis

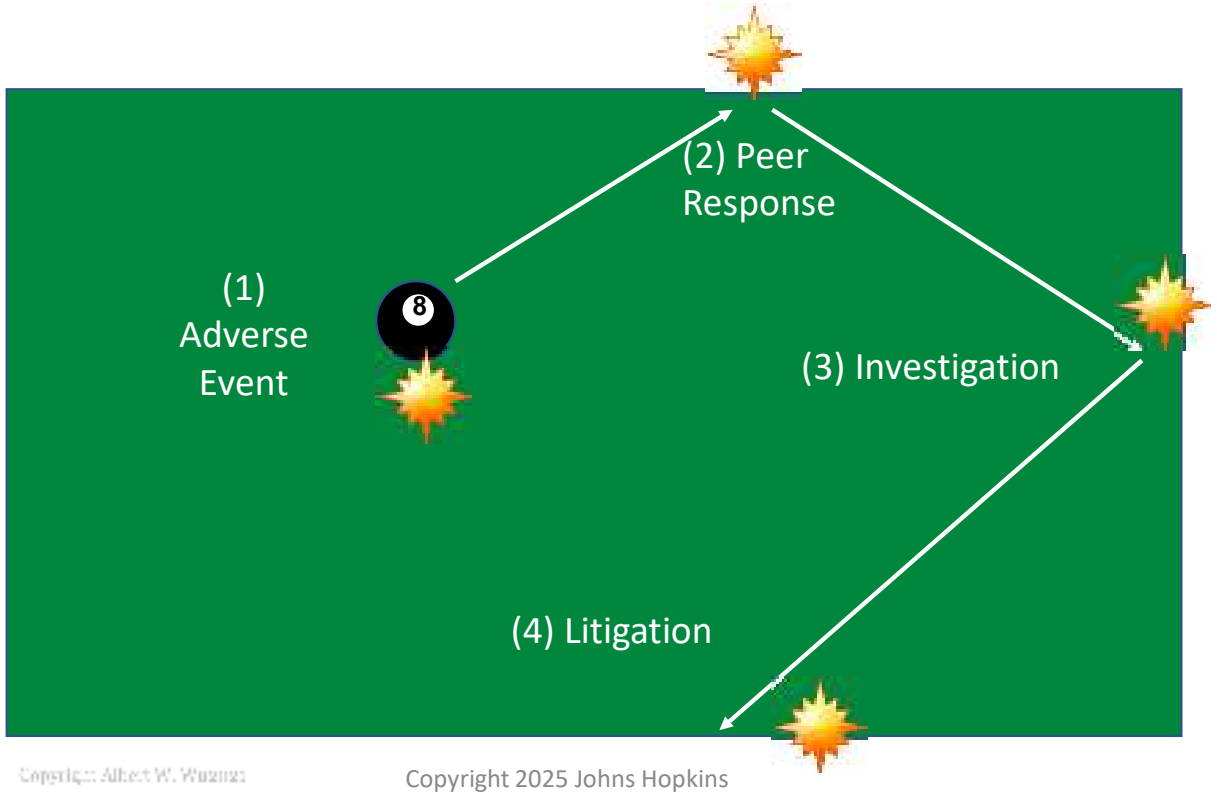
Isolde M. Busch, MSc,† Francesca Moretti, MD, PhD,‡ Marianna Purgato, PhD,§,‖ Corrado Barbui, MD,§,‖ Albert W. Wu, MD, MPH,† and Michela Rimondini, PhD**

- Systematic review + meta-analysis
- Psychological and psychosomatic symptoms
- 18 studies, 11,649 providers

Symptom	% Reporting
Troubling memories	81
Anxiety / Concern	76
Anger at self	75
Regret / Remorse	72
Distress	70
Fear of making future errors	56
Embarrassment	52
Guilt	51
Sleep difficulty	35%

Psychother Psychosom. 2021;90:178-90.

Multiple Traumas Associated with an Adverse Event



Natural History of the Second Victim

(1) Clinician response to initial incident

Natural History of the Second Victim

(1) Initial response to incident

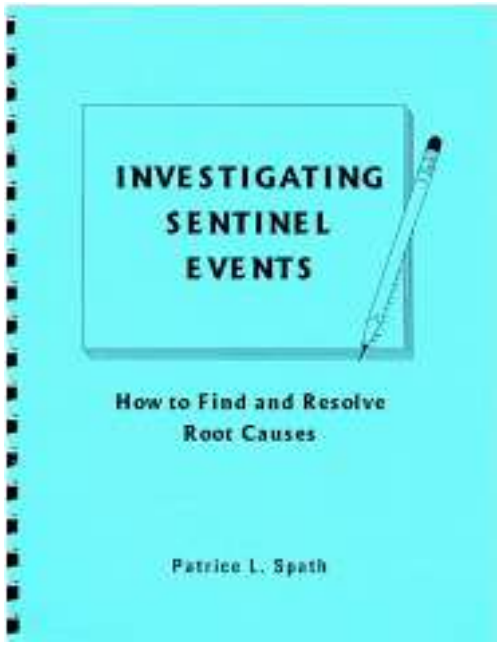
(2) Peer response

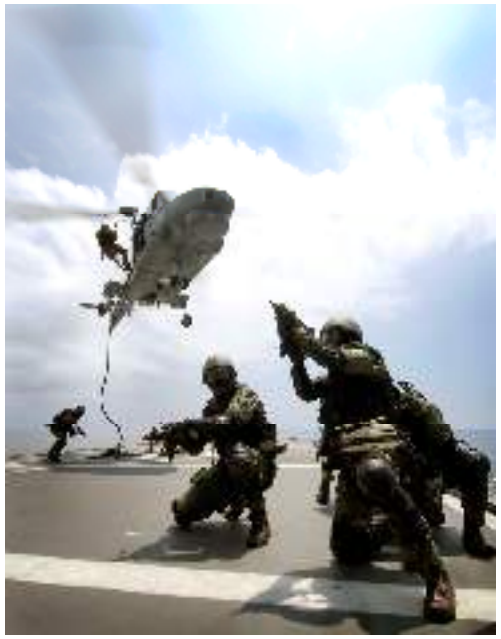
Natural History of the Second Victim

(1) Initial response to incident

(2) Peer response

(3) Investigation





Natural History of the Second Victim

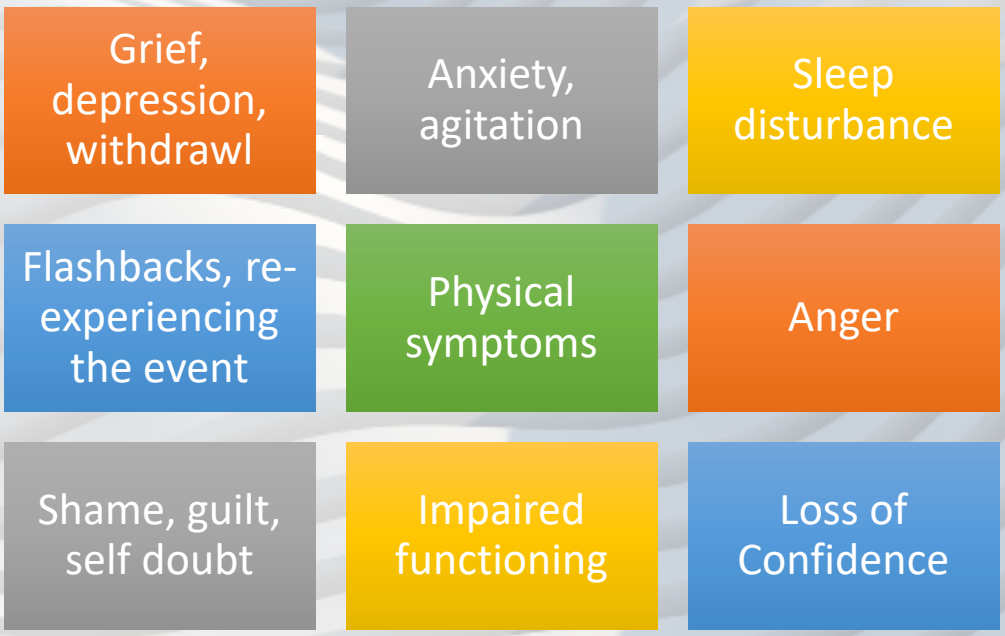
(1) Initial response to incident

(2) Peer response

(3) Investigation

(4) Litigation

Longer- Term Symptoms



Post Traumatic Stress Disorder (PTSD)

- Re-experiencing the original trauma through flashbacks, nightmares
- Avoidance of stimuli associated with the trauma
- Increased arousal: difficulty falling or staying asleep, anger, hypervigilance
- Symptoms lasting > one month

Malpractice Stress Syndrome

- The emotional stress of a medical error may be significantly worse in the setting of a malpractice lawsuit
- Clinicians may develop a “medical malpractice stress syndrome” with symptoms similar to PTSD

Wright W. The Second Victim in Medical Malpractice Litigation: The Stress of Litigation. In: Szalados JE. The Medical-Legal Aspects of Acute Care Medicine, 2021

It's About More Than Errors

Traumatic incidents broader than errors and adverse events

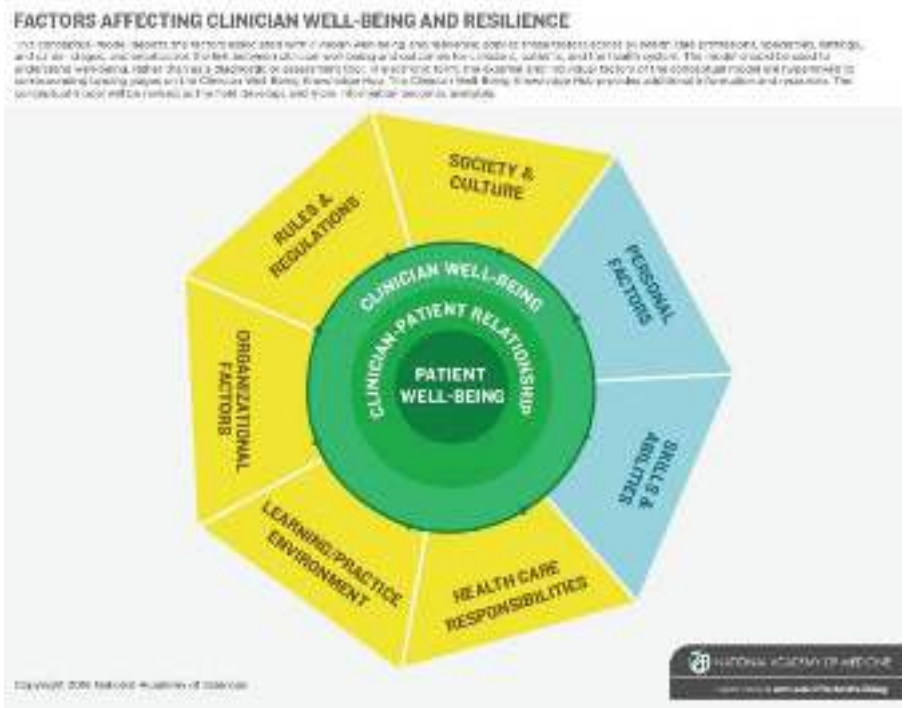
Anyone working in health care can be affected by patient adverse events

Day-to-day stresses related to work life in health care more common than acute events

Larger proportion not preventable, e.g. disappointing outcomes, difficult decisions, conflicts with patients, family and other workers

Not all stresses are associated with bad outcomes, e.g. a prolonged successful resuscitation

Factors Affecting Health Worker Well-being



- Keeping up to date
- Sicker patients
- More paper (electronic) work
- Working in multi-disciplinary teams
- More rules & regulations
- Workplace violence

- Lingering crisis of morale
- Doing more with less

Healthcare Is a High-Risk Occupation

Blame culture

- Blame culture still prevalent in healthcare
  - In a systematic review that included over 750,000 providers, less than half reported hospital response to errors was non-punitive
- To move successfully from medical errors to improving patient safety, hospitals and healthcare need to change their culture

Wu AW, Kachalia AB. Creating a "just culture": More work to be done. *Journal of Patient Safety and Risk Management*. 2023.

CMS Final Rule (FY 2025) Starting Now

- Hospital Inpatient Prospective Payment System rule
- **Patient Safety Structural Measure** (PSSM)
  - Hospital Inpatient Quality Reporting (IQR)
  - PPS-Exempt Cancer Hospital Quality Reporting (PCHQR)

- Annual hospital reporting: Calendar Year 2025
- Pay for reporting incentive: IQR hospitals FY 2027

CMS Patient Safety Structural Measure

- Attestation-based tool to evaluate if hospitals have foundational structures and policies that prioritize a culture of safety
  - Leadership commitment to eliminating preventable harm
  - Strategic planning and organizational policy
  - Culture of safety and learning health systems
  - Accountability and transparency
  - Patient and family engagement

- Hospital performance on PSSM publicly reported on CMS Care Compare website

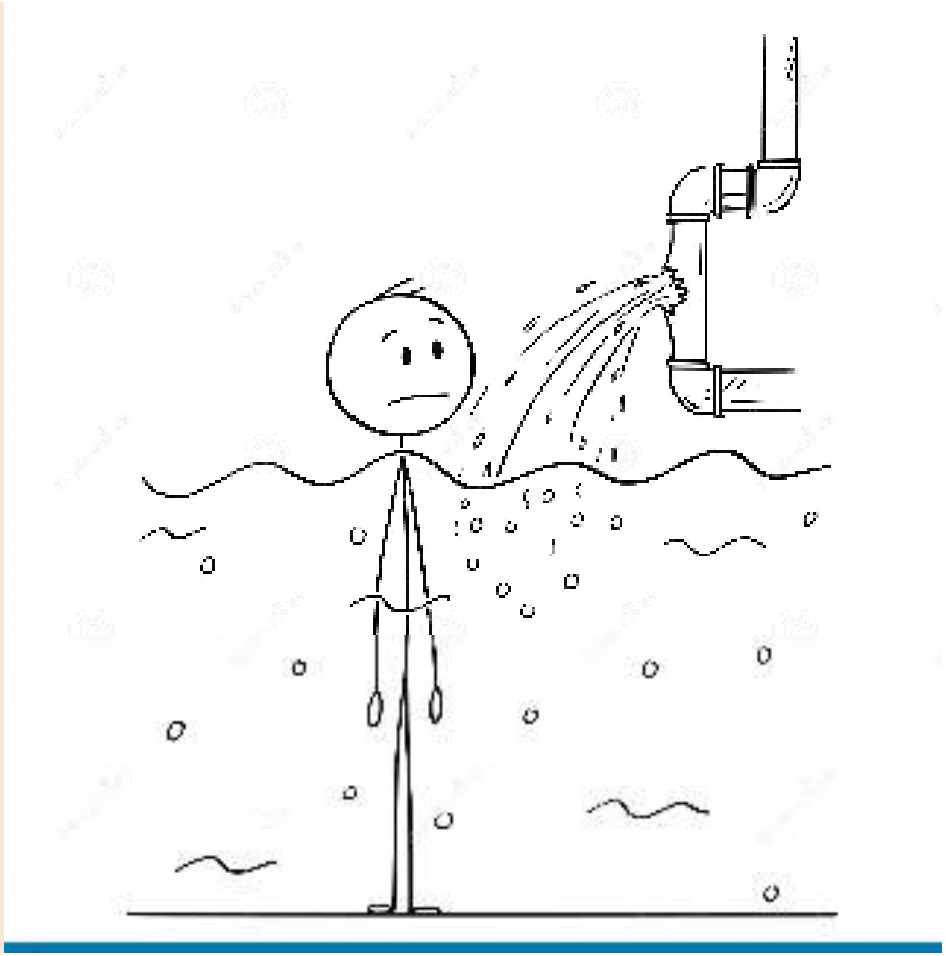
CMS Patient Safety Structural Measures (PSSM)

1. Leadership commitment to eliminating preventable harm
2. Strategic planning and organizational policy
    - **Just culture policy**
    - Action plan for **workforce safety**
3. Culture of safety and learning health systems
    - Safety culture surveys
4. Accountability and transparency
    - **Safety reporting system** to Patient Safety Organization
5. Patient and family engagement

Challenges to Implementing PSSM

- Legal and compliance risk
  - Fear of **discovery**
  - State law protections inconsistent: federal Patient Safety Act (PSQIA 2005) re patient safety work product
- Lack of organizational resources
  - Quality improvement programs
  - Training
- Cultural barriers
  - **Punitive** mindset
- Data and **technology limitations**
- Patient and family engagement barriers

What Can Institutions Do?



Changing Institutional Culture

Institutions Require a "Culture of Safety"

Workers want to feel recognized (**heard, seen, understood) and appreciated**

Hospital leaders are more punitive than they think

- **Non-punitive vs Just Culture**

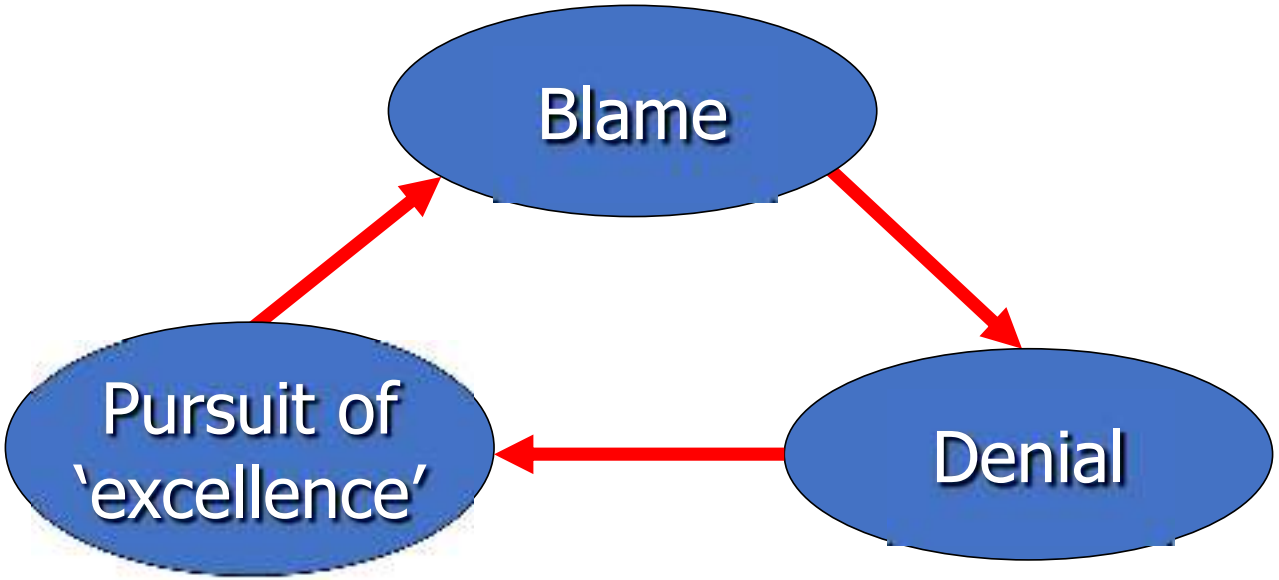
Perceptions of institutional support for “second victims” are associated with workforce well-being*

Workers need Psychological Safety to thrive at work

Institutions should adopt a Culture of Well-being

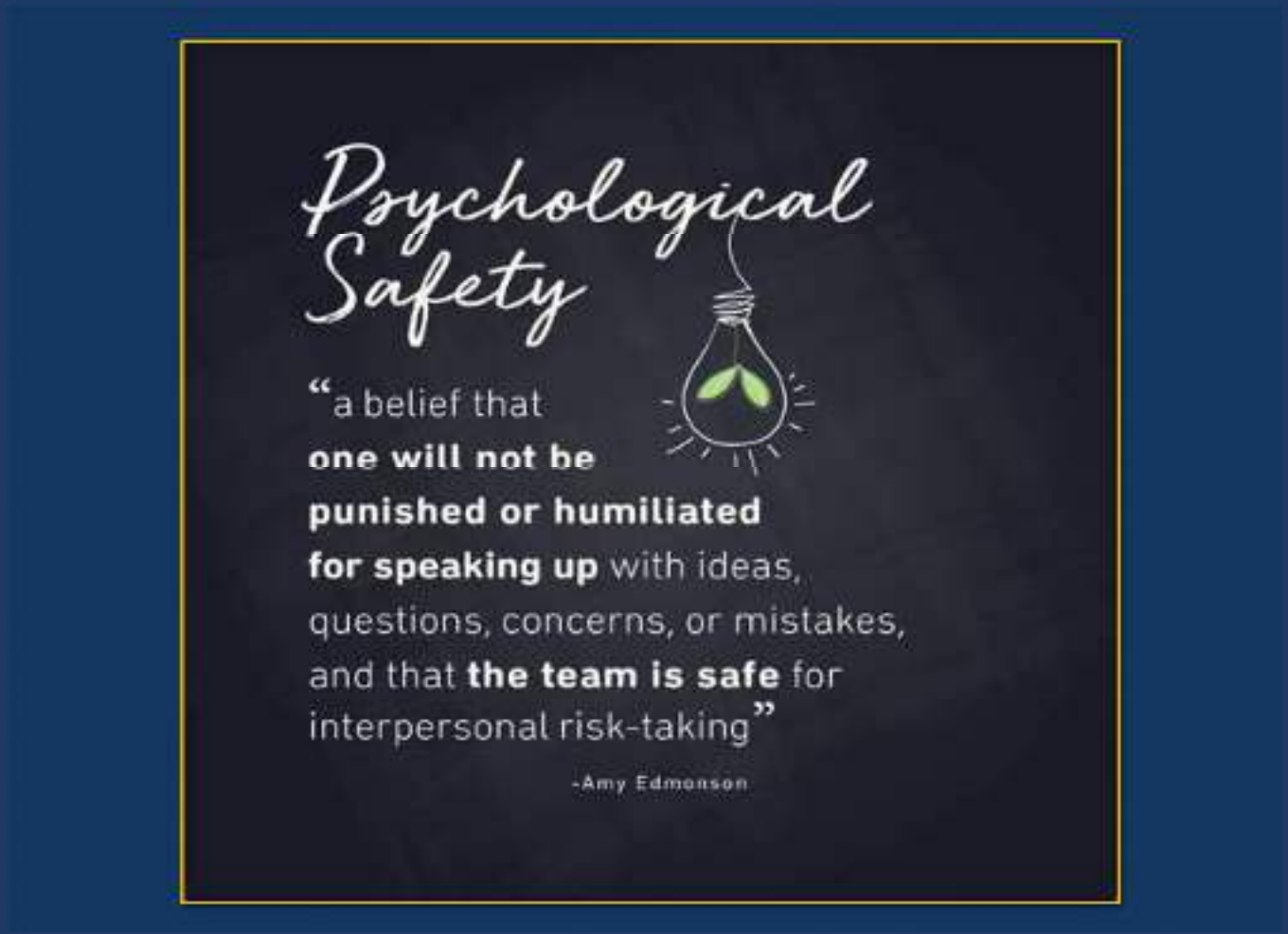
*Sexton et al. Perceptions of Institutional Support for "Second Victims" Associated with Safety Culture and Workforce Well-Being. Jt Comm J Qual Patient Saf. 2021;47:306

Lessons from IOM Report To Err is Human The Workers are not to Blame



The Vulnerable System Syndrome

Reason, 1990



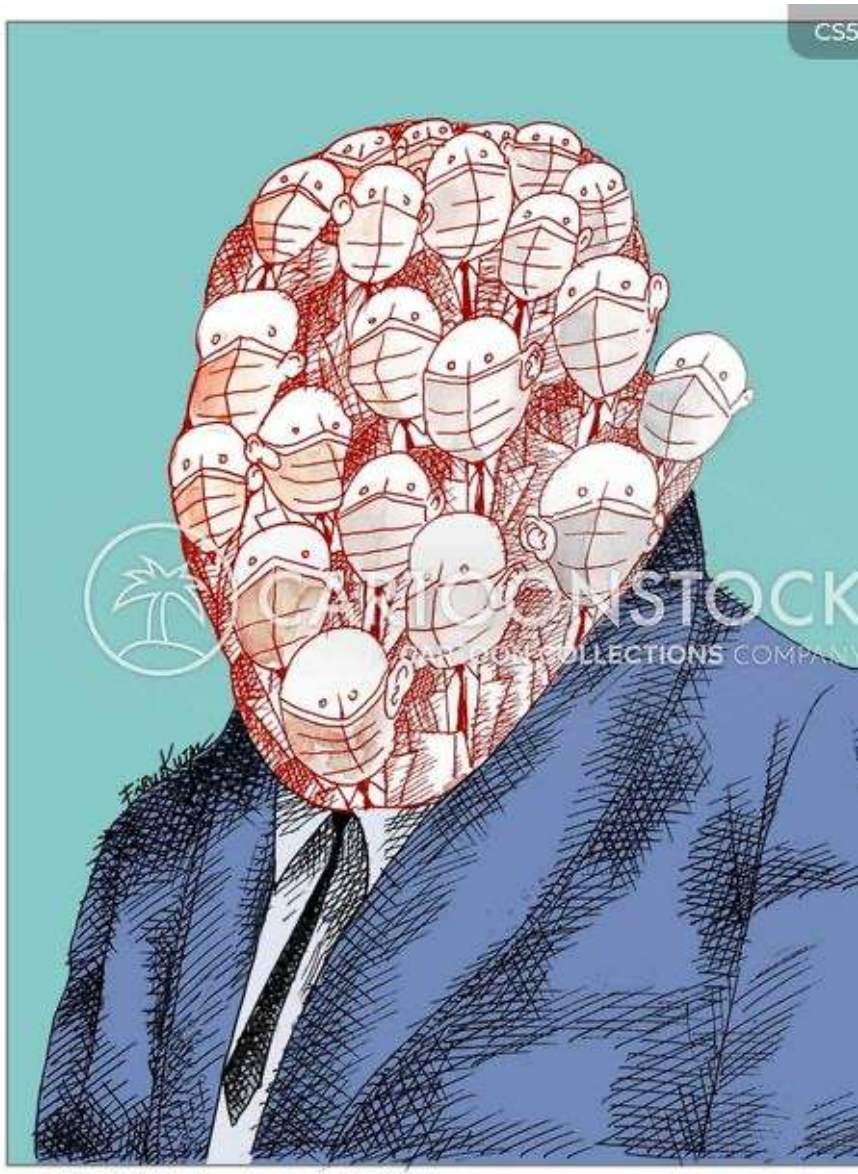
Psychological Safety

- Foundation for high-performing, learning, resilient teams
- When psychological safety is present, workers feel comfortable
  - Speaking up
  - Asking for help
  - Admitting mistakes

Image Jimmy Foulds

Without Psychological Safety:

- Individual Consequences
  - Fear of punishment, shame
  - Burnout
  - Reduced help-seeking
- Impact on Care
  - Reduced event reporting
  - Incomplete information sharing
- Impact on Organization
  - Turnover
  - Reduced trust
  - Lack of learning and improvement



WHO: Leaders need to be committed to a blame-free environment

Design systems to support desired behaviors

Just culture

- The problem in health care is not bad people care—it is that good people are working in bad systems that need to be made safer
- A blame-free culture is one in which individuals feel able to report errors without fear of punishment
- Reason (1997) theory of a “just culture” as part of a culture of safety, required to build trust and allow reporting
- Marx (2001) “…in between a blame-free culture and a punitive culture… (just culture) encourages people to raise their hands and say they made a mistake, yet still holds them accountable if they choose behavior that knowingly puts someone at risk

Wu AW, Kachalia AB. Creating a “just culture”: More work to be done. JPSRM 2023

Just culture

- The problem is not bad people care—it is good people working in bad systems that need to be made safer
- A blame-free culture is one in which individuals feel able to report errors without fear of punishment
- Reason (1997) "just culture" is part of a culture of safety, required to build trust and allow reporting
- Marx (2001) "…in between a blame-free culture and a punitive culture… (just culture) encourages people to raise their hands and say they made a mistake, yet still holds them accountable if they choose behavior that knowingly puts someone at risk

Wu AW, Kachalia AB. Creating a "just culture": More work to be done. JPSRM 2023

PCAST REPORT 2023

2.D Improve Safety for All Healthcare Workers (and Their Patients) Through Supporting a Just Culture of Patient and Clinician Safety in Healthcare Systems

Policy

The Johns Hopkins Hospital
Interdisciplinary Clinical Practice Manual
MEDICAL ERROR DISCLOSURE

Philosophy

The Johns Hopkins Hospital (JHH) strives for safety in patient care, teaching, and research

Policy

- All health care professionals have an obligation to report medical errors as a means to improve patient care delivery and to help promote safety and quality in patient care.
- Since the majority of medical errors can be linked to environmental and systems-related issues that may affect the actions of health professionals, a systems improvement focus will be used in all error analysis.
- Prompt reporting of a medical error in good faith will not result in punitive action by the hospital against the involved individuals except as mandated by law or regulatory requirements. The principles concerning non-punitive reporting do not eliminate the hospital's obligations to conduct ongoing and periodic performance review, where repeated errors or other issues may lead to personnel action.
- It is the right of the patient to receive information about clinically relevant medical errors. The JHH has an obligation to disclose information regarding these errors to the patient in a prompt, clear and honest manner. This is consistent with The Johns Hopkins Hospital Code of Ethics.

Potential Solutions

- **Secure data systems for patient safety work product** and quality improvement data
- Partnership with PSO
- **Incident reporting system that protects anonymity**
- Work with legal counsel
- **Communication and Resolutions Programs (CRPs) e.g. CANDOR**
- Health court
- **Enterprise liability**

BMJ Quality & Safety Online First, published on 2 January 2012 as 10.1136/bmjqs-2011-000605

Medical error, incident investigation and the second victim: doing better but feeling worse?

Albert W Wu,[1] Rachel C Steckelberg[2]

In th… health… more… the ha… incide… a ro… response to an adverse event.[1] In the USA, … event… hospi… analys… standa… Arme… investigations, research and quality improvement efforts are now taking on system improvements required to create a safer healthcare environment.

…workers to do more with less. But in …

In a typical incident investigation, the goal is to identify what happened, the problems that occurred in healthcare related to these events,

…with their responses to medical errors and/or adverse medical events. No standard operating procedure exists for handling the healthcare workers involved, and organisations run the risk of running roughshod over them.

Healthcare workers are often impacted by medical errors as 'second victims', and experience many of the same emotions and/or feelings that the 'first victims'—the …nbers.[13] …nilar to …isorder, …detach- …lisation, …depres- sion, withdrawal or agitation, and … Added … errors …nd self- …on and …on, and … signifi- cantly impaired in performing usual roles. These symptoms may last days to weeks. A few go on to suffer long-term consequences, similar to post-

Leaders need to establish an organizational expectation that "anything less than a supportive response is unacceptable"

Why not begin every investigation by saying to the involved staff member, "This must be very difficult for you. How are you doing?"

Individual vs Organizational Resilience

Individual resilience: Personal qualities that enable one to thrive in the face of adversity

Organizational resilience: The ability to prepare for and adapt to changing conditions and withstand and recover rapidly from disruptions; to carry out its mission in the face of adversity

Individual resilience can be supported or challenged by properties of the organization they work in


OnGuard
A newsletter about patient safety
Fall 2010
75% wanted prompt debriefing for individual or group/team)
The second victims
Helping caregivers through the trauma of medical errors
Copyright 2025 Johns Hopkins

RISE

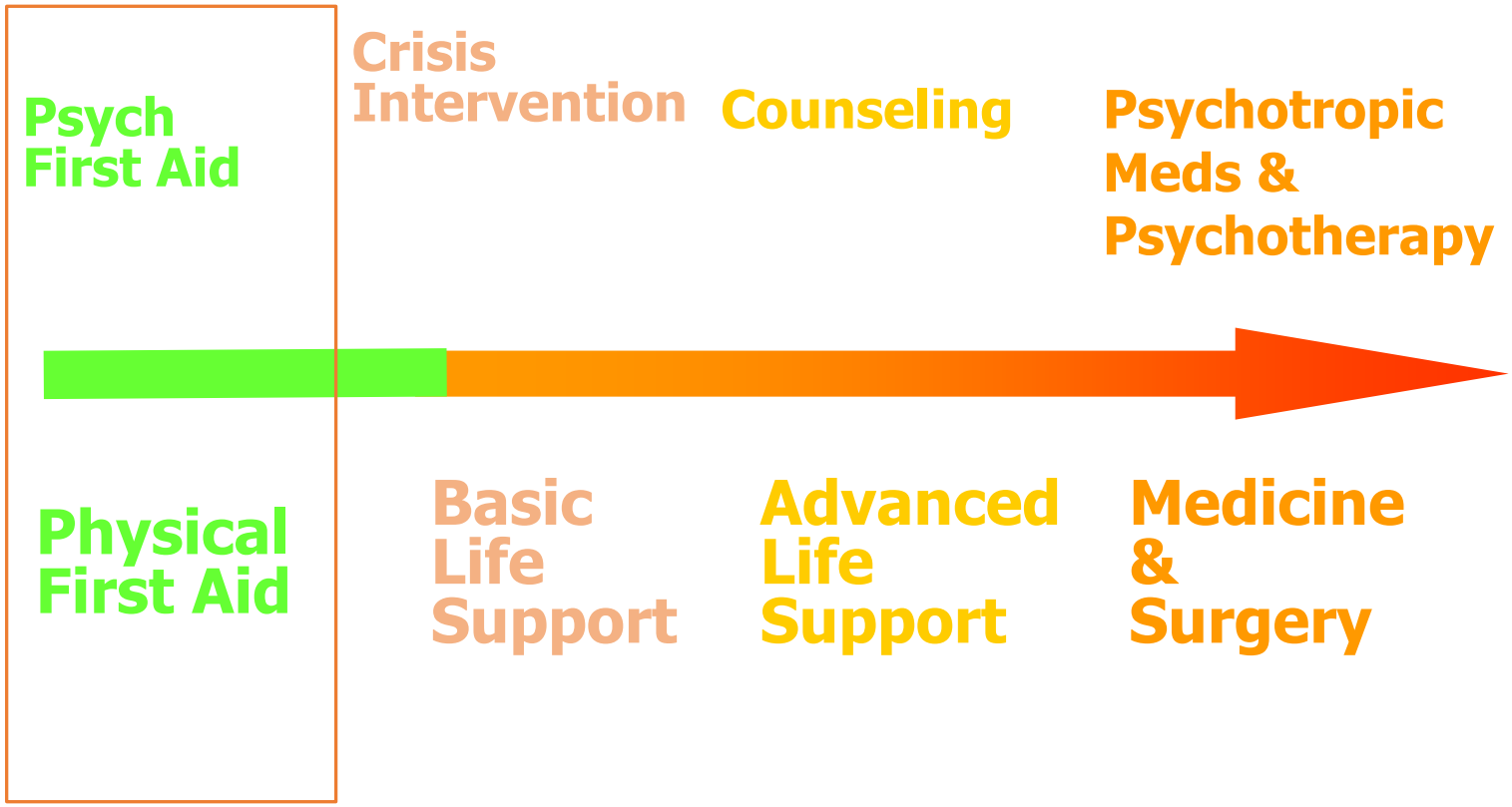
Resilience In Stressful Events

"Provide confidential, timely peer support to employees who encounter a stressful, patient related event"

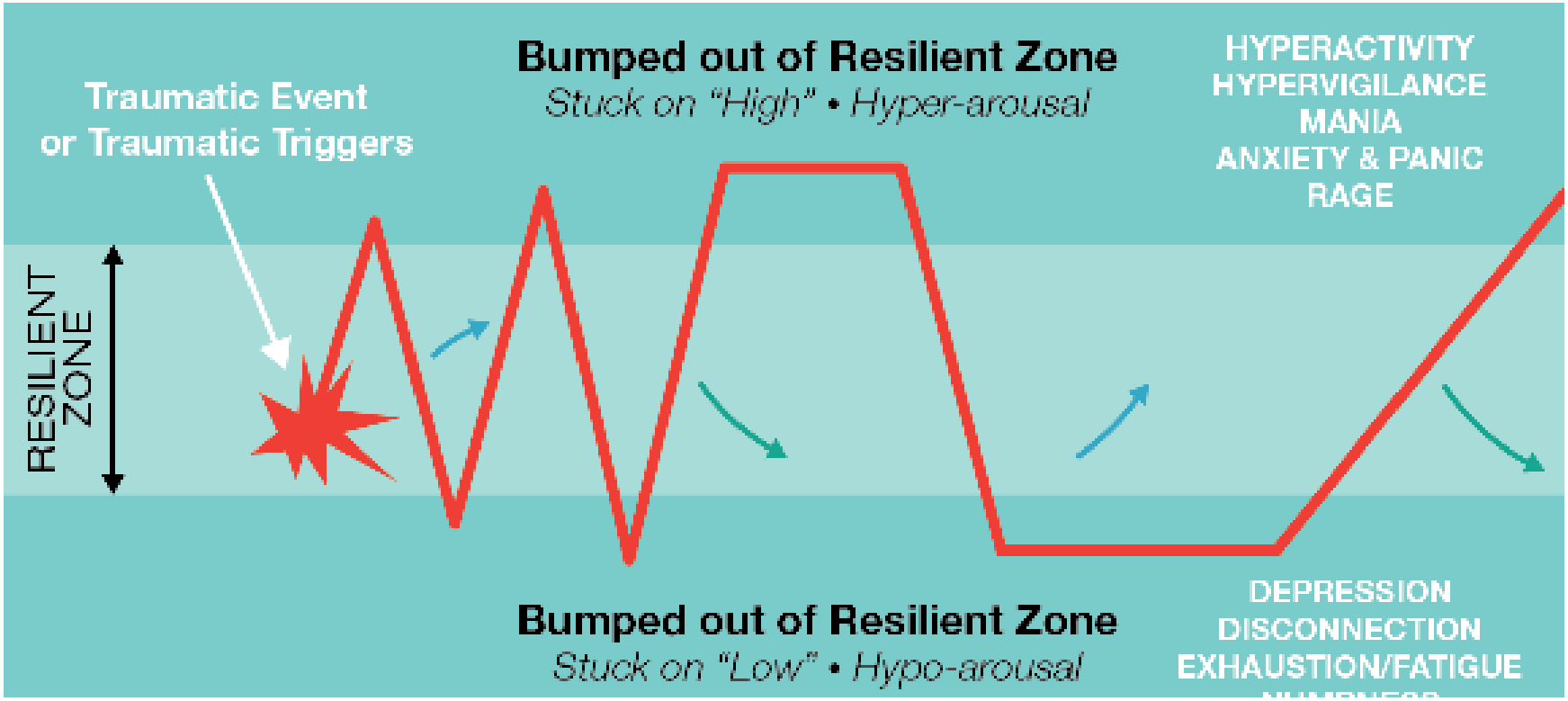
RISE

- Multidisciplinary team
- Reports to no one
- On-call 24/7
- Responds within 30 min
- Any worker
- Individual or group support by **peers**
- No record
- Provides **psychological first aid** + **emotional support**

Psychological First Aid



The Resilient Zone Model



Johns Hopkins Integrated Continuum for Staff Support (Mental Emotional and Spiritual Health (MESH)

- Office of Well-Being
- Healthy at Hopkins
- Spiritual Care
- RISE: Resilience in Stressful Events
- FASAP
- Department of Psychiatry

Strategies to Cope With Litigation

- Call Johns Hopkins RISE
- Discuss your feelings with a trusted person—your lawyer, another physician, a family member, or a friend. **Fact specifics, however, should be discussed only with your counsel.**
- If the above are unavailable, contact your local medical or specialty society for referral to an available peer or support group

Institutional Resources

Office of Well-Being

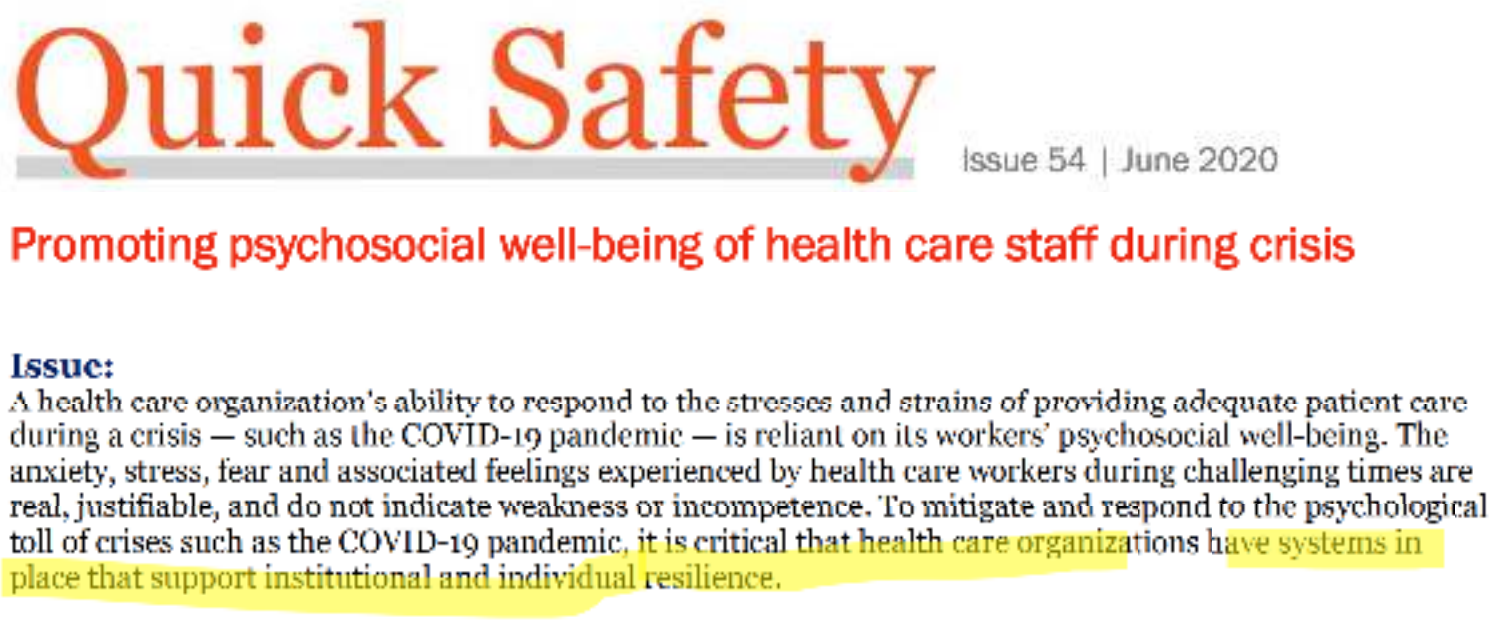
RISE Restorative Space

Institutional Resources

Office of Well-Being

”Tune Bed”

Joint Commission



Quick Safety

Issue 54 | June 2020

Promoting psychosocial well-being of health care staff during crisis

Issue:

A health care organization's ability to respond to the stresses and strains of providing adequate patient care during a crisis — such as the COVID-19 pandemic — is reliant on its workers' psychosocial well-being. The anxiety, stress, fear and associated feelings experienced by health care workers during challenging times are real, justifiable, and do not indicate weakness or incompetence. To mitigate and respond to the psychological toll of crises such as the COVID-19 pandemic, it is critical that health care organizations have systems in place that support institutional and individual resilience.

https://www.jointcommission.org/-/media/tjc/newsletters/quick-safety-54-promoting-hcw-well-being-during-crisis-6-4-20-final2.pdf

Caring for the Caregiver

Implementing RISE

Presented by Maryland Patient Safety Center in collaboration with The Johns Hopkins Hospital RISE Program

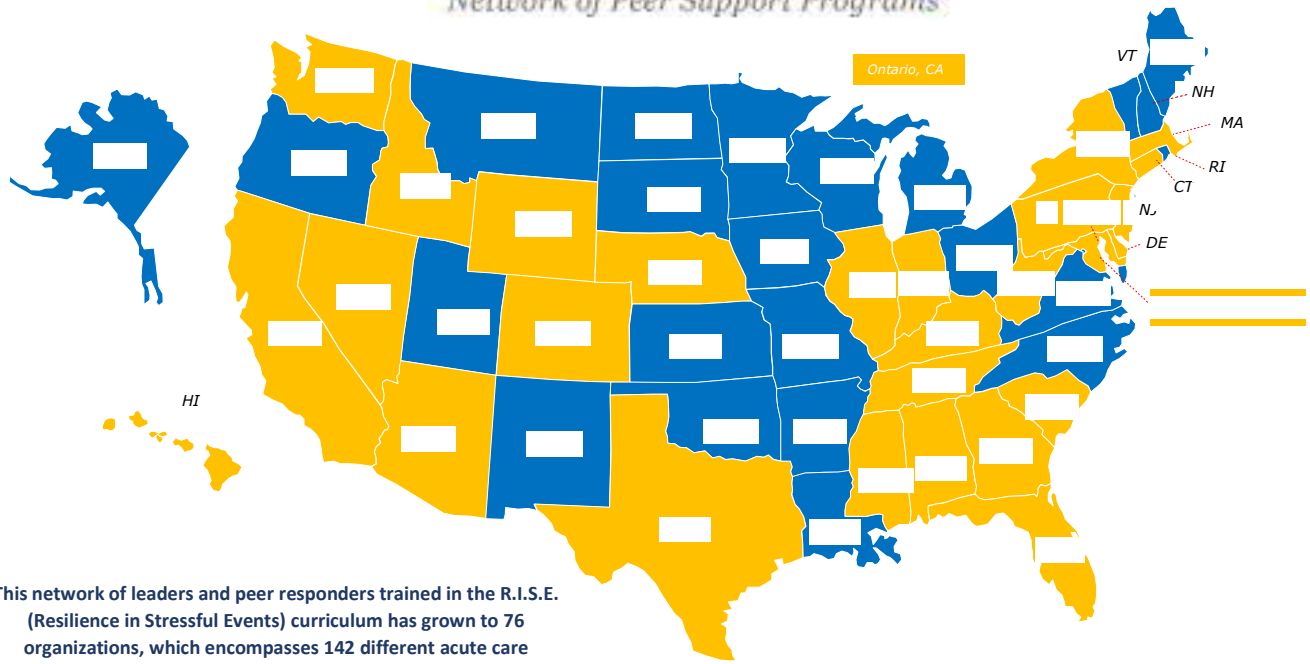
Maryland Patient Safety Center | Johns Hopkins Medicine

JOHNS HOPKINS MEDICINE

CFC RISE PARTNER

Network of Peer Support Programs

MARYLAND *Patient Safety* CENTER



This network of leaders and peer responders trained in the R.I.S.E. (Resilience in Stressful Events) curriculum has grown to 76 organizations, which encompasses 142 different acute care hospitals, six provider groups, three veterinary groups, two schools of nursing, two FQHCs, and one state Public Health Department. Some of these are new as of 2025, and some have been a part of this collaboration since 2011.

Connecting our partners with colleagues across the country has proven to be an effective tool for shared experiential learning and creative best practices.

https://marylandpatientsafety.org/Caregiver

BARRIERS TO PEER SUPPORT

- Low awareness
- Persistent blame culture
- Lack of funding
- Reluctance to show vulnerability

Busch et al Int J Environ Res Public Health 2021;18:5080

Staff members perceive asking for help as being "weak"

Principles for supporting clinician resilience and well-being

01

Let them know you want to support them

02

Make it easy for health care workers to get the support they need

03

Actively coordinate existing support services

What is the Goal?

- Culture of safety
- Just culture
- Culture of well-being

Promote Health Care Worker Well-being

High quality healthcare depends on healthy workers

Summary

- Healthcare is high-risk for clinician mental health
- Medicine has traditionally taken a blame approach to error
- Healthcare needs to foster workplace psychological safety and ultimately a culture of well-being

References

- Busch I, et al. Psychological and psychosomatic symptoms of second victims of adverse events: a systematic review and meta-analysis. Psychother Psychosom. 2021;90:178-90
- Charles SC. Coping with a medical malpractice suit. West J Med. 2001 Jan;174(1):55-8.
- CMS Patient Safety Structural Measure. Explainer. https://betsylehmancenterma.gov/assets/uploads/general/CMS_PSSM_combined.pdf
- National Academy of Medicine. Action Collaborative on Clinician Well-Being and Resilience. https://nam.edu/our-work/programs/clinician-resilience-and-well-being/
- Norvell N, Connors CA, Wu AW. Helping without harm: supporting health workers after medical errors in 2023. Polish Archives of Internal Medicine. 2023;4:164
- Sexton JB, Adair KC, Profit J, Milne J, McCulloh M, Scott S, Frankel A. Perceptions of Institutional Support for "Second Victims" Associated with Safety Culture and Workforce Well-Being. Jt Comm J Qual Patient Saf. 2021;47(5):306-312.
- Wright, W.L. (2021). The Second Victim in Medical Malpractice Litigation: The Stress of Litigation. In: Szalados, J.E. (eds) The Medical-Legal Aspects of Acute Care Medicine. Springer, Cham.
- Wu AW. Medical error: the second victim. BMJ 2000;320:726-727.
- Wu AW, Steckelberg RC. Medical error, incident investigation and the second victim: doing better but feeling worse? BMJ Qual Saf. 2012
- Wu AW. My eye – the importance of clinician well-being in 2020. Journal of Patient Safety and Risk Management. 2020 (February);25(1):3-4.
- Wu AW, Kachalia AB. Creating a “just culture”: More work to be done. J Patient Safe Risk Manage. 2023

Questions?

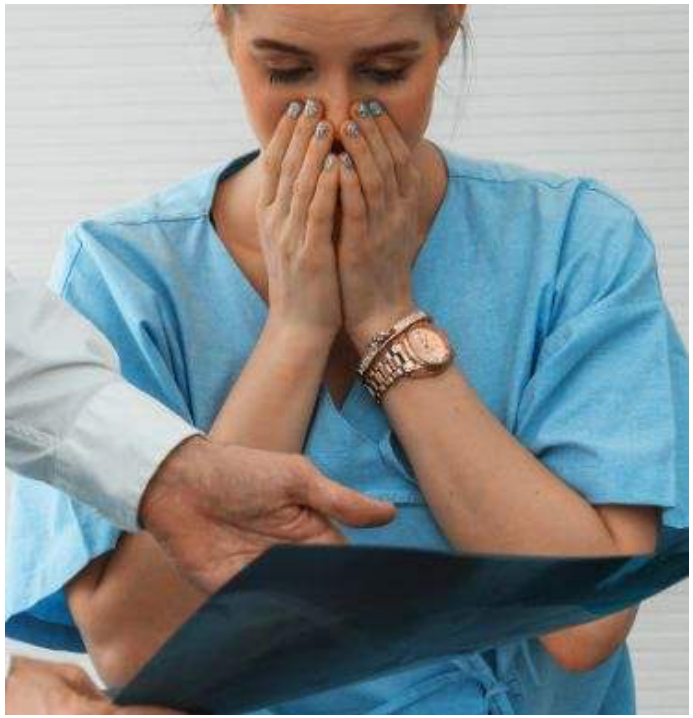
awu@jhu.edu

https://publichealth.jhu.edu/academics/mas-in-patient-safety-and-healthcare-quality

BACK UP SLIDES

Physicians Named in Lawsuits

- Nearly 1/3 of US physicians in 2022 had been in a lawsuit; nearly 1/2 for over 54
- Not an indication of clinician wrongdoing
  - 65% of claims closed 2016-18 were dropped, dismissed, or withdrawn
  - Out of the 6% of claims decided by trial, 89% won by the defendant.



Guardado J. Medical liability claim frequency among US physicians. AMA Policy Research Perspectives 2023

Restore Mastery and Self Esteem

- Ask your lawyer to describe your role in each step of the process
- Ask about the anticipated length of time required to process the case
- Prepare yourself for the unpredictability of the process—the rules, the lawyers, the judge, the experts, and the jury
- Take an active role with your lawyers in the defense of the case
- Identify practice areas that cause anxiety/“loss of control” - find ways to diminish them

Restore Mastery and Self Esteem, cont…

- Do not participate in practice situations that demand compromises in your professional standards
- Engage in activities that will increase your competence: courses, accreditation activities, teaching, or hospital or clinic committee work
- Review the amount of time you devote to family and professional activities and make the necessary changes
- Attend to financial and estate planning, if this is delayed
- Take time away from practice, e.g., a real vacation
- Participate regularly in active sports, workouts, other leisure activities
- Schedule the necessary prep time for depositions and participation in the trial
- Do not try to “fit patients in” during the trial; being on trial is a full-time job

Change the Meaning of the Event

- The charge is you have failed in competence -are therefore, a “bad” doctor; need to work to perceive yourself as “good”
- Review your career objectively – you function well and competently
- Reflect on input from legal + insurance counsel about the case and acknowledge the “truth” about the events in question
- Seek emotional support from family, legal counsel, and mental health professionals to manage any stressors surrounding settlement or going to trial
- Be kind to yourself, even when being objective