Spotlight on the 'Second Victim' term

The aims of this article are to:

1. Outline the origins of the 'second victim' term
2. Reflect on some of the main objections to it and the related consequences
3. Outline work undertaken to try and identify a more acceptable term
4. Demonstrate, term aside, the need to support healthcare staff involved in a patient safety incident (PSI)
5. Make recommendations which, if enacted, will improve support for ALL involved in a PSI

1 What are the origins of 'second victim' term?

Healthcare staff are frequently drawn to their career by a strong personal ethic to help others, and are educated to 'first do no harm'. Being involved in events which lead to harm – or potential harm (defined as a 'near miss') – of a patient in their care can be deeply distressing. The immediate need to address and/or repair the harm is often accompanied by feelings of shock, panic and fear. In addition, deep feelings of shame and guilt are common. Healthcare professionals' competence and identity are called into question and their personal ethics violated.

> *"The incident happened at the end of a night shift. So I went home on the tube. I got home and cried a lot and didn't sleep that whole day. Went back in for the night shift and had to still deal with the same patient and the family and it was just awful (…) I was traumatised by what happened. (…) I can still remember this woman's name, and I'll never forget her. And I can still remember her family very, very clearly." (Anaesthetist)*

Albert Wu is a Professor of Health Policy and Management at the Johns Hopkins School of Public Health and a leading expert on disclosure and the psychological impact of medical errors on both patients and caregivers. He first introduced the term 'second victim' in 2000 to provide a frame for thinking about and describing this phenomenon of healthcare staff being affected psychologically and sometimes physically by the burden of harming patients (the victims) in their care. Read more about Wu and his work here: https://psnet.ahrq.gov/perspective/conversation-withalbert-wu-md-mph-0.

The term was developed to highlight the need to support both patients ***and*** healthcare staff after harm, and to recognise the potential for both to be primary and secondary victims respectively of complex and inadequate healthcare systems[1]. The introduction of the 'second victim' term was a seminal moment, particularly within research, because it provided a framework to investigate the phenomenon.

2a What are the main objections to the 'second victim' term?

There are broadly two main objections or controversies associated with the term 'second victim' in the context of a patient safety incident, these are:

1. It is insensitive and undermines the harm experienced by the patient and family
2. It implies passivity and/or undermines the professional autonomy of healthcare staff

These controversies are now discussed in more detail below.

1. It is insensitive and undermines the harm experienced by the patient and family

Wu may have sought to foster greater understanding and empathy between patients, families and healthcare staff, and to dispel any misconceptions that healthcare staff are robots, unaffected emotionally when they cause unintended harm. However, instead of nurturing a sense of shared humanity, the term is considered by some to be divisive. Clarkson et al[2] argue it has created a platform which further reinforces the separateness and professional privilege of those working in medicine.

Healthcare staff asked about their perceptions of the Second Victim term have also expressed some discomfort with it. For example, some felt that referring to themselves as 'victims' was deeply disrespectful and insensitive to the patient and family, and that the implied lack of accountability in the term may undermine the harm experienced[3].

2. It implies passivity and undermines the professional identity of healthcare staff

Wu himself acknowledges that "the term 'victim' may connote passivity or stigmatize involved clinicians" [1 p.1]. Healthcare staff have also expressed concerns that being labelled a 'victim' undermines or even strips them of their professional competence and identity[3].

Patient and family advocates dislike the term because they feel it obscures the true picture surrounding a PSI: labelling a healthcare professional a 'victim' implies passivity, impotence and no accountability:

> *"Victims bear no responsibility for causing the injurious event and bear no accountability for addressing it. Victims elicit sympathy. They are passive. They lack agency. Preventable patient harm results from a combination of institutional system 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"[2p.1].*

2b What are the consequences of the second victim term 'controversy'?

Dissatisfaction among UK professional bodies

Perhaps understandably, given this controversy, the 'second victim' term has caused unease amongst some UK arm's length and professional bodies. All UK Medical Royal Colleges have a wider agenda of supporting staff wellbeing and recognise, as part of this, the need to support staff who have been involved in a PSI. However, some royal colleges who offer information and support to the public have expressed concern that, by endorsing the 'second victim' term, they would offend patients and their families and deter them from accessing their information and resources.

The term doesn't reflect the future of UK patient safety policy

Whilst current UK patient safety policy refers to the 'second victim' *phenomenon*, some policy makers do not feel the *term* reflects the aspirations of future policy - an NHS where staff involved in PSI are supported optimally to minimise harm and promote healing, learning and action. However, there is also a sense that moving away from the term 'second victim' altogether risks overlooking key research developments. In moving away from the familiar, recognised term we risk being disconnected from the academic literature which continues to use this term; and from key policy documents which use it including the NHS England and NHS Improvement Patient Safety Strategy[5] (updated 2021), the introductory version of the 2019 NHS England and NHS Improvement Patient Safety Incident Response Framework[5] and the 2021 Healthcare Safety Investigation Branch National Learning Report[7].

3 What work has been undertaken to try and identify a more widely acceptable term?

Given the ambivalence and unease regarding the term, attempts have been made internationally to establish an appropriate alternative[8]. We have undertaken our own extensive work to identify an alternative, engaging with patient and lay representatives, healthcare professionals, UK policy makers and professional arm's length bodies.

In focus groups[9] we conducted with patients and members of the public, the 'second victim' term triggered a mixed response. Whilst there was an understanding that there are many causes of/complexities surrounding PSIs, they directed much of the responsibility towards the healthcare staff involved. After watching the staff video stories on this website, participants also expressed a high level of empathy toward staff involved. The patient and public focus groups did generate alternative terms. These centred around emotive language and blame, including 'perpetrator', 'human error', 'guilty' and 'scapegoat'. However, they recognised that none of their suggested terms was suitable in all situations and there was no consensus that any was better than 'second victim'.

In interviews we conducted with healthcare professionals, mixed feelings were also expressed about the 'second victim' term. They had reservations about term 'victim' because they felt it had

connotations with being a victim of a crime which might not truly reflect the context. However, despite this, healthcare staff strongly agreed with validity of the phenomenon it encapsulated - that being involved in a safety incident can have a severe impact on staff mental, physical and psychological wellbeing. None of the healthcare staff interviewed were overtly averse to the use of the term 'second victim'; some alternatives were suggested, such as 'second harmed'. However there was no consensus on a suitable alternative which signified the gravitas of the phenomenon.

In summary, despite the negative connotations of the 'second victim' for many – public, healthcare staff and policy makers included - no suitable alternative has been established[8] and as such, this highly sensitive debate continues.

4 The need to support healthcare staff involved in a PSI.

One of our key goals in writing this spotlight piece is to reassure our website visitors and endorsers that we recognise the sensitivities and controversy surrounding the term. However, there is broad consensus that when PSIs occur, the negative consequences can extend far beyond the patient[10]. Whilst the 'second victim' term may be contested, there is wealth of evidence to support the phenomenon that healthcare providers are deeply affected when they harm those in their care.

When a patient is harmed, the primary focus should be on supporting the patient and/or their family; however, the impact on the physical, mental and psychological wellbeing of healthcare staff involved must also be recognised. To read more about the impact of being involved in a PSI on healthcare staff, visit our Second Victim Support website.

Our position is that we believe the phenomenon should not be discounted because we dislike the term. Healthcare employees deserve to be treated fairly and compassionately when things go wrong[12]. However, despite extensive research articles discussing the 'second victim' phenomenon (a recent Google Scholar search using the term returned 2.85 million results), this has not translated into the development of widespread support for healthcare staff; there is limited organisational awareness of the phenomenon and support remains poor[10]. If the impact on healthcare staff of being involved in a PSI is not recognised and support not provided, the consequences can be further compounded.

Research has indicated that where healthcare staff ***do*** experience organisational support after PSIs, distress and associated absenteeism and intentions to leave are reduced[13,14]. The Healthcare Safety Investigation Branch[6] national learning report highlights the need for support systems for staff. Our own Organisational Staff Support Model Before and After Involvement in Patient Safety Incident - based on Cooper and Cartwright's[15] intervention strategy for workplace stress and adapted from a range of evidence-based sources - is designed to support organisations to create a culture where staff are supported before, during and after involvement in PSIs.

5 Recommendations to ensure support for ALL involved in a PSI

Key Recommendations:

A. Acknowledge the wealth of evidence which emphasises the 'second victim' phenomenon exists irrespective of the controversy with the term used to describe it
B. More research is needed in relation to the patient and family experience after a PSI
C. Organisations need to move towards more holistic view of harm following PSIs and adopt a more restorative approach for all involved - patients, their families and healthcare staff
D. Embed staff support approaches which prioritise meaningful relationships alongside more traditional staff support services to minimise the consequences of PSIs
E. Organisations should strive for a more Just Culture if they are to provide support services to healthcare staff involved in a PSI and should do so whilst avoiding referring to staff as 'second victims'.

A. Acknowledge 'second victim' phenomenon exists

The 'Second victim' phenomenon and the consequences of it must be validated and acknowledged if organisations are to prepare staff on the reality of PSIs when working in healthcare. A deeper appreciation of why healthcare staff involved in a PSI require support offers the potential to minimise the resulting distress/trauma. It offers the ability to protect staff and patients proactively. Only when organisations understand PSIs from the perspective of the healthcare staff will they realise the need to improve access to and the support available for the staff impacted.

B. More research is needed to understand the patient and family experience after a PSI

Titcombe et al[16] state 'The healthcare system needs to ensure that harmed patients and their families are properly cared for with compassion and empathy and not subject to further harm caused by the organisational and system response.' Research to understand the patient and family experience of healthcare harm incidents, their needs and desired support is increasing.

An extensive research project currently underway with our own Yorkshire and Humber Patient Safety Translational Research Centre, the 'Learn Together' project, is seeking to improve how patients and families are involved in investigations after they experience a serious healthcare incident. To understand how patients and families are *currently* involved in such investigations and what needs to change, we analysed 45 NHS Trust serious incident investigation policies and the available research (26 academic papers), and spoke to over 50 patients, families, NHS staff and lawyers. We have drawn upon these findings to co-design, with a large community of

stakeholders, new processes and resources to guide more meaningful involvement of patients and families. We are testing these 'Learn Together' processes and resources within our five partner organisations, across 25 investigations, to understand their impact upon experience, restorative learning and likelihood of seeking legal recourse.

Significant work is also underway exploring restorative approaches to supporting healing for patients and families (and healthcare staff) after healthcare harm in the USA[17,18,19.] New Zealand[20,21] and in Canada[22].

C. *Take a holistic view of harm following PSIs and adopt a more restorative approach for all involved*

A more holistic view of who is harmed and who needs support following a PSI is needed if we are to meet the arising needs of all involved. The response to any PSI should not be about apportioning blame or seeking out a perpetrator but about support, healing, learning and action.

There is growing interest in a more restorative approach (as opposed to retributive/adversarial) after a PSI. A restorative approach recognises various parties are harmed when healthcare goes wrong; and those harmed will all have different needs that need to be acknowledged and met. Respecting the experiences of all involved in a PSI is integral to achieving high quality patient safety investigations. A move to more restorative practices, by including staff, patients and their family/carers as partners in understanding what can be learned from a PSI, can only aid healing and learning to prevent further harm/consequences and prevent the safety incident happening again.

For organisations, an understanding and appreciation of the serious implications of this vulnerable period for the staff offers opportunity for them to respond in proactive manners to address the unique needs of healthcare staff during this period in their professional lives. Systemic organisational responses in the aftermath of a serious adverse incident/PSI should be designed to ensure that healthcare staff are treated with respect, compassion, and support –

D. *Embed staff support approaches which prioritise meaningful relationships alongside more traditional support offers to minimise the consequences of PSIs*

Leaders and managers have a vital role in creating caring and supportive psychologically safe work places where dialogue can take place in an environment which is open and constructive. The behaviour of leaders at all levels throughout an organisation needs to demonstrate that they can be trusted and that they will care for people and treat them fairly at all times but particularly at times of challenge, such as during patient safety investigations.

Michael West[23] argues that NHS leaders 'should be promoting the idea that humans can flourish in the workplace, by ensuring that staff have opportunities for growth and development, the experience of supportive relationships at work, work environments that promote their physical health, and leaders who provide the resources that enable them to cope effectively with the demands of their work'.

E. Healthcare organisations need to role model a more Just Culture

A Just Culture has an important role to play in the management of PSIs. Organisations which understand why a PSI has occurred and learn the lessons from this, are the organisations where staff are more likely to recover following involving in a PSI. A Just Culture prevents enduring or lasting consequences for staff and their employer; enabling learning to gain wisdom and action to improve patient safety.

The Yorkshire Quality and Safety Research Group and the Yorkshire and Humber Improvement Academy are developing a Just Culture Assessment Framework (JCAF) to support organisations in measuring and improving their organisational culture.

The JCAF has been adapted from Dekker[24], the NHS Patient Safety Incident Response Framework[5] and other research evidence in this area[25]. For more information on the prototype Framework go to: A Just Culture Network.

Conclusion

When a PSI occurs, everyone involved is harmed by the experience. Patients and their families are the foremost important victim of a PSI but the serious impact on the physical, mental and psychological wellbeing of healthcare staff involved as 'second victims' must be recognised. We encourage NHS organisations to use holistic relationship focused approaches which consider the needs of patients, their families and healthcare staff involved.

Evidence supports the existence of 'second victim' phenomenon irrespective of the controversy with the term used to describe it. Therefore, despite the difficulties with the term and in the absence of an acceptable alternative, we will continue to adopt the 'second victim' term on this website.

Going forwards, a move away from a focus on the terminology is necessary – acknowledging the impact on healthcare staff of being involved in a PSI will promote uptake of solutions which aim to support all those involved when things go wrong and support learning from these so that improvements can be made.

Authors

A collaboration between the Yorkshire Quality and Safety Research Group (Bradford Institute for Health Research and University of Leeds) and the Yorkshire and Humber Improvement Academy (YHIA).

Second Victim Support Website

Please visit our Second Victim Support website here and complete the short feedback survey and offer your suggestions for alternatives to the 'second victim' term. Please also use the survey to let us know if you would like more depth of information on any of the content or if there is further information which could be added.

[**Please note**: the above links may not work on some earlier versions of Internet Explorer. If this is the case, please right click on the link and copy into an alternative browser.]

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