Surgeon as the Second Victim

Supporting Faculty & Residents
After Adverse Outcomes

Complications

A Surgeon's Notes on an Imperfect Science

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Written during residency

Written from the inside looking out.

On Fallibility

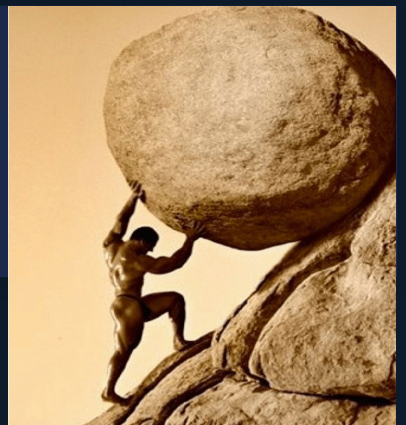
Medicine's ground state is uncertainty. The question is not how to stop bad doctors — it is how to prevent good doctors from causing harm.

On the M&M Paradox

M&M reinforces the idea that error is intolerable — yet its very existence acknowledges mistakes are inevitable. That tension is never resolved for the surgeon in the room.

On Silence & Patient Safety

Where errors are hidden, learning is squelched. Like Sisyphus, clinicians in closed systems are compelled to err and err again. Transparency is patient safety.



INSIDE A SURGEON'S MIND AFTER A COMPLICATION -- What No One Teaches You in Residency

Guilt vs. Shame

"This was not guilt: guilt is what you feel when you have done something wrong. What I felt was shame: I was what was wrong."

Shame attacks identity, not behavior — this is why a complication can feel catastrophic to a surgeon's sense of self, and why silence follows.

The Value of Fear

"If you're not a little afraid when you operate, you're bound to do a patient a grave disservice."

Healthy self-doubt is protective. Surgeons who feel no anxiety after adverse events are the ones who stop learning — and become dangerous.

Imperfection & Aspiration

"No matter what measures are taken, doctors will sometimes falter, and it isn't reasonable to ask that we achieve perfection. What is reasonable is to ask that we never cease to aim for it."

The frame for every M&M, every debrief, and every honest conversation between peers after a complication.

The Second Victim

Healthcare providers who are traumatized — psychologically, emotionally, and professionally — following an unexpected adverse patient event, medical error, or patient-related injury.

— Scott, 2011; Wu, 2000

50% of surgeons report distress after a complication

40% of residents experience burnout post-adverse event

30% delay seeking support due to professional stigma

** Estimates drawn from published surveys in surgical education literature*

IMPACT ON FACULTY & TRAINEES

Both groups share the same wound — but face different institutional power, visibility, and access to support.

Attending Surgeon

- Guilt, shame, and self-doubt
- Fear of litigation & reputation damage
- Second-guessing clinical judgment
- Reluctance to disclose to team
- Sleep disruption & concentration lapses
- Long-term impact on surgical confidence

Resident / Trainee

- Professional identity threat
- Fear of evaluation consequences
- Lack of structured debriefing access
- Dependence on attending for cues
- Amplified imposter syndrome
- Under-reporting for self-protection

A PERSONAL REFLECTION

Two Cases. Twenty Years Apart. The Same Surgeon.

Both ended in death. Both were catastrophic. One left me abandoned. One left me held. What made the difference was not the outcome — it was the institution around me.

Case 1 — Year 3 of Practice
The Young Mother

Case 2 — Year 20 of Practice
The Father of Three

The Young Mother

A 2-month postpartum patient — obstructing ureteral stone — routine ureteroscopy laser lithotripsy

What Happened

- New mother, 2 months postpartum, transferred from another hospital with acute obstructing ureteral stone
- EHRs between institutions did not communicate — complete history unobtainable across systems
- Patient withheld her medications: she had required 3–4 antihypertensives during a complicated pregnancy, and feared they would harm her infant by breast feeding
- Routine ureteroscopy and laser lithotripsy performed without incident
- Admitted overnight for unanticipated postop course – maintained on telemetry
- On postop day 1, while walking the halls before discharge — sudden massive cardiac arrest. She died.

The Institutional Response

DPH mandatory report: Case reported to Dept of Public Health because patient had recently given birth — adding external scrutiny

No support: Department chairman was not supportive — the response was accusatory and blame-focused, not systems-based

No debrief: No structured opportunity to process what happened, what was unavoidable, or how to move forward

Hidden complexity: The critical clinical information (antihypertensives, complicated pregnancy) was undisclosed by the patient to protect her infant

The wound: Left to carry the weight of a death that unfolded at the intersection of institutional gaps, patient fear, and clinical uncertainty — alone

The Father of Three

53-year-old male — 15cm locally advanced & metastatic left renal tumor — cytoreductive nephrectomy

What Happened

- Happily married with 3 young children — presented to multidisciplinary clinic with 15cm advanced left renal tumor
- Retroperitoneal muscle invasion, poor surgical planes with adjacent medial organs; bone and lung metastases
- Over 150 cytoreductive nephrectomies performed at that point in career — extensive experience with complex cases
- During dissection of medial structures, sudden catastrophic hemorrhage
- Help called to OR immediately. Despite all efforts, patient died shortly in the postoperative period
- Case reviewed at Urology M&M, Department of Surgery M&M, and by the institutional quality and safety group

The Institutional Response

Structured review: Case examined at multiple M&Ms and by the quality/safety team — with a systems-based, not person-based, frame

Institutional support: Felt genuinely supported by the institution throughout the process

The call that mattered: A colleague from general surgery called the next morning — not about the case, but to ask: “Are you okay?”

Learning, not blame: The focus was on what could be learned and improved, not on finding fault with the surgeon

The difference: Same tragic outcome. Same surgeon. But I was not left alone with it — and that changed everything.

The phone call cost nothing. It changed everything. That is what second-victim support looks like.

WHAT MADE THE DIFFERENCE?

Same surgeon. Same devotion. Same tragedy. Completely different experience of being a second victim.

Case 1 — Year 3 — The Young Mother	VS	Case 2 — Year 20 — The Father of Three
Chairman was accusatory and blame-focused		Institution provided genuine, structured support
No debriefing or safe space to process the event		Multiple M&Ms framed around systems, not blame
Finger-pointing; individual fault as the narrative		Quality/safety team focused on learning and improvement
Mandatory DPH report added external scrutiny with no support		Colleague called the next morning just to ask: “Are you okay?”
Left alone with guilt, shame, and unanswerable questions		Held by the institution and by a colleague’s simple act of care

Fear of litigation is real — but it is not a reason to hide, blame, or abandon the second victim.

Missed Bowel Injury

The institution provided legal representation — and nothing else.

Missed Bowel Injury

Male in his 60s — GG4 prostate cancer — cytoreductive radical prostatectomy clinical trial

What Happened

- Male in 60s referred with elevated PSA, GG4 disease.
- Discussed at tumor board; recommended surgery.
- Transperitoneal RARP performed without issues. OR time: 4 hours
- POD #1: diffuse abdominal pain, low-grade fever, elevated WBC. CT with PO contrast negative
- General surgery consulted. Taken back to OR — distal jejunum/proximal ileum injury found
- Two OR trips for repair. ICU ~1 week. Discharged home. Patient is alive today

The Institutional Response

Family communication: Spoke to patient's family daily throughout the course, providing updates — transparent and compassionate disclosure

Litigation: Sued for fatigue from missed bowel injury. Based on legal counsel's advice, case was settled

Institutional support: Legal representation provided — and nothing else. No peer support, no debriefing, no check-in from leadership

The wound: Carried the emotional weight of a protracted legal process, a complication, and a settlement — without a single institutional act of human care

The contrast: The patient lived. The surgeon was still alone.

THREE SURGEONS. THREE CASES. ONE PATTERN.

What determined the second-victim experience was not the clinical outcome. It was what the institution did next.

Case 1	Case 2 Father of three	Case 3 Bowel Injury
Outcome Patient died	**Outcome** Patient died	**Outcome** Patient survived
Support None — chairman accusatory	**Support** Institution supportive; colleague called next morning	**Support** Legal only — no peer support, no debrief, no check-in
Experience Left alone with shame and unanswerable questions	**Experience** Held by the institution. Able to process and move forward	**Experience** Carried the weight of litigation alone. No institutional care.

BEST PRACTICES: DISCLOSURE, DEBRIEFING & SUPPORT

IMMEDIATE
0–48 hours

- Structured team debrief in safe space *(if additional cases for the day or week, consider cancelling)*
- Attending leads compassionate family disclosure
- Peer check-in for resident (not evaluation-linked)
- Document facts; separate from judgment

SHORT-TERM
Days to weeks

- Formal M&M with systems-based framing
- 1:1 faculty mentorship for trainee
- Connect to peer support *(consider spiritual services)*
- Normalize emotional response explicitly

LONG-TERM
Weeks to months

- Embed lessons in curriculum (not blame)
- Competency review separate from support
- Faculty development on coaching resilience
- Program-level second-victim policy review

EMBEDDING SECOND-VICTIM AWARENESS INTO TRAINING

M&M Conference Reform

Systems framing: lead with process, not person

Explicit opening: 'This is a safe space to learn'

Resident voice: protected speaking time

Emotional check-in: before case analysis begins

Close with learning: not blame or punishment

Follow-up: assign support contact for all involved

Residency Curriculum Integration

Orientation session: define second victim on Day 1

Simulation debrief: include emotional processing

Mentor training: faculty equipped to hold the space

Anonymous reporting: low-barrier pathway for trainees

Peer support program: RISE / forYOU integration

Annual competency: distinguish from punitive review

A CALL TO THE FIELD

We Train Surgeons to Save Lives — We Must Also Save Our Own.

- Normalize second-victim conversations in every program
- Build peer-support pathways before the next adverse event
- Separate emotional support from performance evaluation
- Make this a national standard in surgical training

Resources: Second Victim Toolkit | RISE Program | forYOU Program | ACS Surgeon Wellbeing Resources

Have you personally experienced the second-victim phenomenon?

A	B	C	D
Yes — as an attending	Yes — as a resident/fellow	I witnessed it in a colleague	I have not experienced it yet

Does your program have a formal second-victim support pathway?

YES	PARTIAL	NO
Formal program exists (RISE, forYOU, or equivalent)	Informal support exists but no structured program	No formal pathway currently in place

From the trainee perspective: What do residents actually need in the 24 hours after a complication?

01 Someone to tell them it wasn't their fault

02 Space away from clinical duties

03 Attending to model open processing

04 Peer conversation (not faculty-led)

05 A structured debriefing script

06 Reassurance it won't affect their evaluation

LARGE GROUP DISCUSSION

In your program, what is the single biggest barrier to supporting surgeons after adverse outcomes?

Common themes to explore:

- Surgical culture of silence
- Fear of appearing weak or unfit
- Time — nobody stops
- No designated peer supporters
- Confusion: support vs. accountability

Before you leave today: Name ONE thing you will do differently in your program next month.

Program Directors

- Add second-victim language to orientation
- Review M&M format for safety culture
- Identify a peer-support point person

Attendings

- Check in on a trainee after next complication
- Share your own story with your team
- Ask residents: “How are you doing with this?”

Residents & Fellows

- Tell a colleague you’re there if they need it
- Ask your program about available support
- Normalize peer-to-peer check-ins