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EDITORIALS

Abandon the term "second victim"

An appeal from families and patients harmed by medical errors

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The term "second victim" was introduced by Albert Wu in a *BMJ* editorial published in March 2000.[1] His purpose was to bring attention to the need to provide emotional support for doctors who are involved in a medical error.

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 term,[7] and even Wu has recently acknowledged concerns about its use.[8]

Patient communities and their advocates do not question the need to support healthcare professionals who have been involved in an incident of patient harm—programmes providing care for the care giver, such as those implemented in the Communication and Optimal Resolution (CANDOR) initiative in the US,[9 10] are crucial for a functional and safe healthcare system. But they do question why victim has become so embedded in the vernacular of patient safety.

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 every such event.

Interest surrounding the second victim phenomenon has revealed another stark reality. Although growing research and attention are focused on the needs of professionals after a medical error, there remains little research or support for the needs of harmed patients and their families. When Wu introduced the term second victim in 2000, it could have cultivated empathy with harmed patients. Instead, it seems to have reinforced the inward gazing, professional centred nature of healthcare systems, insulated from the realities faced by harmed patients and their families.

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Healthcare professionals and institutions must break down this barrier by engaging with patients, families, and advocacy organisations to understand more broadly how everyone—patients, families, and professionals—is affected by medical harm.[12-15]

It's time to abandon the term second victim. We know who the actual victims of medical errors are because we arranged their funerals and buried them.

Competing interests: We have read and understood BMJ policy on declaration of interests and declare that all authors are advocates for safety in the healthcare system. MC is the daughter of Glenn Clarkson, who died in 2012 after a series of medical errors made in treating his burns. HH is the mother of Lewis Blackman, who died in 2000 because of failure to recognise reactions to a post-surgical medication. CH is the mother of Alyssa Hemmelgarn, who died in 2007 because of medical errors. PS is the mother of Michael Skolnik, who died in 2004 from innumerable complications after unnecessary brain surgery.

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