Is the term “second victim” appropriate?

Melissa Clarkson
advocate for safety, transparency, and patient rights in healthcare

Professional affiliation:
Assistant Professor
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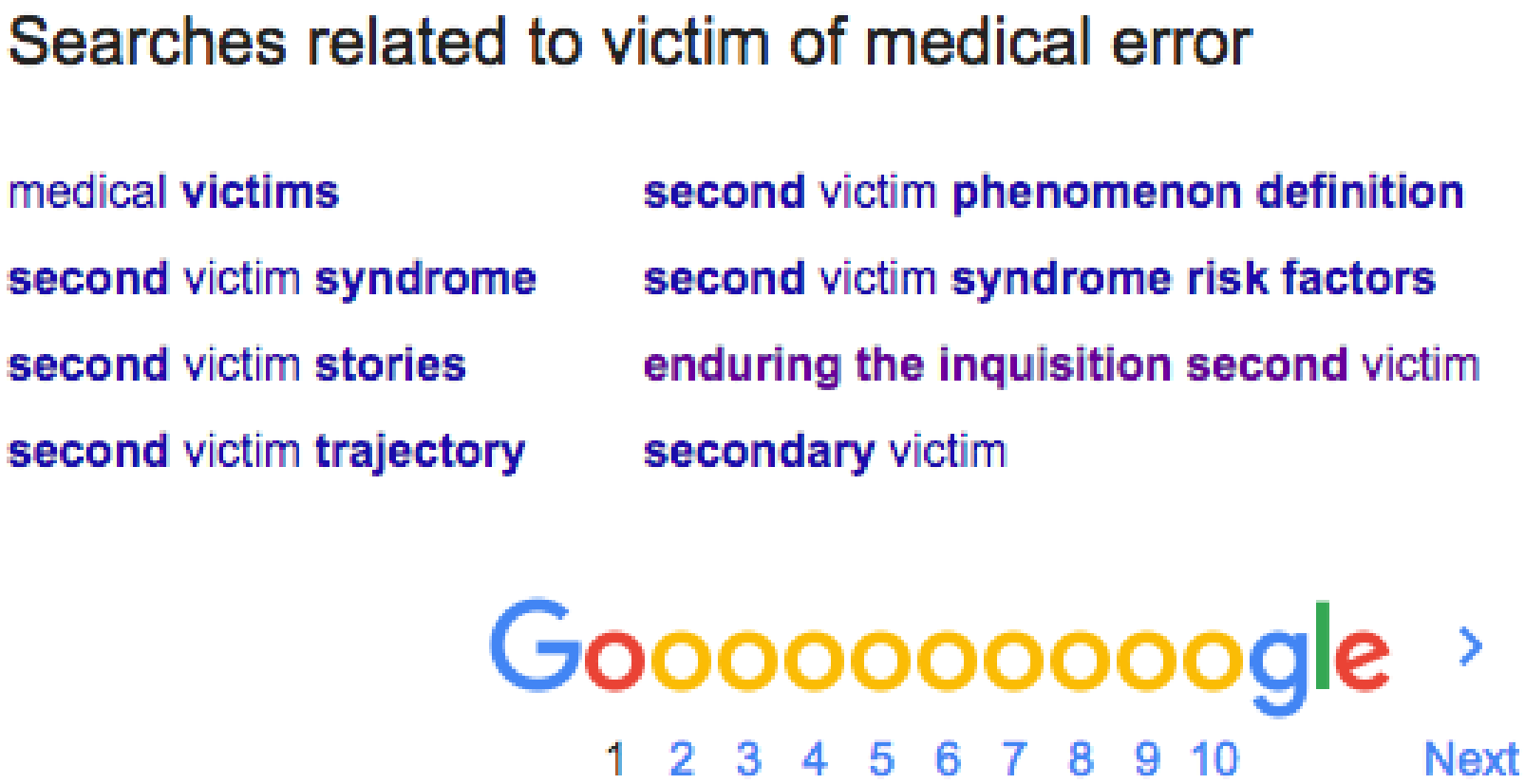
Google has an interesting point of view about victims of medical errors



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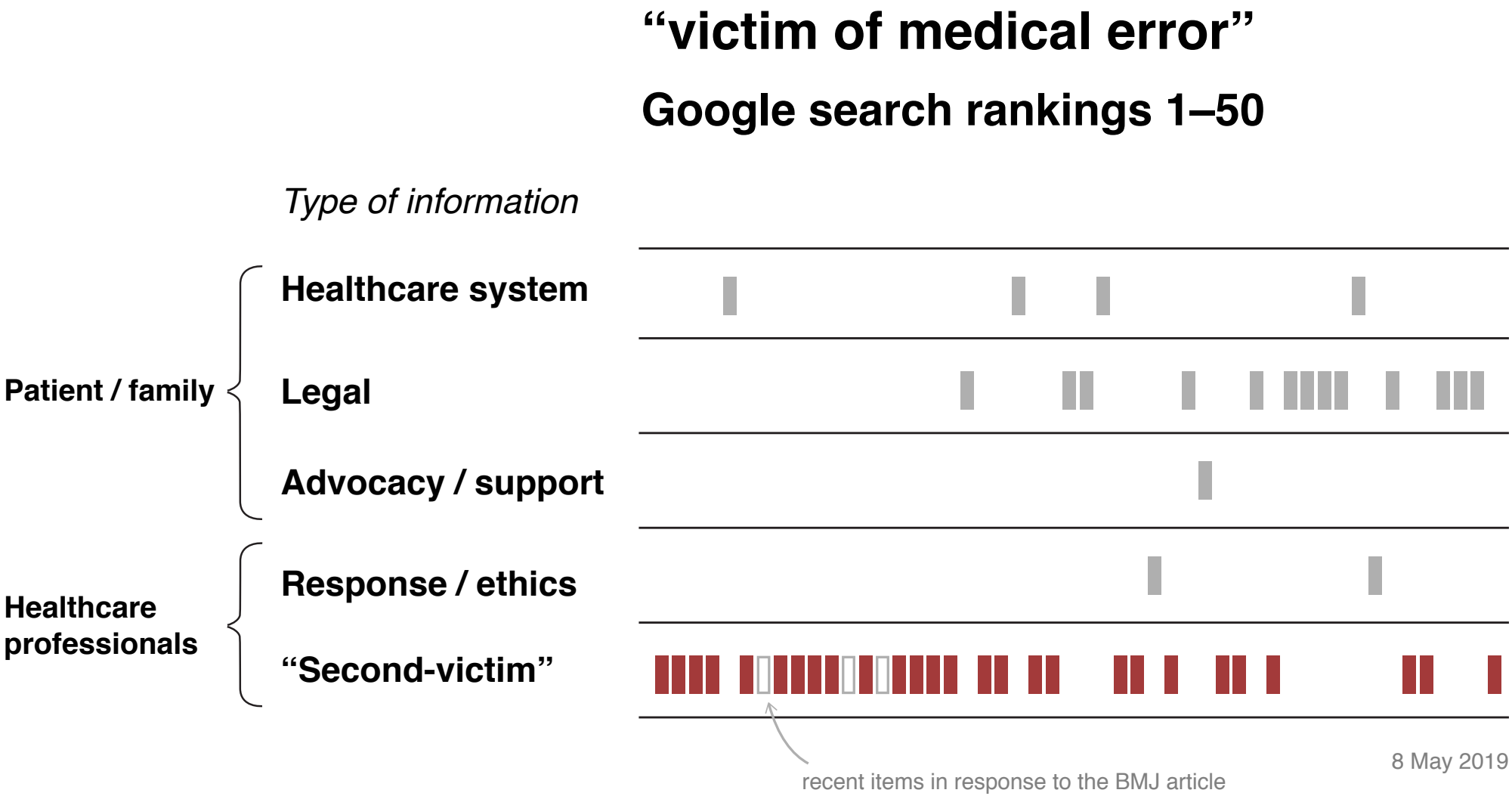

Dr. Albert Wu introduced the term in a BMJ editorial in 2000

Medical error: the second victim

The doctor who makes the mistake needs help too

Personal view
p 812

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

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.[1–3]

The term has been extended by other authors...

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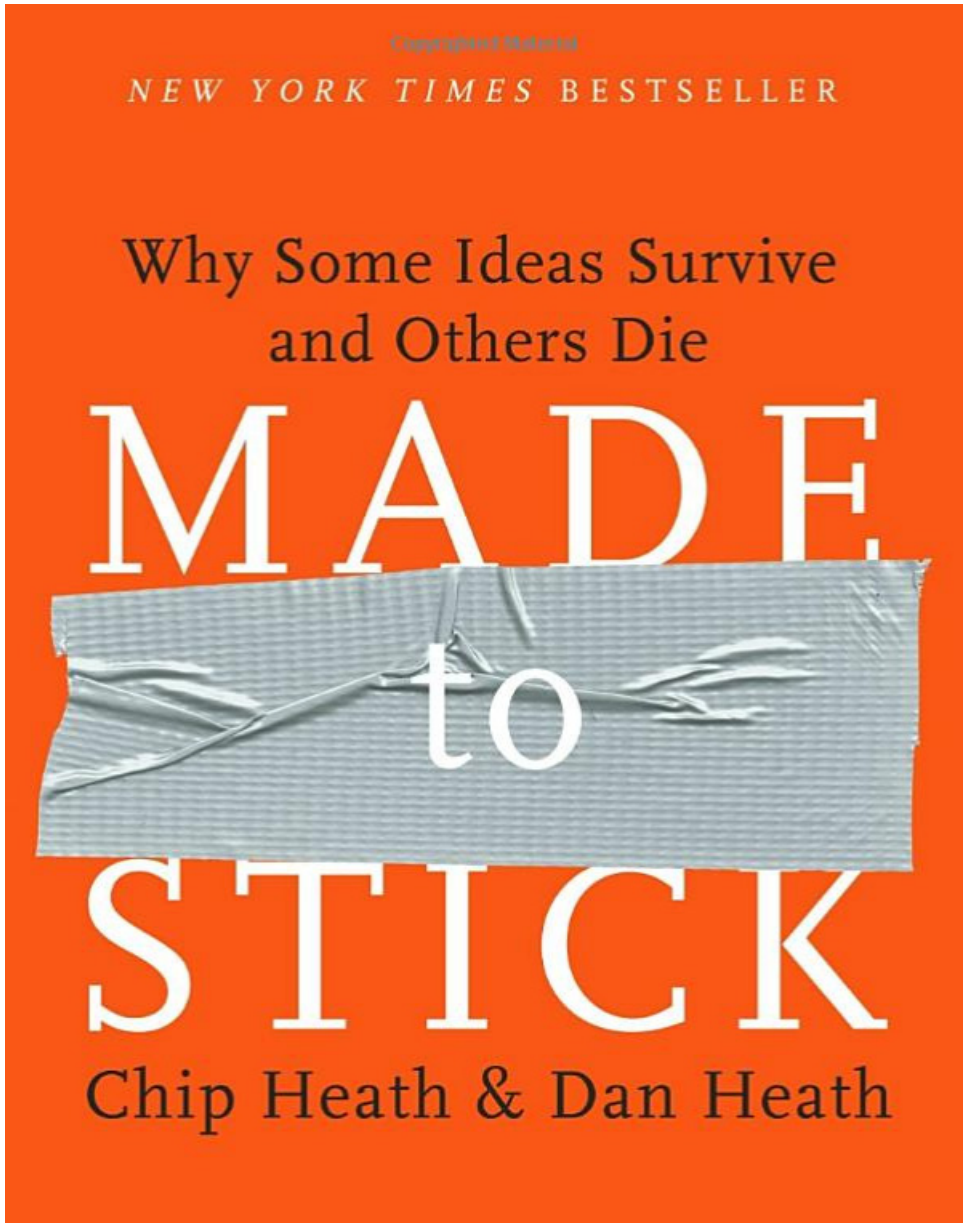
Third, fourth, fifth victims...

- 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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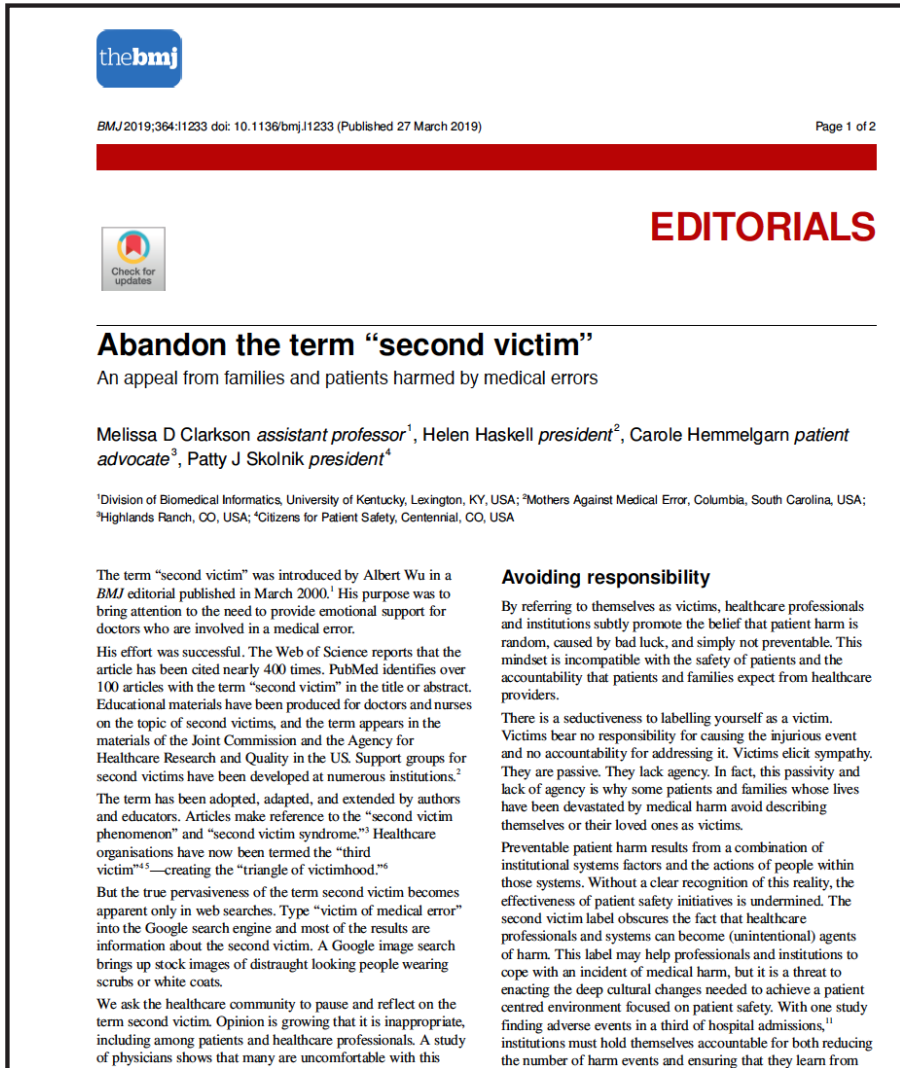

thebmj

BMJ 2019;364:l1233 doi: 10.1136/bmj.l1233 (Published 27 March 2019)

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Check for updates

Abandon the term "second victim"

An appeal from families and patients harmed by medical errors

Melissa D Clarkson *assistant professor*[1], Helen Haskell *president*[2], Carole Hemmelgarn *patient advocate*[3], Patty J Skolnik *president*[4]

[1]Division of Biomedical Informatics, University of Kentucky, Lexington, KY, USA; [2]Mothers Against Medical Error, Columbia, South Carolina, USA; [3]Highlands Ranch, CO, USA; [4]Citizens for Patient Safety, Centennial, CO, USA

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His effort was successful. The Web of Science reports that the article has been cited nearly 400 times. PubMed identifies over 100 articles with the term "second victim" in the title or abstract. Educational materials have been produced for doctors and nurses on the topic of second victims, and the term appears in the materials of the Joint Commission and the Agency for Healthcare Research and Quality in the US. Support groups for second victims have been developed at numerous institutions.[2]

The term has been adopted, adapted, and extended by authors and educators. Articles make reference to the "second victim phenomenon" and "second victim syndrome."[3] Healthcare organisations have now been termed the "third victim"[4 5]—creating the "triangle of victimhood."[6]

But the true pervasiveness of the term second victim becomes apparent only in web searches. Type "victim of medical error" into the Google search engine and most of the results are information about the second victim. A Google image search brings up stock images of distraught looking people wearing scrubs or white coats.

We ask the healthcare community to pause and reflect on the term second victim. Opinion is growing that it is inappropriate, including among patients and healthcare professionals. A study of physicians shows that many are uncomfortable with this

Avoiding responsibility

By referring to themselves as victims, healthcare professionals and institutions subtly promote the belief that patient harm is random, caused by bad luck, and simply not preventable. This mindset is incompatible with the safety of patients and the accountability that patients and families expect from healthcare providers.

There is a seductiveness to labelling yourself as a victim. Victims bear no responsibility for causing the injurious event and no accountability for addressing it. Victims elicit sympathy. They are passive. They lack agency. In fact, this passivity and lack of agency is why some patients and families whose lives have been devastated by medical harm avoid describing themselves or their loved ones as victims.

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 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. With one study finding adverse events in a third of hospital admissions,[11] institutions must hold themselves accountable for both reducing the number of harm events and ensuring that they learn from

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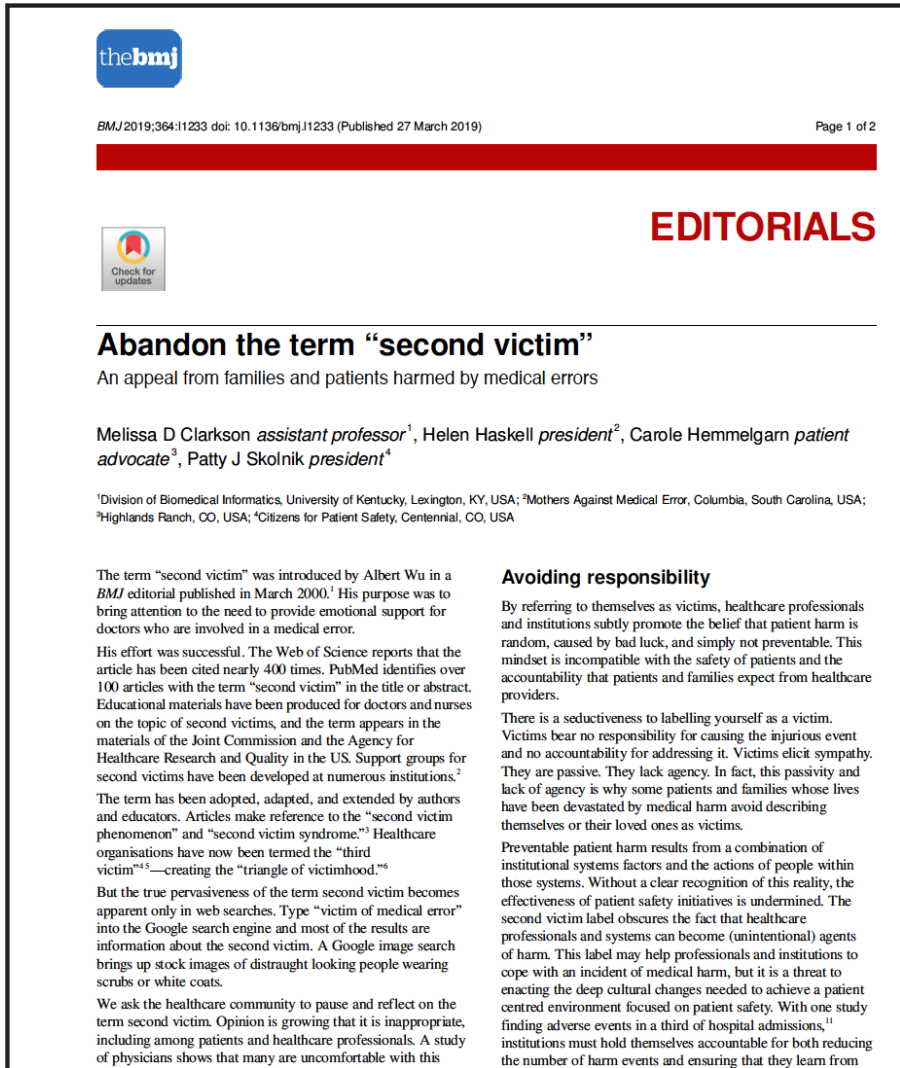

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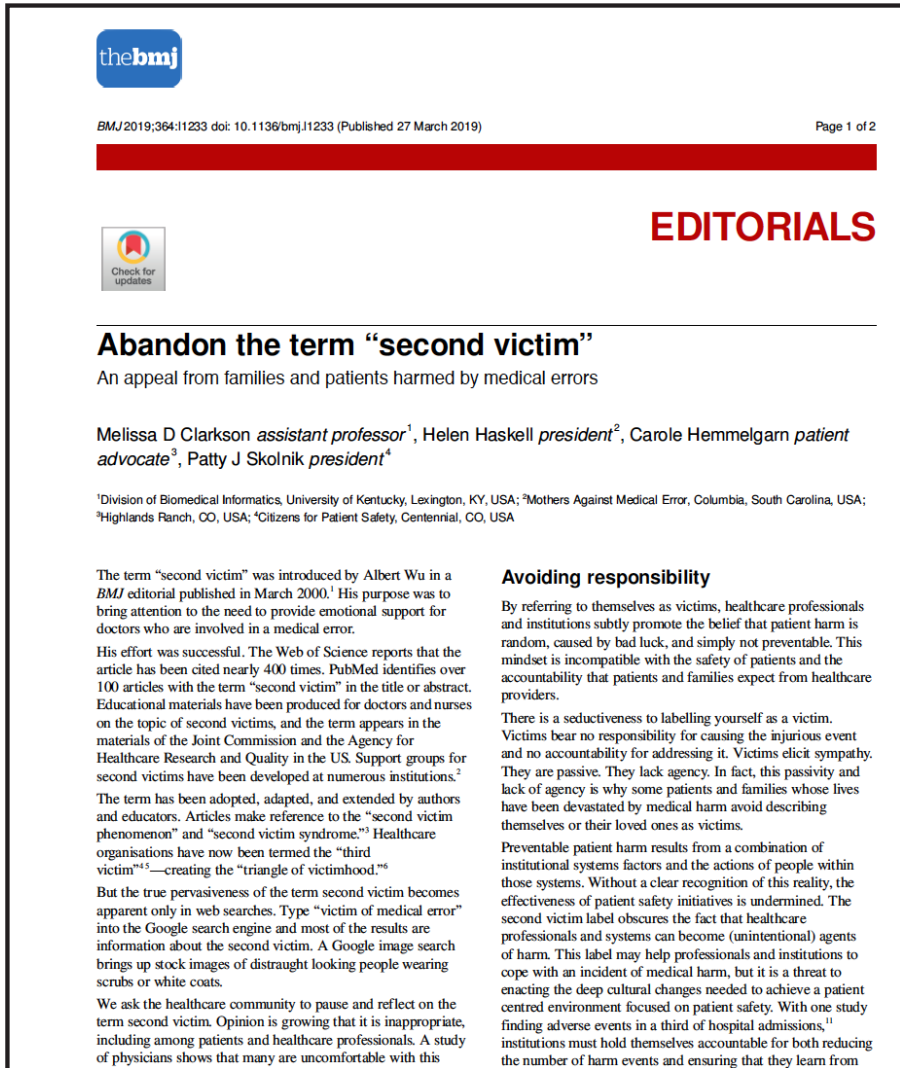

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Our editorial generated quite a number of responses

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

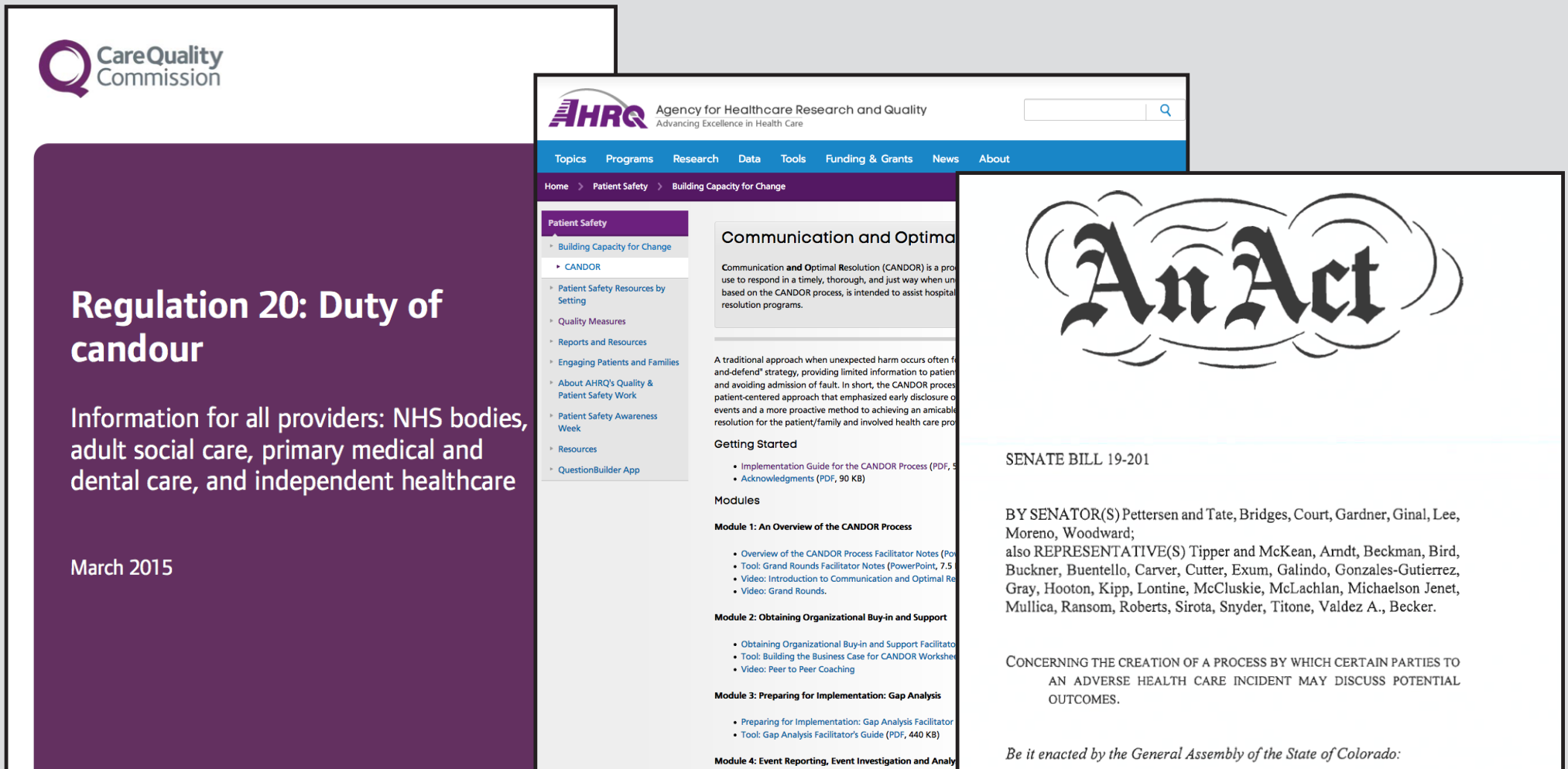
Esperanza L Gómez-Durán *psychiatrist and forensic doctor*, G Tolchinsky, C Martin-Fumadó, J Arimany-Manso

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

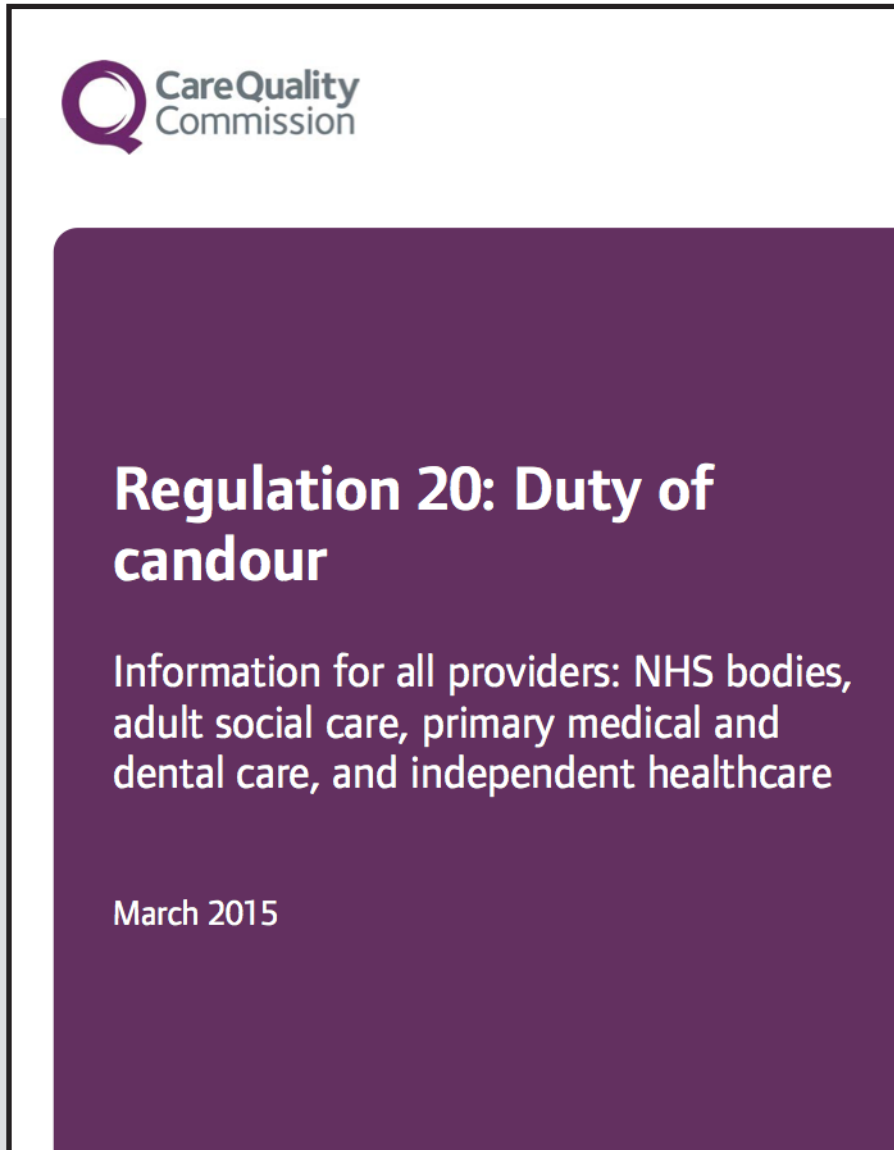
Views on responsibilities to harmed patients vary greatly among policy makers and providers



England established a statutory "Duty of Candour" in 2014

"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..."



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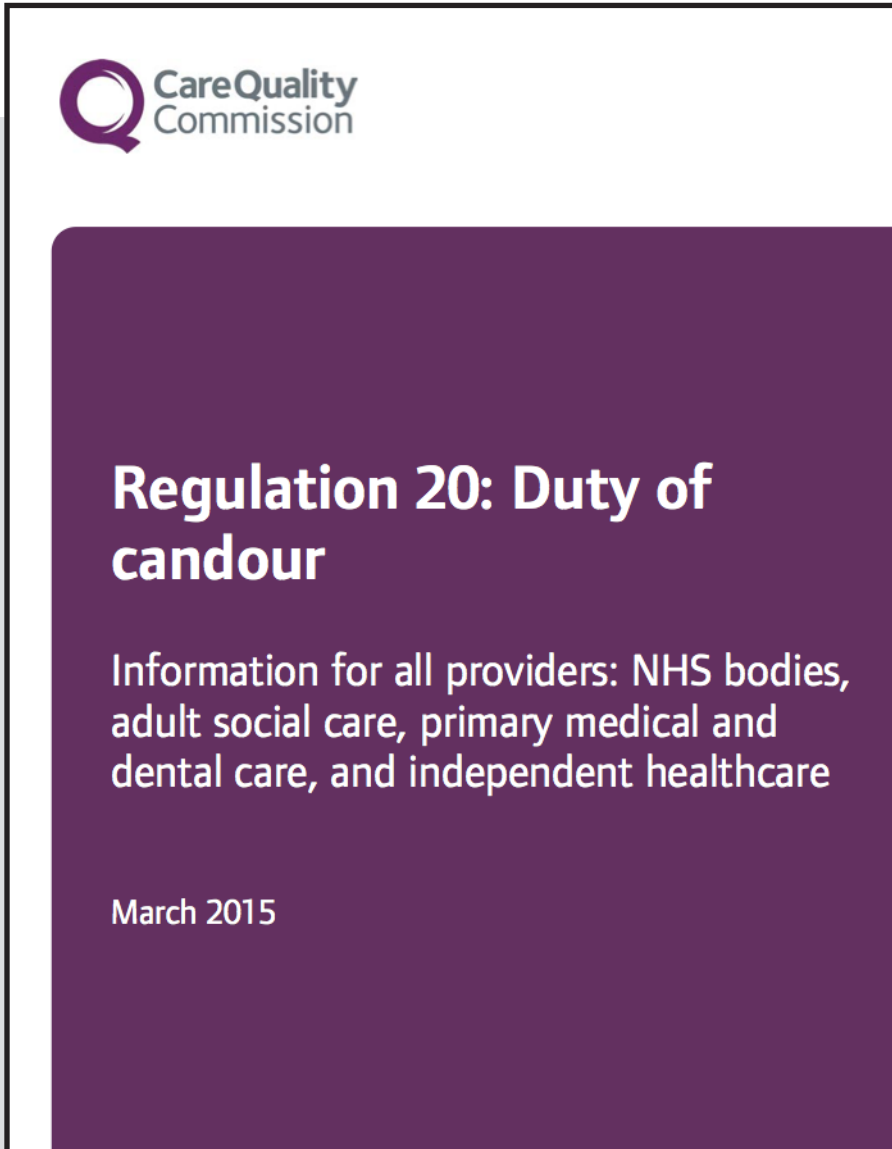
CQC can prosecute for:

- failure of notification
- inappropriate notification



Here in the United States ...

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

Here in the United States ...

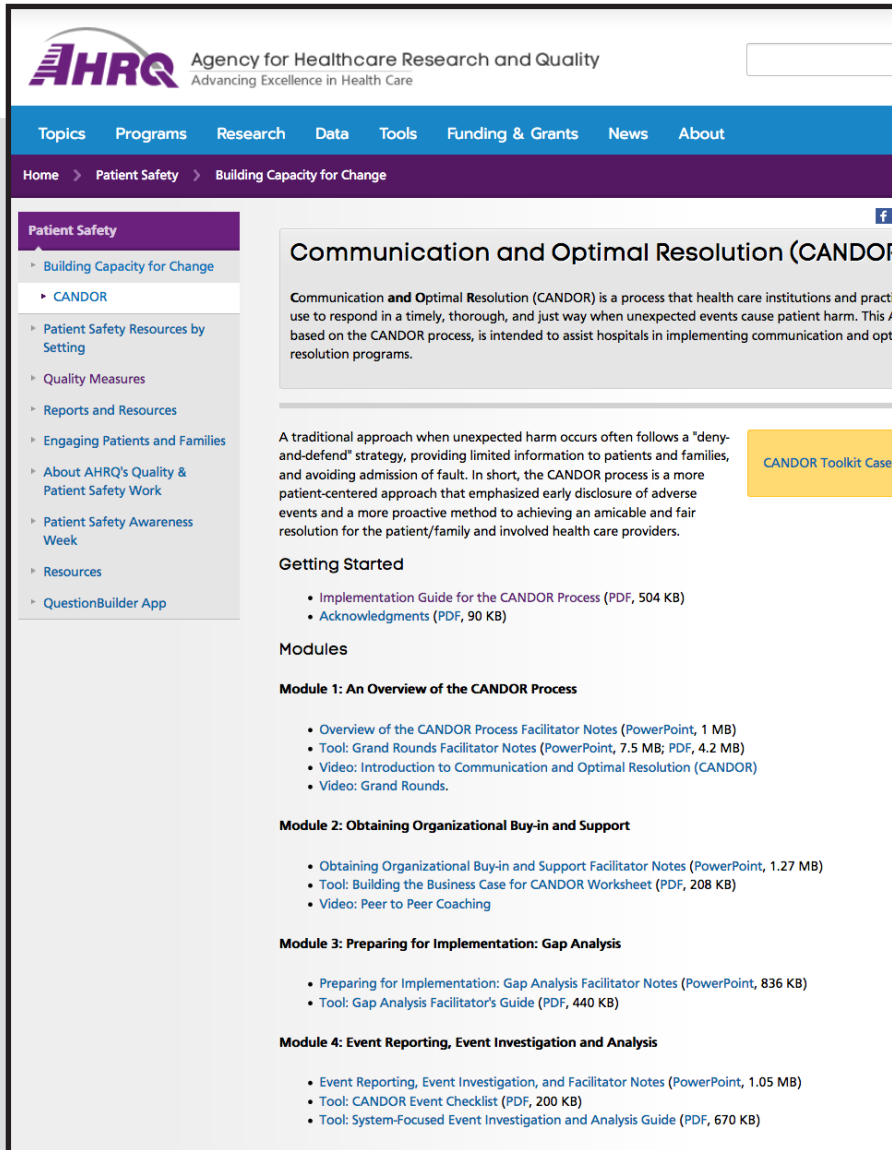
As part of **informed consent** for treatment, patients must be told about expected benefits and risks of harm.

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”



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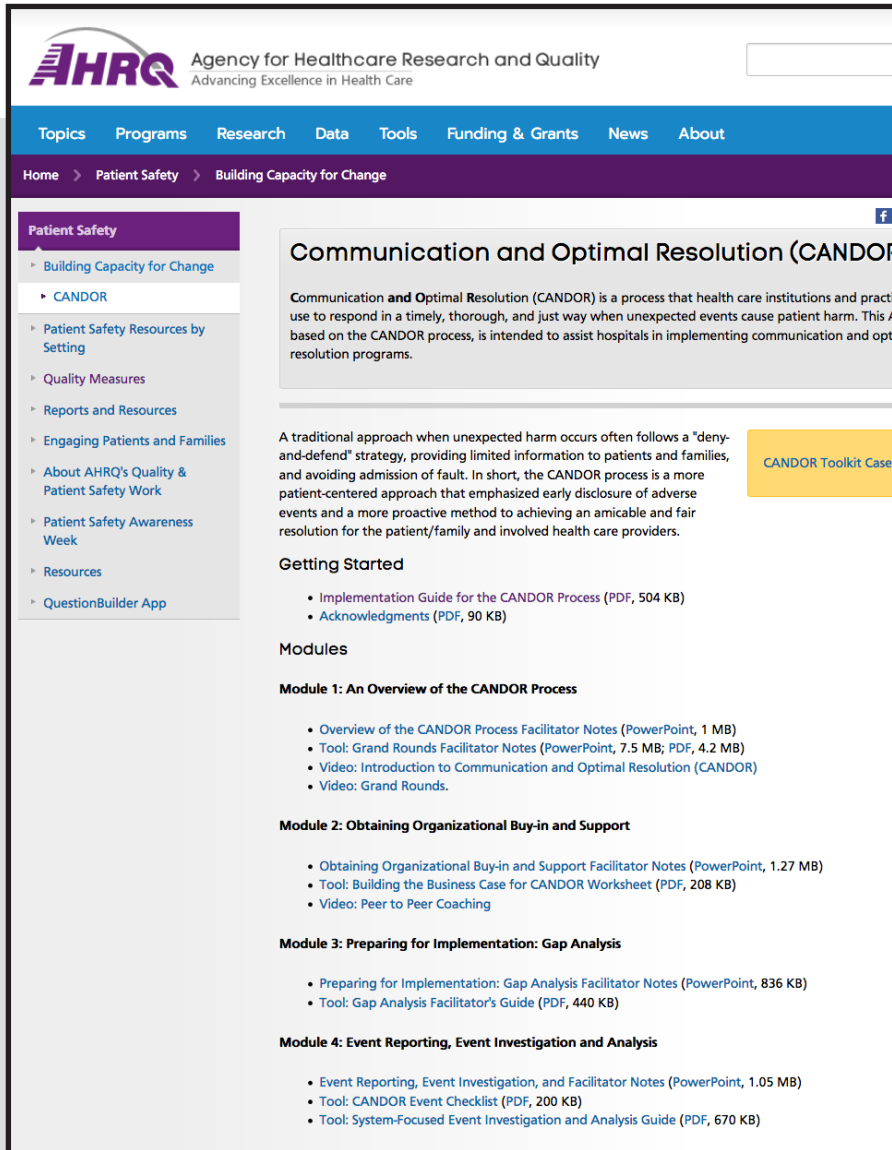
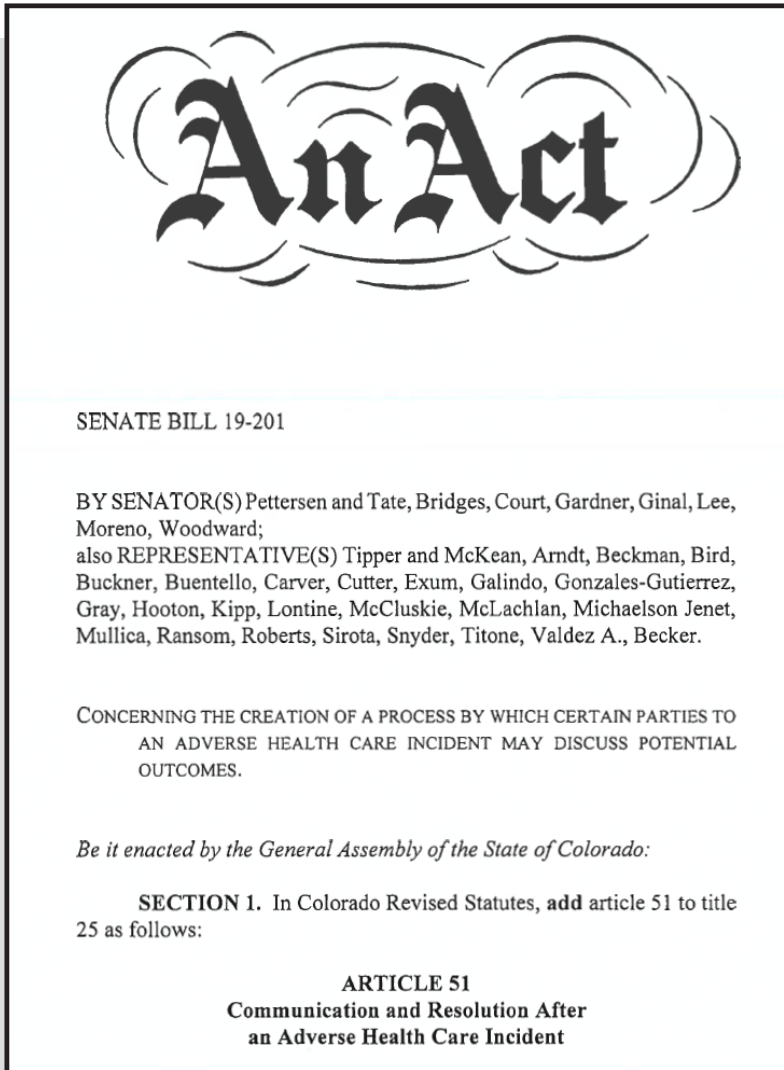
The CANDOR toolkit:

- 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



An Act

SENATE BILL 19-201

BY SENATOR(S) Pettersen and Tate, Bridges, Court, Gardner, Ginal, Lee, Moreno, Woodward;
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CONCERNING THE CREATION OF A PROCESS BY WHICH CERTAIN PARTIES TO AN ADVERSE HEALTH CARE INCIDENT MAY DISCUSS POTENTIAL OUTCOMES.

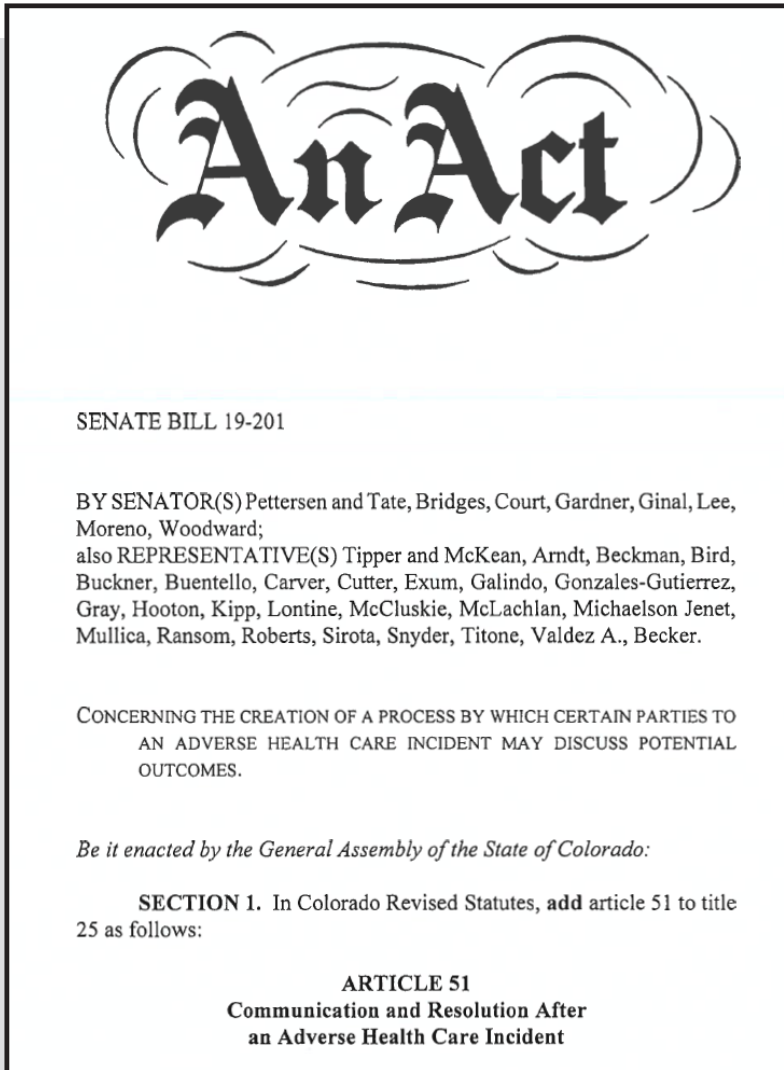
Be it enacted by the General Assembly of the State of Colorado:

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 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.



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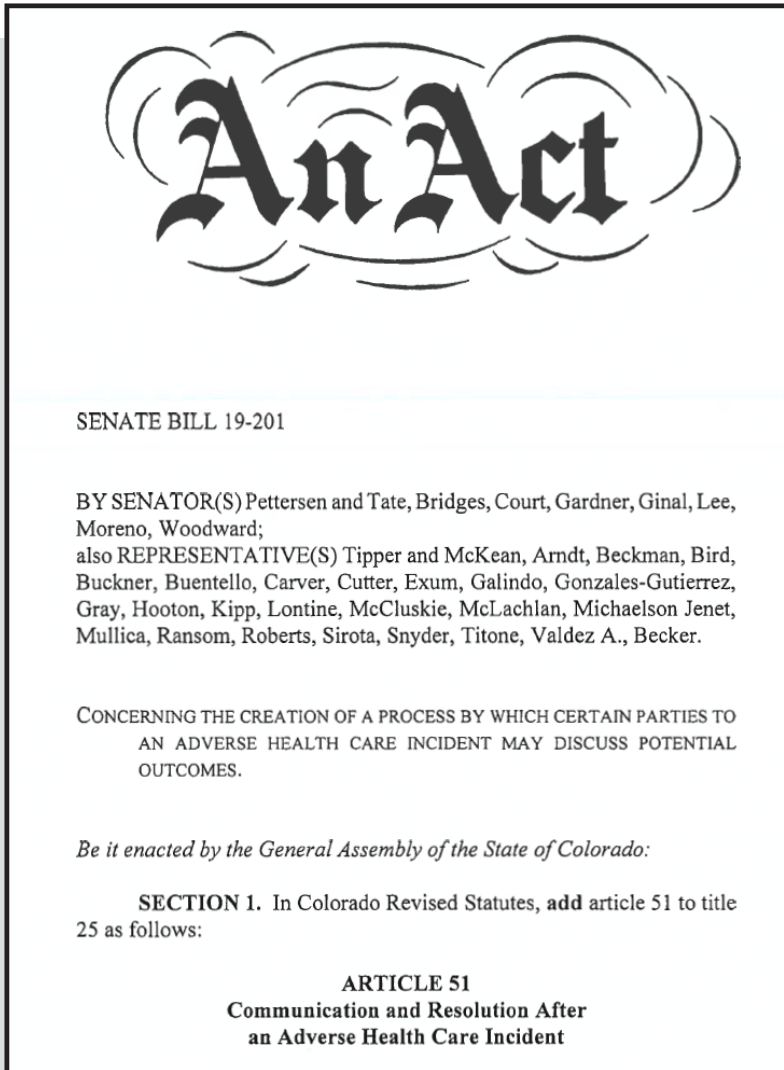
4. The “open discussion” takes place.
5. Patient can terminate process by giving written notification.
6. An offer of compensation may be made.



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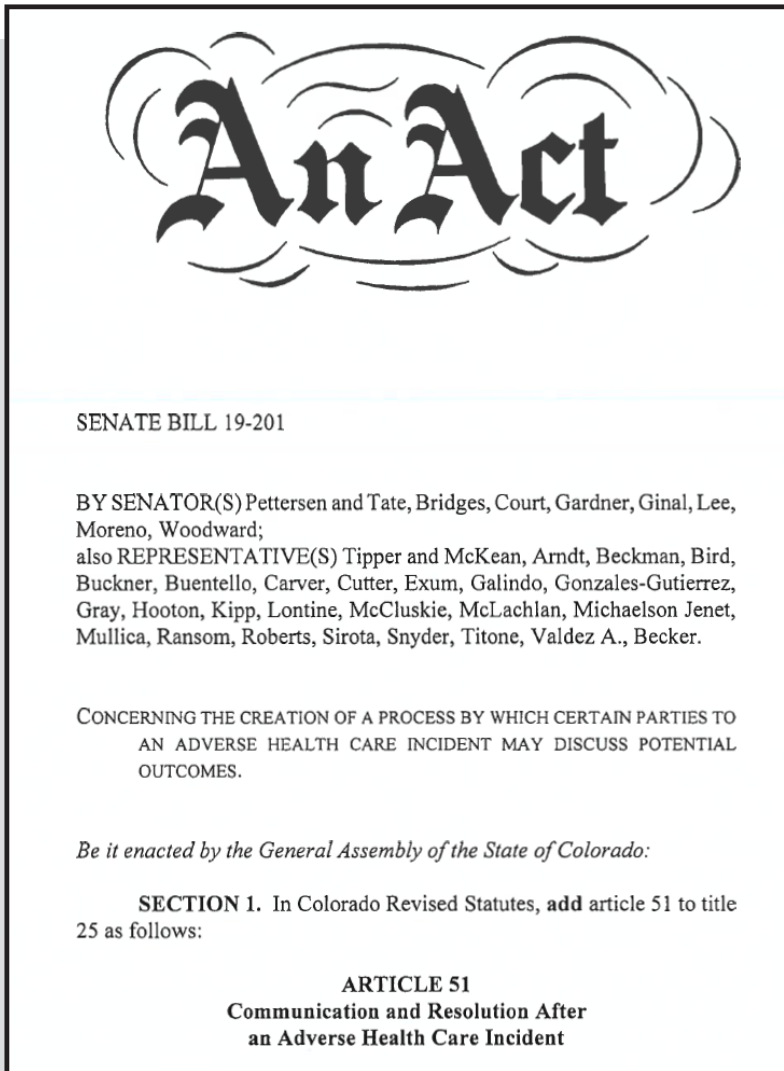
The Colorado CANDOR Act offers many protections for healthcare providers

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)



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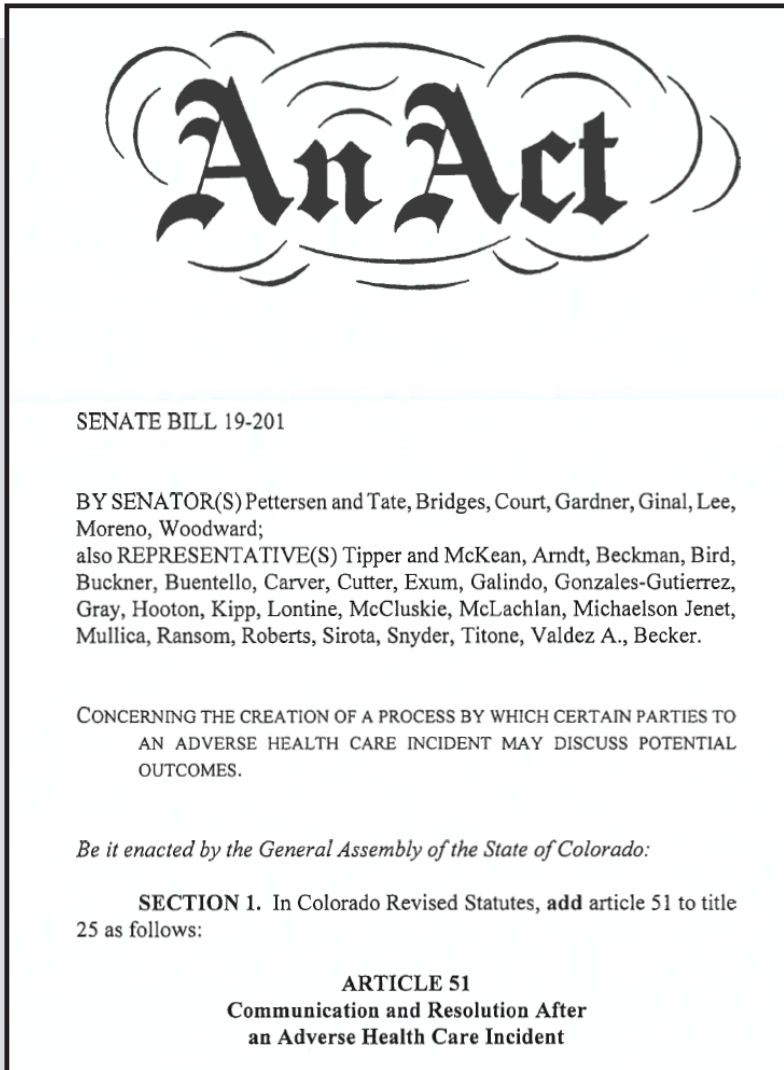
No written communication allowed in open discussion

(except offer of compensation)

25-51-103 (7)



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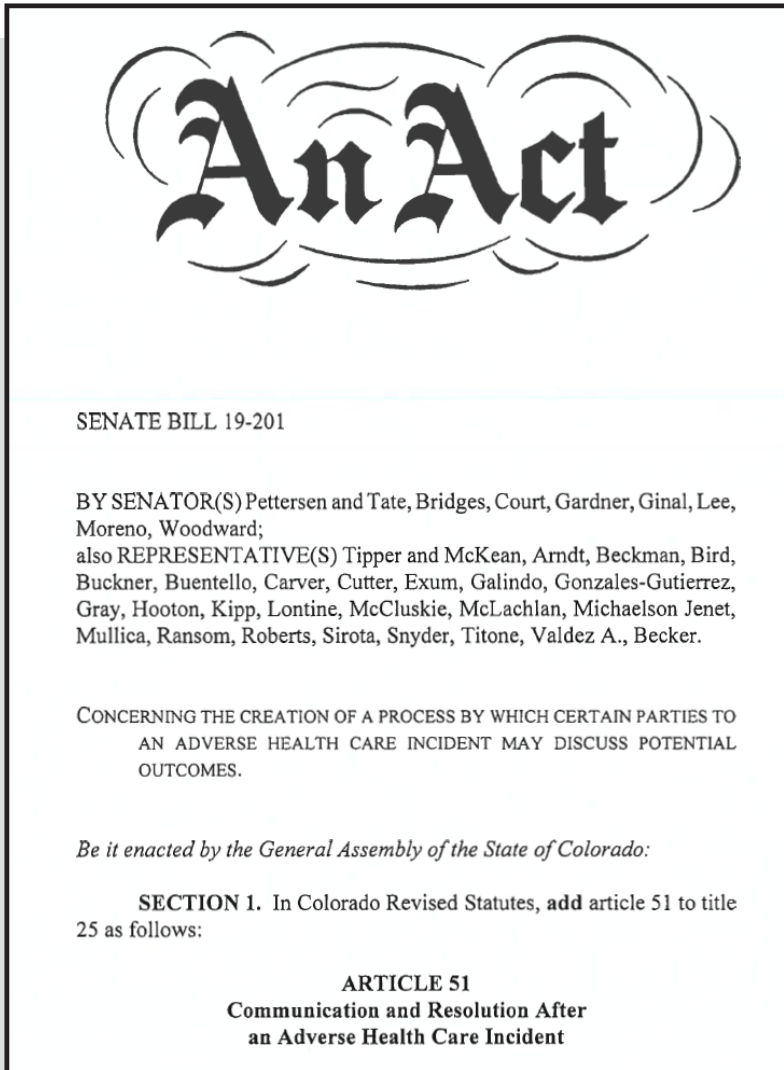
Provider or facility is allowed **(but not required)** to:

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

25-51-103 (4)



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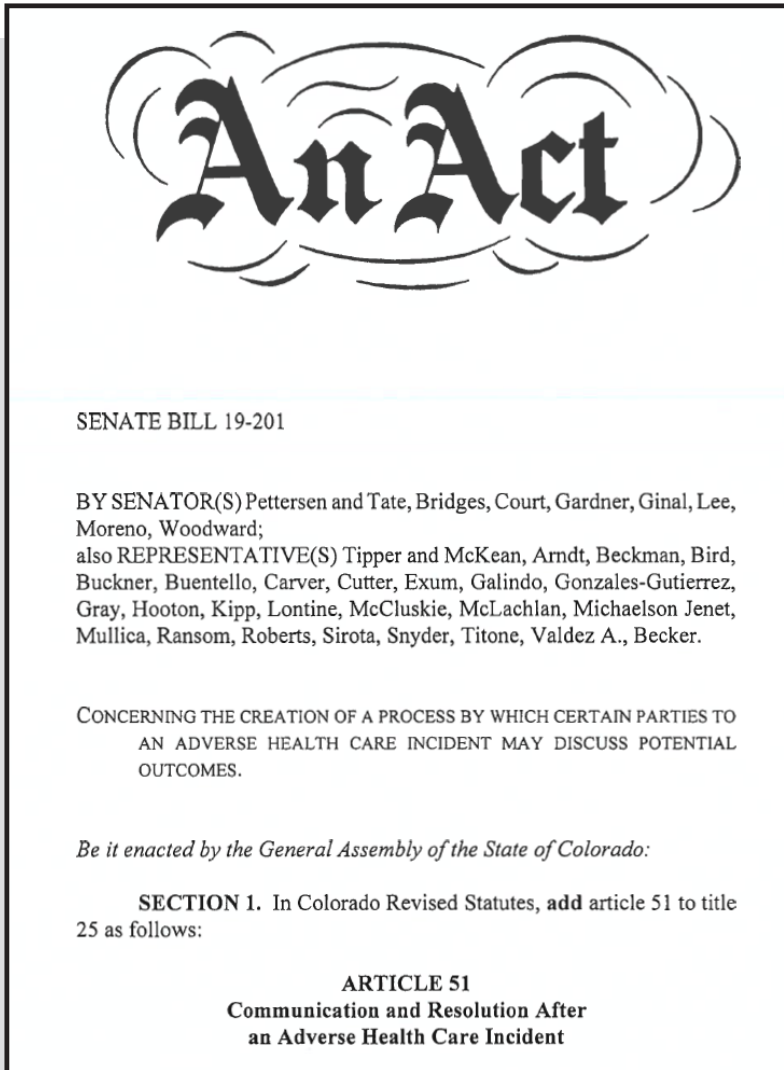
All “open discussion” communications are ***privileged and confidential*** — as well as the initial letter.

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

Does not include the medical record itself



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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:

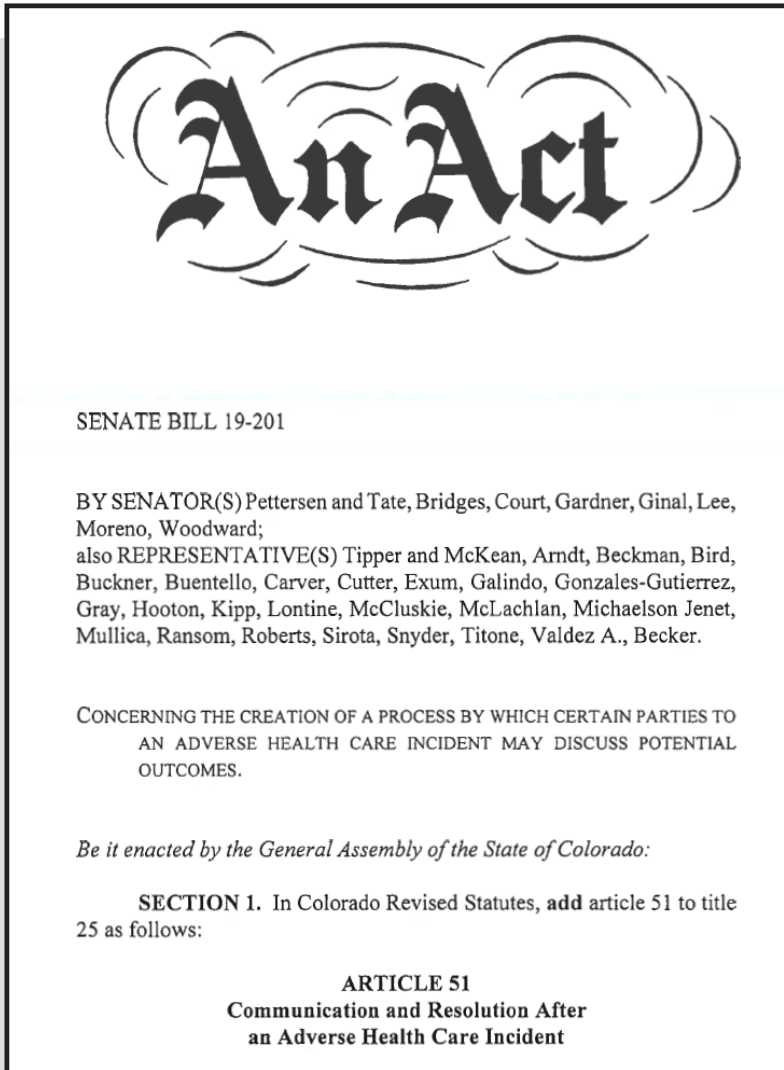
ARTICLE 51
Communication and Resolution After an Adverse Health Care Incident

The Colorado CANDOR Act offers many protections for healthcare providers

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

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

25-51-104



An Act

SENATE BILL 19-201

BY SENATOR(S) Pettersen and Tate, Bridges, Court, Gardner, Ginal, Lee, Moreno, Woodward;
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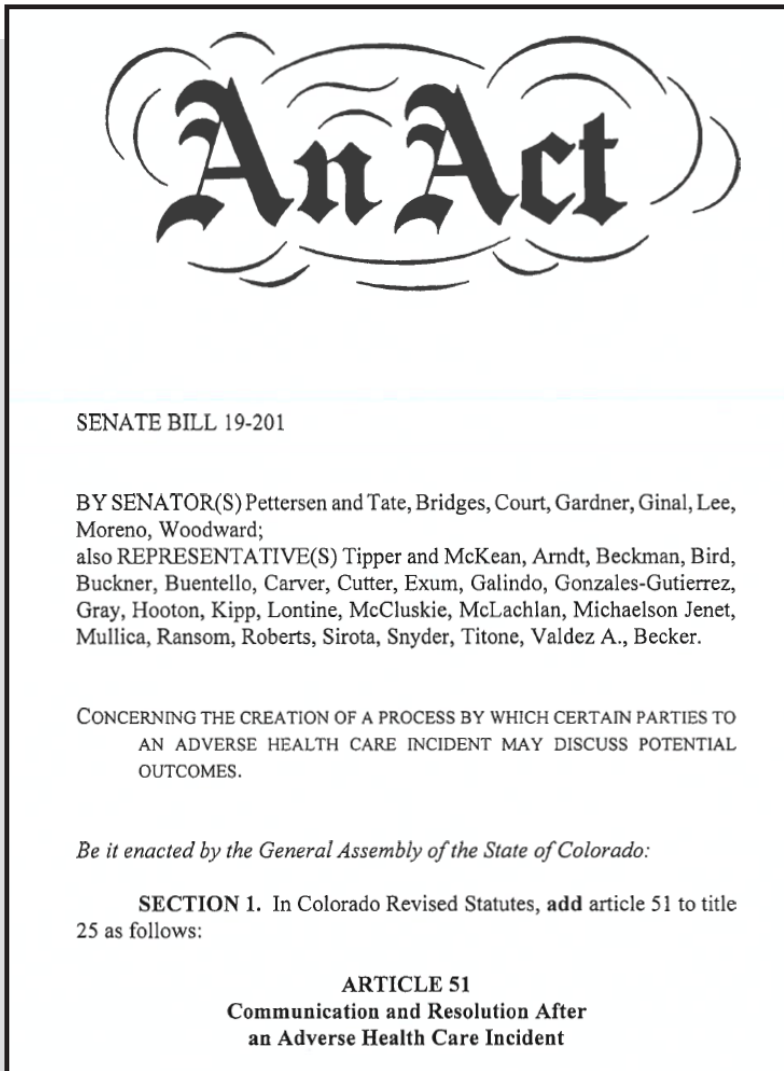
Regulations for reporting to the National Practitioner Data Bank:

"Medical malpractice action or claim means a *written* complaint or claim..."

Federal regulations, Title 45, Section 60.3



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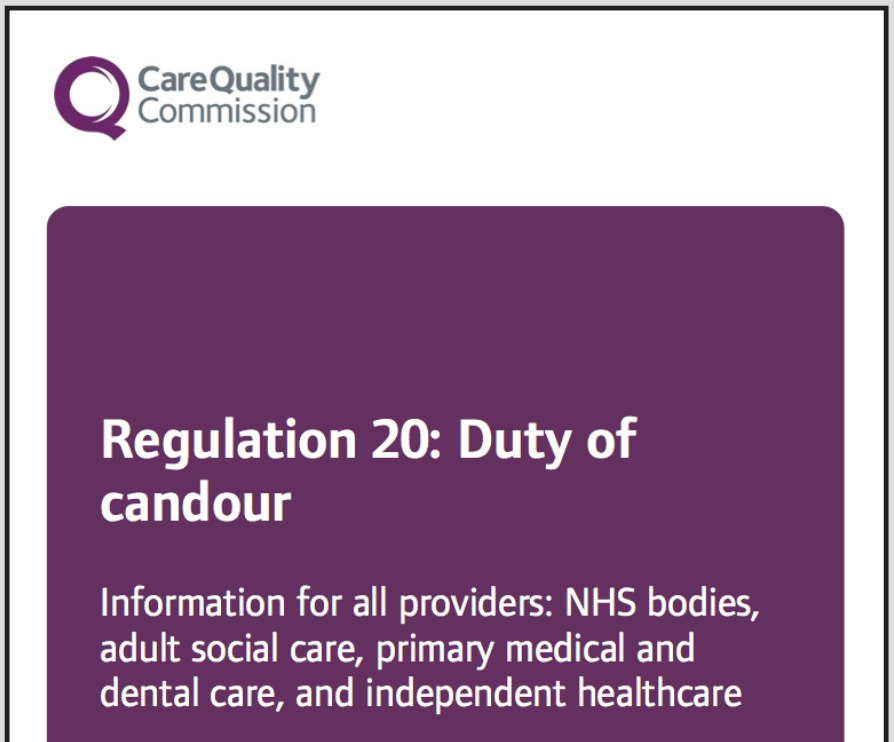
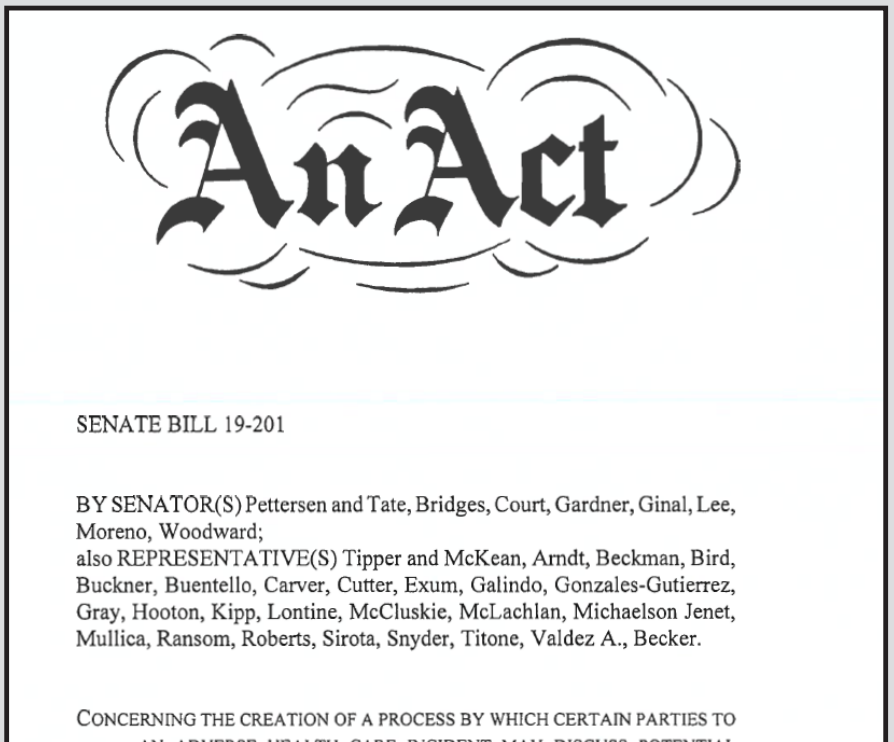
Let’s compare these documents...

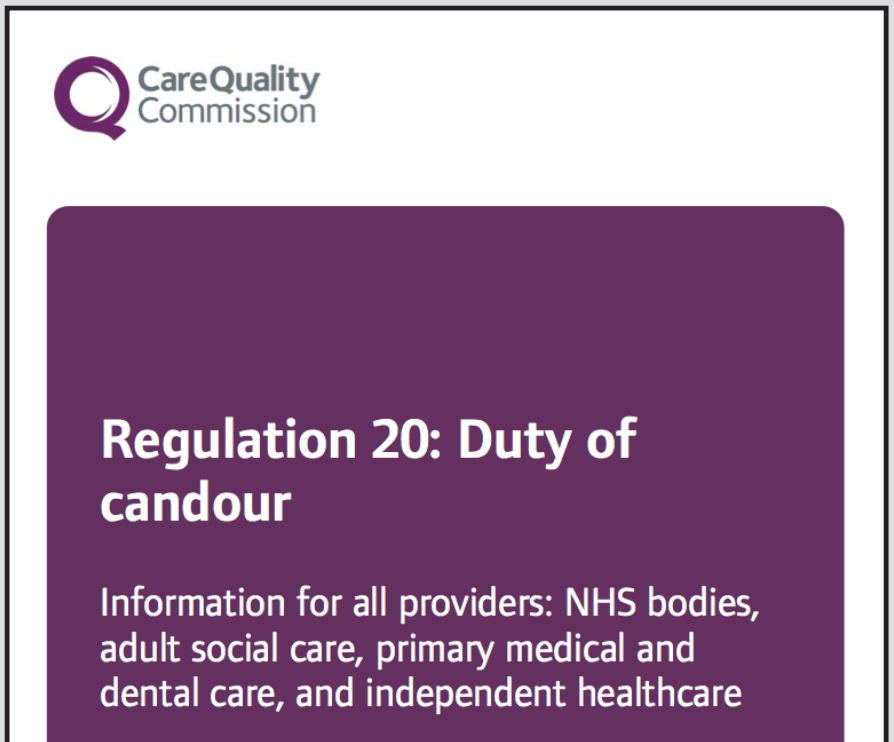




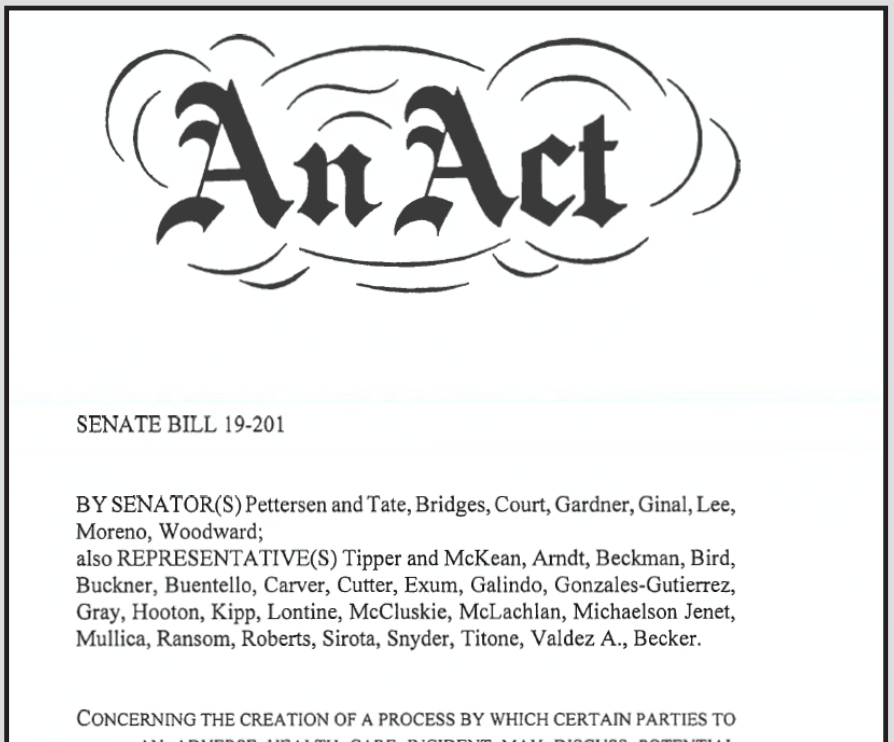
Comparison 1:

Must providers tell patients about a harm event?

Yes



No



Comparison 2:

How soon are patients to be notified of a harm event?

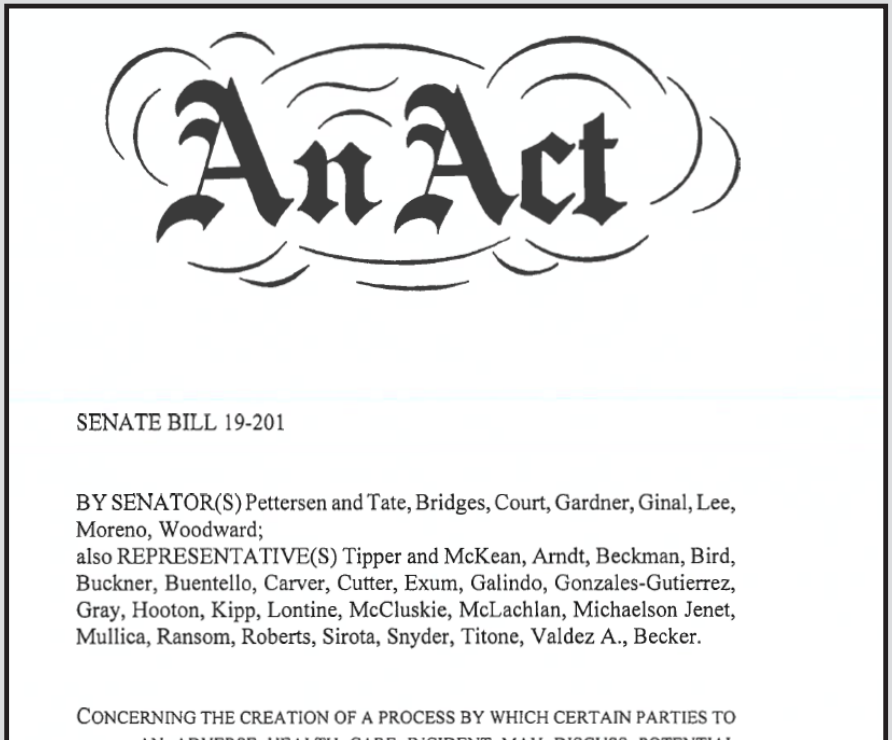
"As soon as reasonably practicable"

Care Quality Commission

Regulation 20: Duty of candour

Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare

within 180 days



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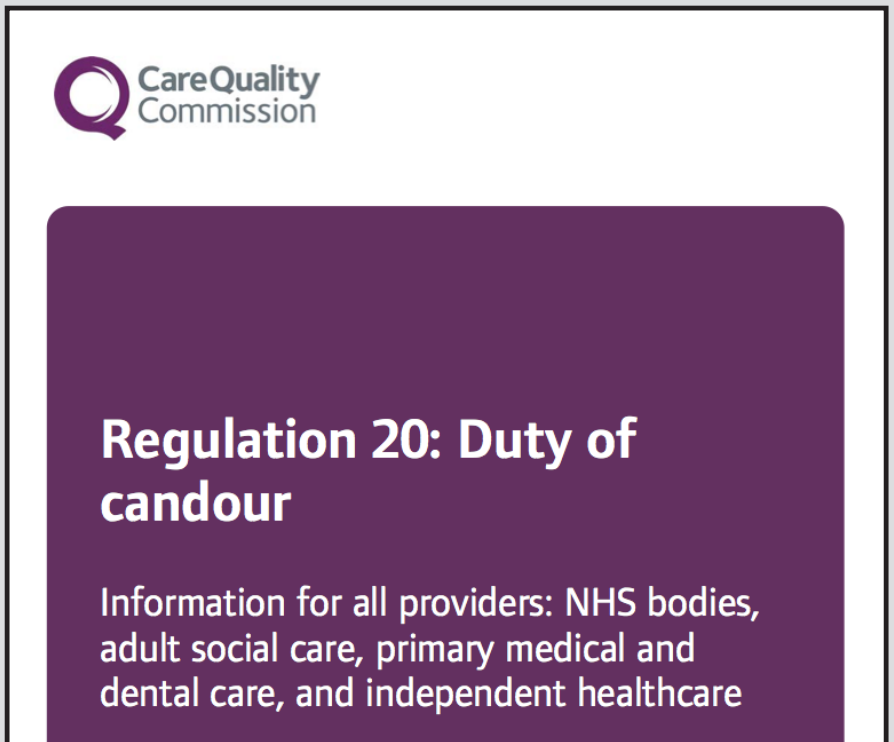
CONCERNING THE CREATION OF A PROCESS BY WHICH CERTAIN PARTIES TO

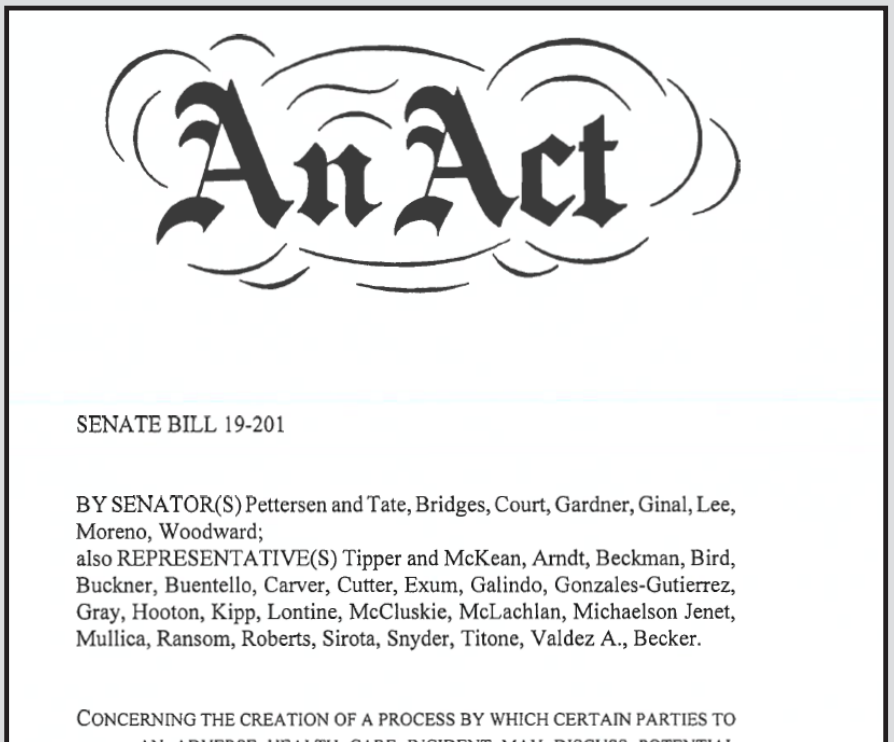
Comparison 3:

What must patients be told about the event?

"all the facts [...] about the incident"



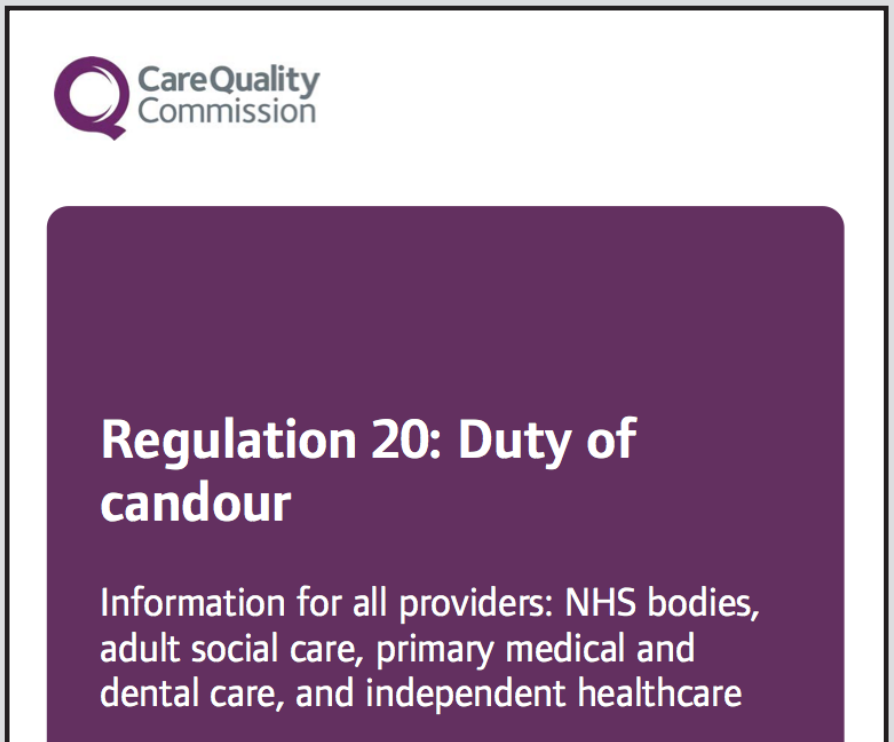
no requirement



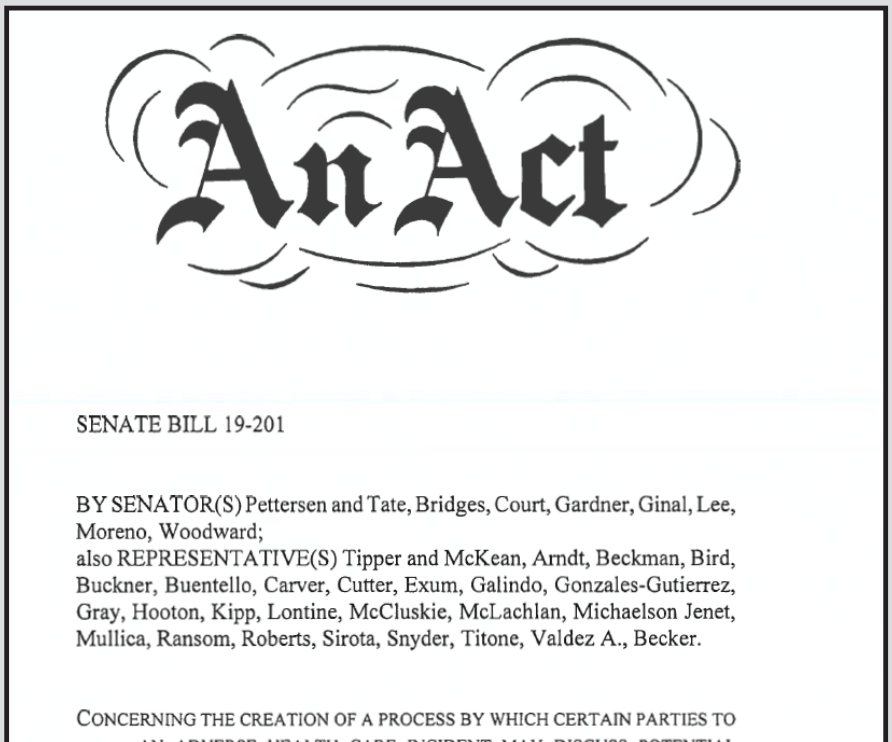
Comparison 4:

Are patients given written communication about the event?

yes – required



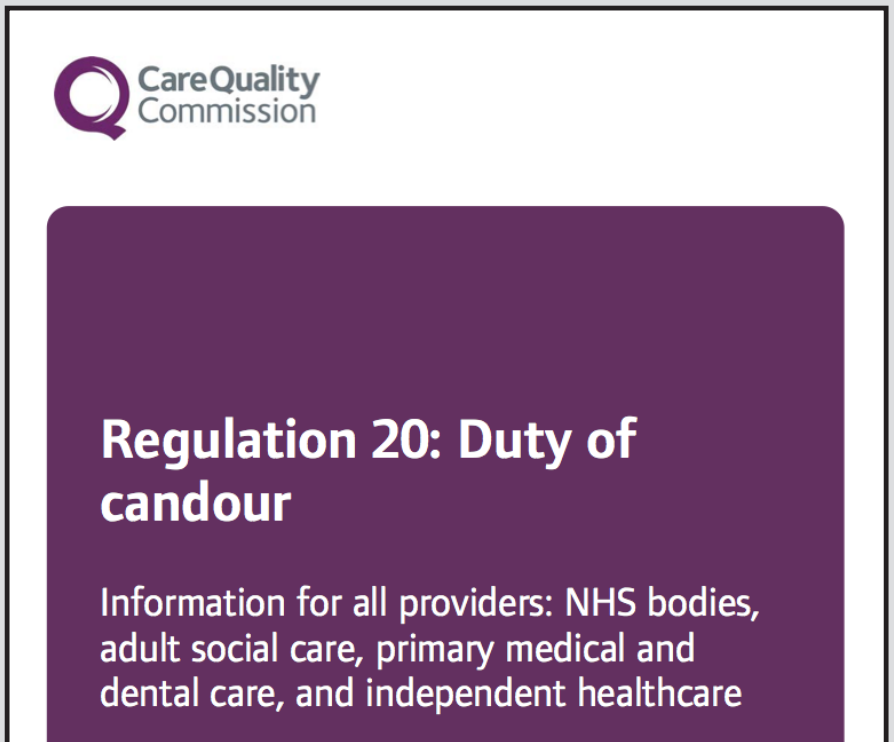
no – prohibited



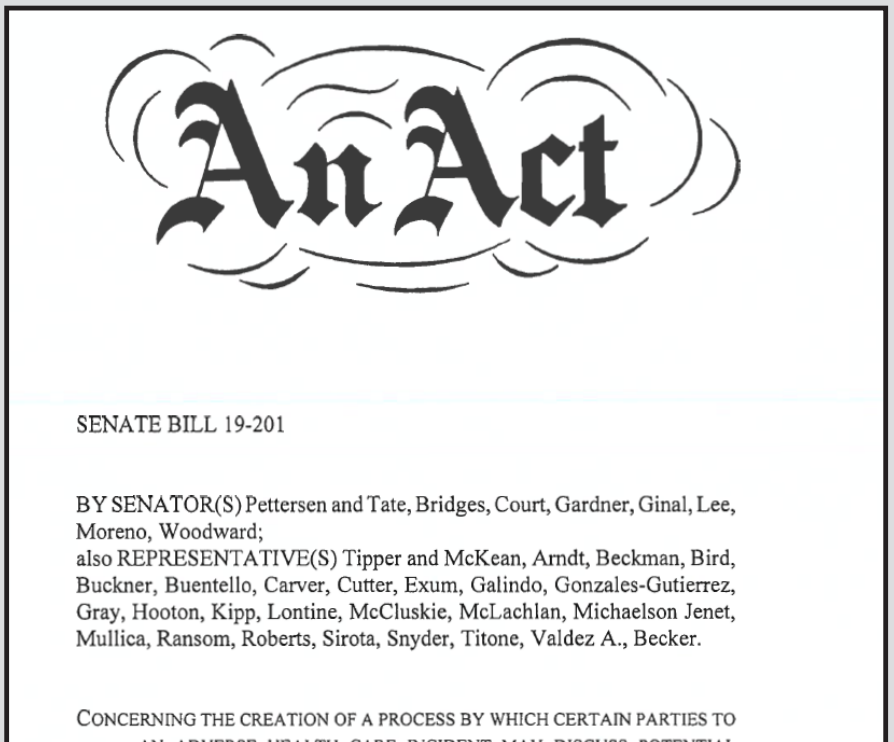
Comparison 5:

Are patients required to keep information they learn confidential?

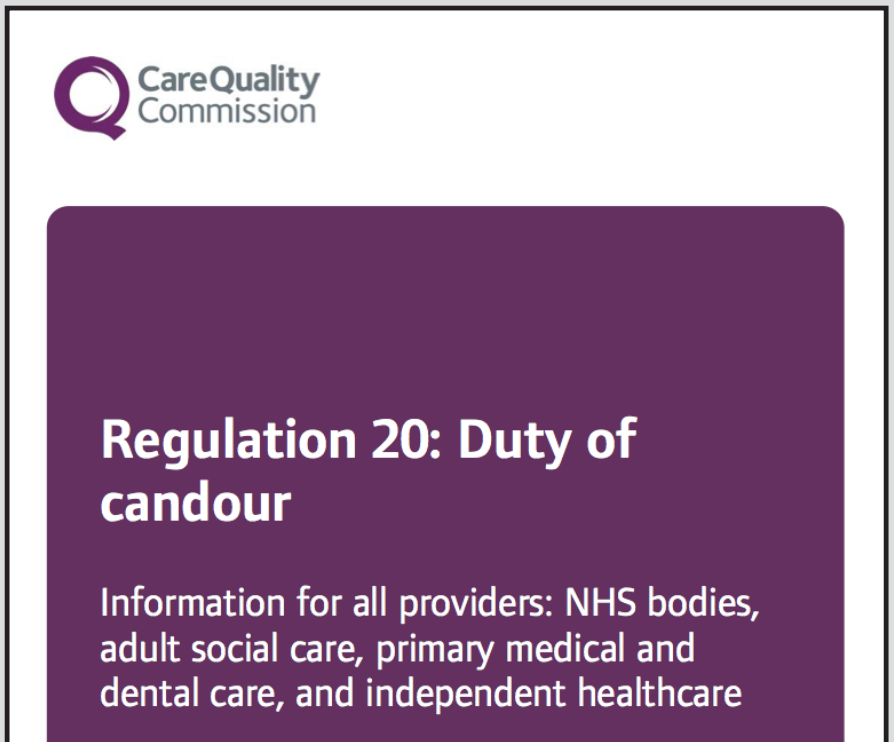
No



Yes



What do these documents reveal about differences in beliefs and values?



Care Quality Commission

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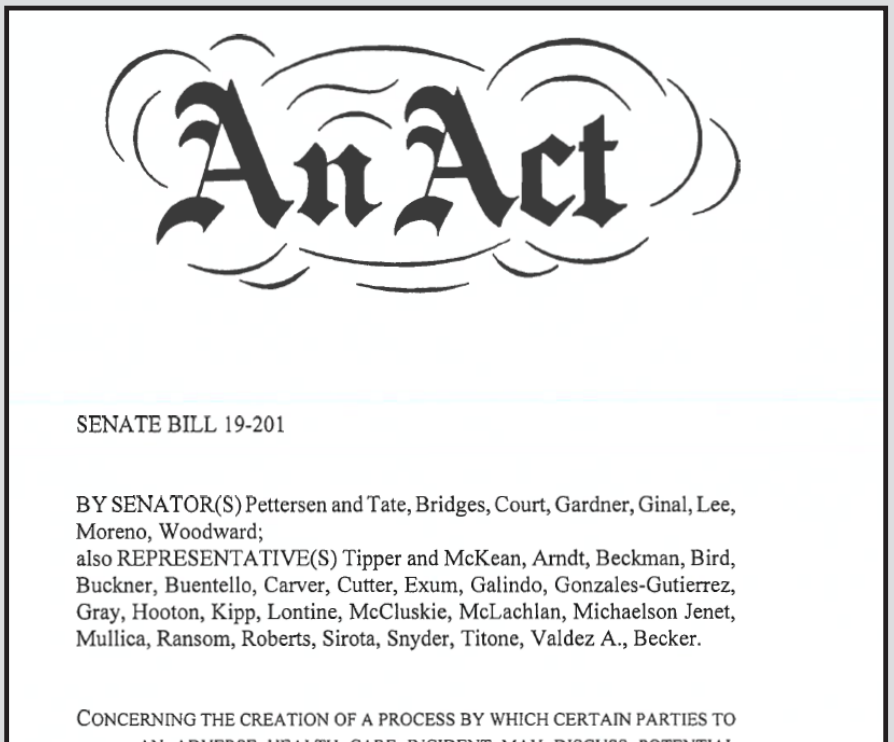

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CONCERNING THE CREATION OF A PROCESS BY WHICH CERTAIN PARTIES TO

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

Melissa Clarkson

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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

https://www.ahrq.gov/patient-safety/capacity/candor/modules.html

Colorado CANDOR Act

https://leg.colorado.gov/bills/sb19-201

COPIC guide to the Colorado CANDOR Act

https://www.callcopic.com/resource-center/guidelines-tools/colorado-candor-act-resources

National Practitioner Data Bank regulations

https://www.npdb.hrsa.gov/resources/aboutLegsAndRegs.jsp