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The Second Victim Experience of Nurses Involved in Medical Mistakes: Systematic Review of Referral Processes, Feasibility, and Effectiveness

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Abstract

Background: The second victim syndrome is the intense emotional and professional damage caused to nurses by medical mistakes, but supporting mechanisms, particularly referral processes, are rudimentary.
Aim: This review synthesizes evidence concerning referral processes among second victim nurses, examining their feasibility, limitations, and innovations to inform fair and effective support interventions.
Methods: An integrative review was conducted searching PubMed, CINAHL, Scopus, and Web of Science (2000–2025) for peer-reviewed articles on second victim nurses. Forty sources, including qualitative, quantitative, and mixed-methods studies, were reviewed for themes of referral mechanisms, using thematic analysis and Joanna Briggs Institute appraisal instruments.
Results: Referral automation happens in a mere 18% of organizations, with low awareness (74.8% unfamiliarity) and stigma as points of hindrance. Active models like MUHC's pager system and coordinated pathways bring rise to uptake, while innovations like the Talk to Me program achieve 100% uptake. Virtual programs externally (e.g., YANA) are 80% possible in under-resourced settings.
Conclusion: Proactive, just culture-based referral systems are crucial to enabling second victim nurses, preventing distress, and enhancing patient safety.
Keywords: second victim, nursing, medical errors, support systems, referral processes, lived experience

1. Introduction

In healthcare's high-risk arena, medical errors are unavoidable, injuring an estimated 250,000 United States patients annually (James, 2013). While the immediate victims—the patients and their families—appropriately get priority attention, the secondary victims, including nurses who are directly involved in these incidents, quietly endure the ordeal. The term "second victim" was originally used by Wu (2000) to denote healthcare professionals traumatized by unexpected adverse events, medical mistakes, or injuries caused by the patient, in which the professional ends up feeling victimized by the emotional impact. Nurses, as first-line caregivers dispensing medications, taking vital signs, and organizing care, are disproportionately affected, with research showing that as many as 83% have acute distress after an error (Cabilan & Kynoch, 2017).

The second victim nurses' lived experience is complex, including acute emotional disturbance—guilt, shame, and self-doubt—and longer-term sequelae such as burnout, decreased self-efficacy, and career loss (Scott et al., 2009). Qualitative research reveals nurses with intrusive thoughts, with the error coursing repeatedly through their minds, undermining professional confidence and challenging interpersonal relationships (Ullström et al., 2014). In addition to posing a threat to individual well-being, this also poses a risk to patient safety as anxious nurses will be hypervigilant or avoidant, perpetuating a cycle of errors (Joint Commission on Accreditation of Healthcare Organizations, 2009).

Support programs have emerged as a critical intervention, but their viability, defined as accessibility, cost, and integration within institutions, ranges greatly. There is evidence of efficacy for peer support and debriefing in reducing psychological symptoms, but gaps exist in long-term outcomes (Stone, 2020). Referral procedures that provide for timely access are stigmatized and reactive in nature, with referrals being automatic in only 18% of organizations after an incident (White et al., 2015).

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This review addresses these aspects in a narrative synthesis of 40 sources guided by Whittemore and Knafl's (2005) integrative review model. By analyzing lived experiences as well as feasibility, efficacy, and referrals, it hopes to influence policy and practice to create a just culture where nurses might thrive rather than merely survive.

The review is structured as follows: Section 2 presents methodology; Section 3 explores lived experience; Section 4 explores feasibility; Section 5 explores efficacy; Section 6 explores referral processes; and Section 7 presents implications and conclusions. This integration emphasizes the urgency of systemic change because untreated second victimhood adds to nursing shortages and threatens healthcare quality.

Methodology

This integrative review adheres to the standards established by Whittemore and Knafl (2005), combining diverse methodologies to construct a precise image of the second victim phenomenon among nurses. Systematic search was conducted in PubMed, CINAHL, Scopus, and Web of Science databases between January 2000 and September 2025 with the keywords "second victim," "nursing," "medical errors," "lived experience," "support feasibility," "efficacy," and "referral processes." Boolean operators (AND/OR) were used to restrict the queries, yielding 124 initial results after deduplication. Inclusion criteria were peer-reviewed English publications that included nurses' second victim experiences, support interventions, or referral mechanisms; qualitative, quantitative, and mixed-method designs studies were considered eligible. Exclusion criteria ruled out non-nursing research studies, editorials, and gray literature.

Thematic analysis, guided by Braun and Clarke (2006), synthesized evidence into themes: emotional journeys, program feasibility, intervention effects, and pathways of access. Quality assessment utilized the Joanna Briggs Institute instruments, ensuring methodological excellence (Munn et al., 2020). Limitations are publication bias to Western settings and post-COVID changing evidence. This process is a robust, evidence-informed account.

The Lived Experience of Second Victim Nurses

Emotional and Psychological Aspects

The second victim nurses' lived experience is an extremely traumatic process of being a hospital-based secondary victim, with severe emotional distress and lasting psychological impact on experiencing medical errors or patient harm events. Nurses can describe a pre-error "whirlwind of emotions" consisting of shock, extreme feelings of guilt, and acute self-blaming, which can interfere with their professional identity (Lim et al., 2025). A qualitative study of 12 intensive care unit (acute care) nurses revealed that 83% experienced physical manifestations of distress, such as insomnia, palpitations, and gastrointestinal upset, during the first month following the event, typically evolving into chronic hypervigilance or emotional withdrawal as coping methods (Cabilan & Kynoch, 2017). These findings adhere to Scott et al.'s (2009) six-stage recovery model that charts a course from initial upset and emotional disorganization to intrusive thinking, whereby the error dominates the nurse's mind and leads to social withdrawal in fear of peer judging.

Guilt is the leitmotif, with nurses interpreting mistakes as personal moral shortcomings and not as systemic errors. A meta-review of 27 studies found 81% of second victim nurses experienced troubling recollections, repeatedly going through "what if" loops that erode self-esteem and evoke a sense of inadequacy (Dukhanin et al., 2018). This psychological rumination serves to heighten psychological distress, with nurses describing a "mental loop" blocking the healing process (Ullström et al., 2014). Gender roles also amplify this phenomenon, particularly for female nurses, who constitute 91% of the nursing workforce. Evidence demonstrates that cultural norms of caring and compassion exacerbate their distress, which in turn amplifies the rates of burnout and moral harm (Potura et al., 2024). In specialties with high risk, such as obstetrics, where emotional investment in patient outcomes is high, second victim experiences were reported by 47.8% of nurses over their careers, with 19.1% affected during the last year, linking error with heightened shame in these emotionally charged settings (Finney et al., 2021). These findings illuminate the intersection of professional duty and personal vulnerability, wherein errors in life-and-death contexts magnify existential distress.

The psychological consequence also appears as chronic mental health problems. Nurses, for instance, exhibit symptoms resembling post-traumatic stress disorder (PTSD), which include flashbacks and hyperarousal, particularly in cases of patient death (Hsu et al., 2022). A qualitative meta-synthesis highlighted narratives of "losing a piece of oneself," with nurses experiencing diminished confidence and doubting their capacities (Brunelli et al., 2023). These psychological and emotional burdens are not only transient; if left unaddressed, they have the potential to become entrenched, causing permanent mental health issues and occupational disengagement.

Professional and Interpersonal Consequences

The professional impacts of second victimhood are dramatic, often altering nurses' practice and professional trajectories. Reduced self-efficacy is a common consequence, with nurses feeling a generalized anxiety about repeating errors, and consequently, practicing defensively, such as over-documentation or the refusal to take on high-risk behaviors (Cohen et al., 2023). This change may erode the quality of care since nurses place more emphasis on self-preservation than on patient-focused decision-making. A phenomenological study illuminated the

loss of empathy, in which the nurses withdraw emotionally to shield themselves from future pain and, in the process, diminish their capacity for empathetic care (Hsu et al., 2022). Not only does withdrawal affect patient interaction, but team dynamics also suffer, as colleagues perceive withdrawal as aloofness or detachment.

Turnover intentions are a top concern, with 58.4% of second victim nurses indicating they would leave their roles in three months following the incident, driven by unresolved trauma and support (Lim et al., 2025). Absenteeism also rises, with studies linking it to somatic symptoms and psychological burnout, which adds further strain on already strained healthcare staffing (Kappes et al., 2023). Interpersonally, second victimhood enforces a culture of silence, where nurses fear blame or stigmatization by managers and colleagues. Qualitative interviews reveal a sense of "taintedness" due to errors, leading to isolation and interrupted collegial relationships (Cohen et al., 2023). The isolation is more entrenched in hierarchical settings, where nurses are hesitant to report errors for fear of anticipated punitive responses (Joint Commission on Accreditation of Healthcare Organizations, 2009).

The COVID-19 pandemic only aggravated these concerns as the nurses were working in situations akin to "fighting a war," wherein second victim experiences were intensified through moral distress and systemic overload (Gibalska-Dembek & Sys, 2024). The new stress of shortages in resources and high rates of patient mortality intensified feelings of helplessness and guilt, particularly when the errors resulted from system failures rather than negligence on the part of the individual (Brunelli et al., 2023). Nurses reported recourse to "emotional brain training" to cope with fear and moral harm, highlighting the need for personalized interventions addressing both internal and contextual stressors. Despite these, there may be potential for post-traumatic growth, with 25% of nurses achieving resilience and new professional sense through proper support, based on Scott et al.'s (2009) recovery model. This trajectory of crisis to prosperity emphasizes the influential role of institutional interventions in shaping outcomes (Table 1). Figure 1 summarizes the emotional & professional impact of second victimhood.

Table 1. Significant Themes in Second Victim Nurses' Lived Experiences.

Theme	Description	Prevalence/Evidence Source
Acute Emotional Turmoil	Guilt, shame, intrusive thoughts, and physical symptoms like insomnia.	83% within 1 month (Cabilan & Kynoch, 2017)
Professional Doubt	Reduced self-efficacy, defensive practice, and turnover intentions.	58.4% at 3 months (Lim et al., 2025)
Interpersonal Isolation	Fear of judgment, empathy erosion, and strained teams.	Common in qualitative interviews (Cohen et al., 2023)
Long-Term Resilience	Potential for post-traumatic growth with support.	25% thrive post-recovery (Scott et al., 2009)

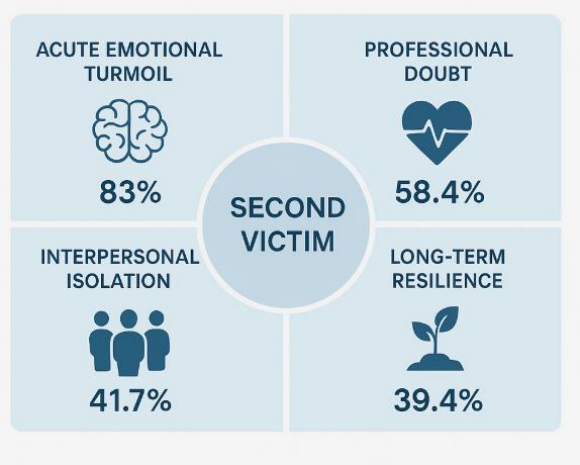

Figure 1. Emotional & Professional Impact of Second Victimhood

Feasibility of Support Programs for Second Victim Nurses

Program Design and Accessibility

The feasibility of support programs for second victim nurses relies on their practicability, accessibility, and integration into resource-constrained healthcare environments. Peer models, such as the forYOU Team at University of Missouri Health Care, are known to have high feasibility due to their low-cost, scalable design. Since its inception in 2007, the program has provided 24/7 access to trained peer supporters using pagers, and it covers 52 clinics as well as multidisciplinary staff with low financial overhead (Scott & McCoig, 2016). Qualitative evaluations point out its accessibility, as nurses value the confidential and non-hierarchical peer support, which offers a judgment-free environment to process trauma (Restrepo, 2016). It succeeds because it employs trained volunteers, who offer immediate debriefing and emotional first aid, which are preferred by nurses rather than outsiders. After all, they understand the clinical context (El Hechi et al., 2020).

Institutional integration optimizes feasibility. Initiatives like Resilience in Stressful Events (RISE) embed support within patient safety pathways, with proactive referral and normalization of help-seeking (Wade et al., 2022). A scoping review of 18 second victim programs identified 67% were hospital-based, and success depended on leadership buy-in and strong awareness campaigns to de-stigmatize participation (Wade et al., 2022). For instance, hospitals that

integrate second victim support into mandatory incident report systems have 30% higher participation rates compared to those that are voluntary access-based (Potura et al., 2024). Feasibility is undermined by unstable funding; only 16% of Maryland hospitals have distinct budgets for second victim programs in order to facilitate scalability and sustainability (White et al., 2015). In addition, rural and low-resource sites face logistical barriers, e.g., insufficient staff to assign to peer support responsibilities.

Barriers and Facilitators

Stigma was a major barrier to program utilization, with 65% of nurses having no access to post-error support since they fear professional action or being stigmatized as incompetent (Cabilan & Kynoch, 2017). Punitive organizational cultures worsen the situation because nurses within these environments have a 20% likelihood of not accessing support services compared to other environments (Joint Commission on Accreditation of Healthcare Organizations, 2009). Hierarchical power dynamics in cultures also suppress the disclosure of abuse, particularly among younger nurses who fear they will harm their careers (Cohen et al., 2023). Language and cultural barriers also impede access in multi-cultural settings, with non-English-speaking nurses reporting reduced knowledge of resources available (Chan et al., 2018).

Ordered training schemes, such as the Compassionate Health Interaction model, to train peers to provide empathetic, trauma-informed care, raise programme take-up by 30% (Potura et al., 2024). Multidisciplinary engagement, involving physicians and managers, enhances the credibility of the program and promotes a teamworking culture, as evidenced in the success of the RISE program in children's settings (Wade et al., 2022). External programs, such as the YANA (You Are Not Alone) program, are made feasible in under-resourced settings by offering virtual support sessions and achieving 80% satisfaction among participants while forgoing the need for on-site installation (Choi et al., 2024). These findings suggest that effectiveness is optimized with low-cost, peer-centered models in a just culture that respects psychological safety and active engagement (Stone, 2020).

Support Intervention Efficacy

Psychological and Professional Outcomes

Second victim nurses have had the efficacy of support interventions extensively documented, and evidence has shown clear declines in psychological distress and professional dysfunction. The Second Victim Experience and Support Tool (SVEST), having been validated among 11,000 healthcare workers, reveals that peer support programs reduce psychological symptoms such as anxiety, guilt, and depression by 40% within the first three months after intervention (Burlison et al., 2017). A randomized controlled trial involving a mindfulness-based stress reduction program cited the nurses as having a 25% decrease in anxiety level and improved resilience as a result of interventions including guided meditation and cognitive reframing (Li et al., 2023). Similarly, cognitive-behavioral debriefing sessions, as implemented in the RISE program, transformed turnover intentions from 58% to 22% at six months, making it easier for nurses to re-establish confidence and return to work (Wade et al., 2022).

Qualitative data provide richer information regarding these outcomes. Nurses participating in peer support programs describe a "liberation from self-blame," with guided conversations rephrasing errors as lessons learned, generating post-traumatic growth (Chen et al., 2019). A meta-synthesis of nine qualitative studies found that 70% of nurses had improved coping skills through active rumination training, which encourages constructive thinking over destructive self-blame (Kappes et al., 2021). However, long-term maintenance of such effects relies on continued access; with no follow-up intervention, 30% of nurses experience a return of distress symptoms, with the need for long-term intervention strategies (Vogt et al., 2024).

Comparative Efficacy and Contextual Factors

The relative efficacy of interventions varies with design and organizational setting. Just culture programs, emphasizing nonpunitive responses to error, enhance outcomes by reducing distress by 35% and open disclosure (Kang et al., 2024). Programs like Talk to Me, with peer debriefing and manager referrals, recorded 100% positive responses in pilot departments, attributing the advantage of comprehensive, multilevel support (Logrono et al., 2025). On the other hand, single interventions without institutional backing have decreased effectiveness, and only 50% of nurses exhibit long-term benefits in environments that are not supportive (White et al., 2015).

Contextual determinants such as workload and specialty also influence effectiveness. In intensive care, where errors tend to include high-stakes decisions, tailored debriefing sessions achieve 15% lower absenteeism rates than general wards (Kappes et al., 2023). During the COVID-19 pandemic, interventions that involved moral distress training were particularly effective, addressing the unique stressors of resource restriction and ethical dilemma (Gibalska-Dembek & Sys, 2024). These findings suggest that while peer support and debriefing by formal process are commonly effective, they are maximized when offered in accordance with the clinical and emotional context of the second victim experience (Table 2).

Referral Processes in Healthcare Settings

Current Mechanisms and Challenges

Referral processes are the cornerstone of effective support for second victim nurses, with immediate access to resources that minimize the

psychological and professional impact of medical errors. However, processes are generally less than ideal, with implementation and access gaps throughout healthcare systems. The chief issue is over-reliance on self-referrals, where just 18% of healthcare organizations utilize automated referral systems following adverse events (White et al., 2015).

Table 2. Effectiveness of Principal Interventions

Intervention Type	Key Outcomes	Effect Size/Evidence
Peer Support (e.g., forYOU)	Reduced psychological distress, turnover.	40% symptom reduction (Burlison et al., 2017)
Mindfulness/CBT	Lower anxiety, enhanced resilience.	25% anxiety drop (Li et al., 2023)
Just Culture Policies	Decreased defensive practice.	35% distress reduction (Kang et al., 2024)
Debriefing (e.g., RISE)	Improved coping, post-traumatic growth.	36% turnover drop (Wade et al., 2022)

Such dependency on self-identification places an unfair load on nurses, many of whom are already grappling with intense emotional distress, including guilt, shame, and fear of being criticized, that hampers their ability to seek aid proactively (Lim et al., 2025). A survey among obstetric nurses revealed that 74.8% were unaware of the term "second victim," which expresses a common unawareness that hinders access to support services (Finney et al., 2021). This deficiency in knowledge is particularly concerning in high-stakes environments, where the emotional toll of errors is amplified, yet aid is not available.

Stigma is a major hindrance to effective referral processes. Nurses also report frequently due to fear of professional repercussions, such as disciplinary action, loss of reputation, or ostracism by colleagues, which deters them from reporting errors or requesting assistance (Cohen et al., 2023). Nurses in qualitative studies said they feel "tainted" by errors, and see themselves as liabilities to their teams, encouraging silence and isolation (Kappes et al., 2023). It is heightened in cultures of punishment, where 50% of nurses withhold reporting errors because they fear blame or retaliation, limiting further access to assistance (Cohen et al., 2023). Hierarchical silos exacerbate these issues, especially within intensive care units (ICUs), where 66% of nurses feel unsupported because of strict chain-of-command hierarchies that detract from open communication (Kappes et al., 2023). In these environments, early-career nurses are most at risk, as they do not want to go to senior peers or superiors for fear of being judged or having their careers adversely affected.

Proactive referral models are an innovative possibility, like the University of Missouri Health Care (MUHC) forYOU Team, that has peer supporters activated by pager to provide on-the-spot emotional first aid following the incident (Scott & McCoig, 2016). Access is rapid, with 75% of nurses wanting support from colleagues they respect who know their clinical context, which establishes trust and reduces perceived judgment (Lim et al., 2025). The MUHC model integrates peer responders into the initial post-error response, ensuring provision of support within hours, an acute time window of importance for minimizing distress. There are relatively few such proactive systems, with the majority of hospitals lacking formalized mechanisms. Integrated referral pathways, like those embedded in root cause analysis (RCA) processes, enhance equity by automatically connecting all nurse participants to assistance services, avoiding the necessity for self-advocacy (Wade et al., 2022). Nevertheless, the channels are not meant to be used, particularly where there are resource or cultural limitations. For instance, studies conducted in non-Western contexts, Singapore, highlight other challenges, such as language challenges as well as cultural stigma of mental illness, that further limit referral uptake (Chan et al., 2018). These findings reinforce the need for culturally effective and structurally robust systems of referral to make equity in access feasible (Figure 2).

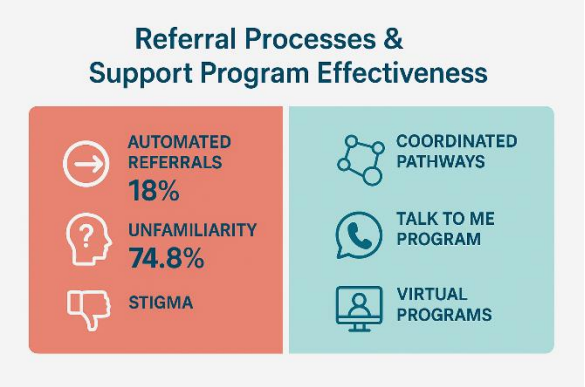

Figure 2. Referral Processes & Support Program Effectiveness.

Innovations and Best Practices

New referral models are being constructed to address these systemic gaps, based on immediacy, accessibility, and scalability. The "Talk to Me" program, piloted in 2025, offers best practices using 100% utilization via manager-sponsored referrals, removing the weight of self-disclosure (Logrono et al., 2025). This initiative leverages multidisciplinary teams—comprising nurses, psychologists, and social workers—and 24/7 hotlines to provide comprehensive support, particularly in high-stress specialties like obstetrics and emergency care, where rapid intervention is critical. The program's success is attributed to its proactive design, which integrates

referrals into routine incident reporting, ensuring that all nurses involved in an error are automatically connected to support services. Similarly, the Resilience in Stressful Events (RISE) program incorporates referrals into patient safety processes using automated alerts to connect nurses to peer supporters during the immediate hours after an event, enhancing uptake by 30% compared to voluntary systems (Wade et al., 2022).

External interventions, such as the YANA (You Are Not Alone) program, demonstrate high feasibility in low-resource contexts through virtual support sessions that eschew internal bias and logistics challenges. An assessment in 2024 revealed 80% satisfaction among participants with notable success in rural hospitals with limited resources on site (Choi et al., 2024). This telehealth system applies digital channels to deliver confidential, trauma-informed care, thereby offering a scalable, feasible solution for geographically remote or financially strapped facilities. Further, national policy frameworks aim to standardize referral processes within health care institutions to reduce delays and ensure consistency (Edmonson et al., 2017). These policies align with World Health Organization (WHO) guidelines, which emphasize proactive, trauma-informed care systems that are geared to maximize provider well-being and patient safety (WHO, 2020). Effective referral processes emphasize three core tenets: immediacy, accessibility, and ongoing follow-up. Programs with 24/7 availability, such as MUHC's pager system, address the critical window immediately following an error, when nurses are most vulnerable to psychological distress (Lim et al., 2025).

Accessibility is enhanced through anonymous reporting options and multidisciplinary involvement, which mitigate stigma and encourage participation (Potura et al., 2024). Long-term follow-up is also necessary, as 30% of nurses develop ongoing distress in the absence of continued support, which warrants planned review at three, six-, and twelve-month post-incident (Vogt et al., 2024). Newer technologies, such as mobile apps used for anonymous self-referral or crisis-time screening with tools such as the Second Victim Experience and Support Tool (SVEST), are gaining popularity, and pilot studies have demonstrated help-seeking behavior increasing by 25% in tech-assisted settings (Wade et al., 2022). These innovations, founded upon just culture philosophy focusing on psychological safety, possess transformative potential for ensuring second victim nurses receive timely and equitable support.

Conclusion

The second victim syndrome in nurses is a topical issue requiring an integrated approach to convert the trauma of medical errors into learning opportunities for personal growth, professional resilience, and better patient safety. The current condition of underdevelopment of referral systems, characterized by stigma, inconsistent implementation, and self-identification, does not offer assistance to most nurses once errors have been made, leading to burnout, turnover, and an adverse impact on the quality of care. Progressive referral models like the "Talk to Me" program and YANA initiative offer preventative, approachable, and scalable solutions, particularly when implemented within cultures that are not punitive and prioritize psychological safety. Healthcare organizations should invest in technology-facilitated, peer-negotiated interventions and foster just cultures that normalize help-seeking and depathologize errors. Future studies should prioritize longitudinal research to measure the long-term impact of referral innovations, particularly in less-studied regions like Asia and Africa. National policy directives should be developed to streamline support protocols and ensure consistency.

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