Is the term “second victim” appropriate?

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Google has an interesting point of view about victims of medical errors
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"victim of medical error"

Google search rankings 1–50
Dr. Albert Wu introduced the term in a BMJ editorial in 2000

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.

Strangely, there is no place for mistakes in modern medicine. Society has entrusted physicians with the burden of understanding and dealing with illness. Although it is often said that “doctors are only human,” technological wonders, the apparent precision of laboratory tests, and innovations that present tangible images of illness have in fact created an expectation of perfection. Patients, who have an understandable need for 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 tell anyone, what to say. Later, the event replays itself over and over in your mind. You question your competence but fear being discovered. You know you should confess, but dread the prospect of potential punishment and of the patient’s anger. You may become overly attentive to the patient or family, lamenting the failure to do so earlier and, if you haven’t told them, wondering if they know.
The term has been extended by other authors...
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Third, fourth, fifth victims...

- the healthcare organization
- the organization’s reputation
- support staff
- the healthcare system
- other patients
- society / the community
The term “second victim” is very sticky

- simple
- unexpected
- credible
- emotional
- inspires stories
I believe this term has implications for patient safety
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“Preventable patient harm results from a combination of institutional systems factors and the actions of people within those systems. Without a clear recognition of this reality, the effectiveness of patient safety initiatives is undermined. The second victim label obscures the fact that healthcare...
I believe this term has implications for patient safety...

...professionals and systems can become (unintentional) agents of harm. This label may help professionals and institutions to cope with an incident of medical harm, but it is a threat to enacting the deep cultural changes needed to achieve a patient-centred environment focused on patient safety.”
Our editorial generated quite a number of responses

Most medical error is the result of system issues

Crystal Strader manager of risk and claims

Clinicians are victims of a bad system and want change

Doug Wojcieszak president

Everyone is affected, everyone a victim

Giuseppe Vetrugno forensic pathologist and risk manager\(^1\), Fabio De-Giorgio forensic pathologist\(^2\), Federica Foti forensic pathologist\(^1\)

Neglecting the “second victim” will not help harmed patients or improve patient safety

Esperanza L Gómez-Durán psychiatrist and forensic doctor, G Tolchinsky, C Martin-Fumadó, J Arimany-Manso

Supporting doctors who make mistakes

Rebecca Lawton professor of psychology of healthcare\(^1\), Judith Johnson lecturer\(^1\), Gillian Janes senior research fellow\(^2\), Robbie Foy professor of primary care\(^1\), Ruth Simms-Ellis theme manager,
A look at Colorado’s CANDOR Act
Views on responsibilities to harmed patients vary greatly among policy makers and providers

“As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a registered person must—

(a) notify the relevant person that the incident has occurred...”
England established a statutory “Duty of Candour” in 2014

CQC can prosecute for:

- failure of notification
- inappropriate notification
 Patients do have a right to their medical records. Patients do not have a right to information about patient safety activities involving their medical care.

Federal regulations 45 CFR 164.501
As part of informed consent for treatment, patients must be told about expected benefits and risks of harm.

If harm occurs, patients do not have a right to know about that harm*.

* some required notification for patients in Massachusetts, California, Florida, Nevada, New Jersey, Pennsylvania, Tennessee, Vermont
AHRQ released a “Communication and Optimal Resolution” (CANDOR) toolkit in 2016

“The CANDOR process improves patient safety through an empathetic, fair, and just approach to medical errors and promotes a culture of safety that focuses on caring for the patient, family, and caregiver; an in-depth event investigation and analysis; and resolution.”
AHRQ released a “Communication and Optimal Resolution” (CANDOR) toolkit in 2016

The CANDOR toolkit:

• Outlines best practices
• Provides training material
• Describes implementation phases
The Colorado CANDOR Act went into effect in July 2019

Describes a voluntary process initiated by a healthcare provider after an adverse event.

SENATE BILL 19-201

BY SENATOR(S) Pettersen and Tate, Bridges, Court, Gardner, Ginal, Lee, Moreno, Woodward; also REPRESENTATIVE(S) Tipper and McKeen, Arndt, Beckman, Bird, Buckner, Buentello, Carver, Cutter, Exum, Galindo, Gonzales-Gutierrez, Gray, Hooton, Kipp, Lontine, McCluskie, McLachlan, Michaelson Jenet, Mullica, Ransom, Roberts, Sirota, Snyder, Titone, Valdez A., Becker.

CONCERNING THE CREATION OF A PROCESS BY WHICH CERTAIN PARTIES TO AN ADVERSE HEALTH CARE INCIDENT MAY DISCUSS POTENTIAL OUTCOMES.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, add article 51 to title 25 as follows:

ARTICLE 51
Communication and Resolution After an Adverse Health Care Incident
The Colorado CANDOR Act sets up a process for “open discussion”

1. The patient receives letter from the provider to notify them of “the desire [...] to enter into an open discussion”.

2. If the patient agrees, they sign and return the consent form.

3. Others (family members, attorney) may sign a Participation Agreement.
The Colorado CANDOR Act sets up a process for “open discussion”

4. The “open discussion” takes place.

5. Patient can terminate process by giving written notification.

6. An offer of compensation may be made.

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CONCERNING THE CREATION OF A PROCESS BY WHICH CERTAIN PARTIES TO AN ADVERSE HEALTH CARE INCIDENT MAY DISCUSS POTENTIAL OUTCOMES.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, add article 51 to title 25 as follows:

ARTICLE 51
Communication and Resolution After an Adverse Health Care Incident
The Colorado CANDOR Act offers many protections for healthcare providers

Only a healthcare provider can initiate (not a hospital)

25-51-103 (1)

Up to 180 days since adverse advent before sending letter

25-51-103 (2)
The Colorado CANDOR Act offers many protections for healthcare providers.

No written communication allowed in open discussion (except offer of compensation)

25-51-103 (7)
The Colorado CANDOR Act offers many protections for healthcare providers

Provider or facility is allowed (but not required) to:

• Investigate the incident and the care provided
• Disclose results of any investigation
• Communicate how future occurrences will be prevented

25-51-103 (4)
The Colorado CANDOR Act offers many protections for healthcare providers.

All “open discussion” communications are privileged and confidential — as well as the initial letter.

25-51-103 (2e), 25-51-105(1b)

Does not include the medical record itself.
The Colorado CANDOR Act offers many protections for healthcare providers

If a payment of compensation is made, there is no need to report to:

- National Practitioner Data Bank
- (professional licensing boards?)

25-51-104
The Colorado CANDOR Act offers many protections for healthcare providers

Regulations for reporting to the National Practitioner Data Bank:

“Medical malpractice action or claim means a written complaint or claim...”

Federal regulations, Title 45, Section 60.3
Let’s compare these documents...

Regulation 20: Duty of candour
Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare

SENATE BILL 19-201

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CONCERNING THE CREATION OF A PROCESS BY WHICH CERTAIN PARTIES TO AN ADVERSE HEALTH CARE INCIDENT MAY DISCUSS POTENTIAL
Comparison 1:
Must providers tell patients about a harm event?

Yes

No

Regulation 20: Duty of candour
Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare
Comparison 2:
How soon are patients to be notified of a harm event?

“As soon as reasonably practicable”

within 180 days
Comparison 3:
What must patients be told about the event?

“all the facts [...] about the incident”

no requirement
Comparison 4:
Are patients given written communication about the event?

yes – required
no – prohibited

Regulation 20: Duty of candour
Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare

SENATE BILL 19-201
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CONCERNING THE CREATION OF A PROCESS BY WHICH CERTAIN PARTIES TO AN ADVERSE HEALTH CARE INCIDENT MAY DISCLOSURE POTENTIAL
Comparison 5:

Are patients required to keep information they learn confidential?

No

Yes
What do these documents reveal about differences in beliefs and values?
For discussion:

• Scenarios about the confidentiality requirement for “open discussions” under the Colorado CANDOR Act

• Do you see a common theme connecting these two topics?

  “second victim”

  *Colorado CANDOR Act*
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BMJ article: Abandon the term “second victim”
https://doi.org/10.1136/bmj.l1233

England’s “Duty of Candour”
https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour

AHRQ Communication and Optimal Resolution (CANDOR) toolkit

Colorado CANDOR Act
https://leg.colorado.gov/bills/sb19-201

COPIC guide to the Colorado CANDOR Act

National Practitioner Data Bank regulations
https://www.npdb.hrsa.gov/resources/aboutLegsAndRegs.jsp