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Adverse events as transitional markers - Using liminality to understand experiences of second victims

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ABSTRACT

Healthcare professionals are socialized into a tacit, professional identity of competences and skills – to save lives, repair trauma and facilitate good and trustful relational care. When severe adverse events happen, healthcare professionals may struggle to accept their own fallibility, and the event may pose a threat to the selfdeclared 'superior' or 'infallible' professional identity. The consequences of a sudden identity shift between the 'potentially infallible HCP' and 'potentially fallible HC P' caused by an adverse event is the analytical object of this study. The aim of the paper is to derive new understandings of how HCPs in maternity services experience adverse events by using Arnold van Gennep's and Victor Turner's 'rites of passage' theorizations and the concept of liminality to explain the process of transition between the two professional identities. Through five focus groups conducted in June 2018 with midwives and obstetricians-gynecologists, we have examined i) how second victim experiences can be understood using theories of transition and liminality, and ii) how the organizational procedures in a Danish university hospital may serve as a ritual for the involved HCPs in the aftermath of adverse events. The findings suggest that the inconsistency in the level of support contributes to the chaos that may be experienced by the healthcare professional. The organizational structure does not provide rites of transition or any other ritual processes, except for debriefings that, in many cases, are experienced as deficient. Since liminal states suggest danger and threat, because the previous professional identity is replaced by ambiguity and separation, the lack of clear rituals and support may put further strain on the HCP adding to the associated psychological and social distress. Considering the liminality and the need for structured transition rites within the work environment may prove useful when constructing adequate second victim support programs.

Credit author statement

Katja Schrøder: Conceptualization, Methodology, Investigation, Formal analysis, Writing – original draft. Astrid Janssens: Validation, Writing – review & editing. Elisabeth Assing Hvidt: Conceptualization, Formal analysis, Writing – review & editing

1. Introduction

Virtually every practitioner knows the sickening feeling of making a bad mistake. You feel singled out and exposed—seized by the instinct to see if anyone has noticed. (Wu, 2000, p. 726). Second victims in healthcare are the healthcare professionals (HCPs) who are involved in unanticipated adverse patient events, medical errors or patient-related injuries and become victimized in the sense that the provider is traumatized by the event. Frequently, these individuals feel personally responsible for the patient outcome (Scott et al., 2009; Wu, 2000). They report symptoms of fear, guilt, shame, remorse, physical symptoms, sleep disorders, depression, troubling memories, anxiety, PTSD - and occasionally and tragically this leads to acts of self-harm and/or suicide (Busch et al., 2019; Coughlan et al., 2017; Seys et al., 2013b). The risk is higher for female HCPs or when subjected to incidents involving young, healthy patients and multiple lives (Coughlan et al., 2017; Schrøder et al., 2016b); hence HCPs in maternity services are particularly at risk of developing second victim symptoms. According to Swedish and Danish research, between 71 and 92% of midwives and

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obstetricians-gynecologists (ob-gyns) have experienced severe adverse events in the labor ward (Schrøder et al., 2016b; Wahlberg et al., 2017), yet both ob-gyns and midwives seem to have a high regard of their own capabilities and a low acceptance of their own fallibilities (Schrøder et al., 2016a).

There is very little guidance for HCPs on how to respond to adverse events (Cauldwell et al., 2015). This is described as an "intolerable paradox": the HCPs see the horror of their own mistakes, yet, they are given no permission to deal with the immense personal impact (Coughlan et al., 2017; Hilfiker, 1984). The level of second victim support provided seems to play an important role in regaining a professional self-image, and a low level of support may instigate a negative trajectory of insecurity, feeling isolated and fear of being blamed (Kerkman et al., 2019; Schrøder et al., 2018; Scott et al., 2009; Wahlberg et al., 2018).

The recovery of the second victim has been described as a six-stage post-event trajectory moving from an initial chaos and accident response to a final stage of moving on, either through dropping out, surviving or thriving (Scott et al., 2009). Wahlberg et al. (2018) have described the erratic pathway to regaining professional self-image after a severe obstetric event as follows: 1. Depending on the patient's reaction; 2. Searching for collegial acceptance; 3. Fearing the verdict; 4. Fighting guilt and shame; 5. Accepting vulnerability and 6. Contemplating work future. The HCP goes through a transition in the aftermath of an adverse event, and the potential outcome is described in terms of either *re*gaining the self-image from before the event or gaining a new self-image or identity (Scott et al., 2009; Wahlberg et al., 2018). Adverse events may thus be a disruptive event threatening the identity of the HCP.

Professional identities and self-images of HCPs are a product of intersubjective and external social processes within specific discursive formations and practices (Monrouxe, 2010). Medical education is as much about learning to talk and act like a doctor as it is about learning the content of the medical curriculum (Monrouxe, 2010). Davis-Floyd (1987) has viewed medical training as an initiatory rite of passage through which nascent obstetricians are socialized into the core values and belief system of American obstetrics. Wackerhausen (2009) argues that many elements and dimensions of the HCP's professional identity are not possessed in an explicit and conscious form; they have an embodied existence by virtue of habituation. The obligation of the student is "*to become* one of our kind" and "*to stay* one of our kind" ever after (Wackerhausen, 2009, p. 462). Medical students develop a capability identity with a great focus on competence and perhaps with less emphasis on caring (MacLeod, 2011). Traditionally, medical education has portrayed 'the good doctor' as a collection of competences produced by medical education in a 'manufacturing model' of medical training (Bennett et al., 2017). The archetypal 'good midwife' is capable and competent to provide safe physical care as well as respecting the emotional and spiritual dimensions of pregnancy and childbirth. Being a midwife implies a relationship of knowing each other, of mutual trust, of working in the best interest of the woman around the time of childbirth in ways that recognize that the physical, emotional and spiritual aspects of pregnancy and birth are equally important (Page, 2008). Midwives and doctors are socialized to a tacit, professional identity of competences and skills – to save lives, repair trauma and facilitate good and trustful relational care. An adverse event might be a threat to this 'superior' or 'infallible' occupational identity.

The aim of the paper is to derive new understandings of how HCPs in maternity services experience adverse events by using the rites of passage theory and the concept of liminality to explain the process of transition from one professional identity to another. Through the accounts of midwives and ob-gyns we will examine i) how second victim experiences can be understood using theories of transition and liminality, and ii) how the organizational procedures in the aftermath of adverse events may serve as a ritual for the involved HCPs. This will contribute to the existing body of knowledge about second victims in healthcare and provide a new frame for the design of organizational support strategies.

2. Contextual and conceptual framework: rites of passage and liminality

The study is situated within a constructionist worldview. From this perspective, knowing occurs during socially negotiated processes that are historically and culturally framed (Järvinen, 2005; Koro-Ljungberg, 2008). Social constructionism emphasizes how meanings of phenomena do not necessarily inhere in the phenomena themselves, and that meanings are developed and shaped by cultural and social systems. Hence, a contextualization of second victims in a Danish labor ward setting is required to conceptualize the framework for this study. In Denmark, midwives are authorized to manage uncomplicated childbirths, and complicated births are handled in close collaboration with obstetricians.

2.1. Institutional procedures after an adverse event

Denmark was one of the first countries to pursue a 'just safety culture' in healthcare, supporting the rights of both patients and HCPs within a blame-free setting (Svansoe, 2013). Whereas other countries legislated to sanction HCPs involved in adverse events, Denmark focused on improving safety of both patients (first victims) and HCPs (second victims) by learning from mistakes, without sanctions, through a formalized reporting system (Schrøder et al., 2019; Svansoe, 2013). However, it has been argued that although an open, system-based approach is preferable to finger-pointing and blame, a just safety culture *an-sich*, cannot alleviate the emotional impact of an adverse event on the second victim (Schrøder et al., 2019).

A national survey among midwives and obstetricians in Danish obstetrical departments collected midwives' and obstetricians' experiences of social community, social support and feedback from colleagues and managers in general and after adverse events. Midwives and obstetricians scored high on general social support and feedback from colleagues and social community at work; 95% of the respondents had spoken to their colleagues after adverse events, but only 48% experienced *meaningful and sustain*ed support. Results were less positive when questioning experienced support from immediate superiors, with less than half reporting they had talked to their immediate superior about the adverse event. The study also revealed a lack of clarity on how to report an adverse event, and access confidential emotional support (Schrøder et al., 2018). Additional qualitative interviews illustrated the diversity of support offered, with formal debriefings led by a senior consultant in ob-gyns within one or two weeks following the adverse event being most common.

2.2. Liminality and 'rites of passage'

The concept of liminality stems from the work of anthropologist Arnold van Gennep and, subsequently, cultural anthropologist Victor W. Turner, on rituals and rites of passage (Turner, 1967; van Gennep, 1960). Rites of passage are defined by van Gennep as 'rites that accompany every change of place, state, social position and age', hypothesizing that they were intended to smoothen the potentially disturbing effects of an individual's transition from one social world to another (Turner, 1967, p. 94). Although birth, puberty, marriage and death are considered critical moments of transition, any change from one state to another or entry into a new achieved status may be accompanied by rites of passage (Turner, 1967). Van Gennep ([1906] 1960) observed all ritual ceremonies to have a three-part structure: rites of separation, rites of transition (or liminal rites) and rites of incorporation. The first part involves rites that mark the separation of the individual from its preceding role or social status, the second a period of transition in which the individual has neither the old nor the new status, and a third set of rites in which the individual reintegrates into society in

its new social state through various rituals of incorporation (postliminal rites or rites of incorporation) (Davis-Floyd, 1987; Turner, 1967). Turner adopted van Gennep's framework and focused on the liminal rites which he described as a process of potential change, an in-between state, 'betwixt and between' recognized social statuses, an uncertain period of limbo where one's identity is temporarily suspended (Turner, 1967). This transformative transition involves letting go of previously held views, attitudes, and status, and being prepared to reconsider and recalibrate (Bigger, 2010). Turner suggested that transition can be transformative, thus describing liminality as a 'stage of reflection' where 'the reformulation of old elements in new patterns' occurs (Turner, 1967, p. 99). The performance of rituals presents a means of resolving discrepancies and enabling the transformation from one state of being to another (van Gennep, 1960). Rituals are deliberate, detailed, and repeated patterns of activity that are infused with multiple meanings, and they are considered to be transformative because they help liminal persons integrate narratives of their past, present, and future, and thus gain a greater sense of continuity in their life. They serve to reaffirm social ties, mark changes in identity, generate meaning that fosters a sense of solidarity, and manage crises (Romanoff and Thompson, 2006).

Below we illustrate how the theories of transition and liminality described above provide useful analytical and conceptual tools to understand second victim experiences in obstetrics and midwifery in Denmark.

3. Data and methods

3.1. Study design and sampling

The data used for this analysis were generated as part of an intervention study, 'The Buddy Study', which developed, implemented and evaluated a peer support program for HCPs after adverse events. Users of the program were involved in the development, and five focus groups were conducted in June 2018 with 21 participants; 12 midwives and 9 ob-gyns. There was a two-fold aim with the focus groups: 1) to get knowledge about second victim experiences in the department, and 2) to present the peer support program and get feedback from the potential users. A purposive sampling was used to establish four homogeneous groups (Green and Thorogood, 2018): i) female ob-gyns, ii) male ob-gyns, iii) midwives (less than 5 years of experience), and iv) midwives (more than 5 years of experience). Our previous research has found that midwives and doctors, and men and women differ in their response to second victim experiences (Schrøder et al., 2016b), and given the sensitivity of the topic we decided to construct homogenous focus groups (same profession and same gender). Since no male midwives were employed at the department, we conducted one focus group with junior and one with senior midwives. Participants were recruited through information sent via staff mailing lists and pinup boards in staff rooms at an obstetric department in a large university hospital in Denmark. Participants were included through self-selection (Green and Thorogood, 2018).

3.2. Focus groups and data analysis

After a brief introduction, the focus groups were all initiated with a round where each participant was asked to tell about an adverse event in a labor ward. Everybody had at least one event to disclose and detailed descriptions of the impact of the event were shared in an atmosphere of mutual understanding.

The focus groups were conducted within an interactional constructionist (IC) approach where all narratives are perceived to be constructed *in situ*, and the moderator's and participants' constitutive contributions to the dialogue are acknowledged (Holstein and Gubrium, 1995). From an IC approach, all individuals engaged in the interview process were considered "knowing subjects". This implies that all interview participants create knowledge and are actively and intentionally engaged in the knowledge production during the interview (Koro-Ljungberg, 2008). Subsequently, the moderator (KS), actively used her own clinical experiences and understandings as a midwife during the interviews.

All focus groups were audio-recorded with the participants' permission and were transcribed verbatim and pseudonymized by the first author (KS). Non-verbal communication was noted and made part of the data, as these interactions contributed to explicate how meanings, their linkages and horizons, were actively constituted within the interview environment (Holstein and Gubrium, 1995). NVivo 12 Pro was used to facilitate systematic approaches to the coding and retrieval of data related to anticipated and emergent themes. First cycle coding (Miles et al., 2014) was performed independently by the first (KS) and last author (EAH), using primarily descriptive and in vivo coding. The interrelationships of the codes were compared and discussed. Drawing on the theories of professional identity, we conducted the analysis from the hypothesis that adverse events cause a transition or transformation of the HCP's professional identity, and we also considered the reactions of the community to be central to the experiences of the second victims. KS performed a second cycle coding (Miles et al., 2014), where pattern codes were developed. During this process, theories on liminality and 'rites of passage' were consulted, and a process of cycling back and forth between the data and the theories led to the final construction of the analytical object of 'the potentially infallible HCP' and the adverse event as a trigger for a transitional phase towards 'the potentially fallible HCP'.

3.3. Research ethics

The study was approved by the Danish Data Protection Agency (17/6114) on February 21, 2017. All participants signed a written consent informing them about the aim of the focus groups and about the possibility to withdraw the consent at any given time. At the end of each focus group, the moderator (KS) repeated that data would be pseudonymized during transcription and that any doubt about recognizability would be conferred with the relevant participants prior to publication.

4. Findings

Using theory on professional identity and on liminality, we constructed the analytical object of 'the potentially infallible HCP' and 'the potentially fallible HCP', and we used the concepts of separation, transition (or liminality) and incorporation. This led to three main themes: i) The adverse event is an abrupt and unanticipated separation, ii) Indefinite rituals provide unclear transitional guidance, and iii) Re-entering the society is a lonesome accomplishment of the individual. In the second theme we identified two rites of passages (debriefing; the formal rite after adverse events and peer support; the informal rite after adverse events). The debriefing was defined with unclear structure and leadership of the ritual, and three types of debriefing rituals were distinguished (a ritual to promote learning, to provide care or to invoke blame).

4.1. The adverse event is an abrupt and unanticipated separation

Through the rites of separation the novices are separated from their previous way of life and social status and led by the community (*communitas*) towards the liminal state (Turner, 1969). According to Turner the stage of separation is often an anticipated stage that may prepare the novice for the liminal stage.

When adverse events occurr in clinical work, the separation happens abruptly without prior anticipation. The focus group participants remarked that during their professional training no one had prepared them for future experiences of adverse events or medical error. In three of the groups, the participants even started laughing sarcastically when asked about how they had been trained to handle traumatic or adverse events:

Moderator: And how do you think that you were *trained* to handle this?

Midwife 1, Focus group 4: Not a lot.

M5: Hardly at all.

M1: A couple of hours perhaps? (pause).

M5: It has been the hard way.

M1: Learning by doing.

M2: Too little, one might say. (small giggle).

Moderator: You all agree on this? It was not a part of your educational program?

M6: I can't even remember it. (others agree 'me neither'). So, it probably wasn't there. (laughs).

M5: I think we had one day on … grief and crisis …

M1: Yes, grief and crisis.

M5: That was it.

Moderator: For you or the patients?

M6: Probably the patients. (sarcastic laughter).

M5: Definitely the patients! Not on how *we* would sort of cope, oh no no no. We weren't that interesting … (laughs).

The lack of preparation for adverse events and their impact on HCPs was discussed with a certain sarcasm, but also with a certain degree of pragmatism as a compliance to the culture of their professions. Giving an example of this culture, and shared capability identity, one physician shared an experience of her first encounter with the death of young children who were taken to the emergency department after a severe accident. The young doctor was distraught and called the consultant for advice on how to cope with the distressing sight of the small corpses, and the consultant responded:

Ob-Gyn 2, Focus group 1: "You're a doctor now. Get used to it." Wham! [slams the phone down]. So … that sort of culture was part of our education.

Recounting their experiences of unanticipated separation in clinical work, the participants also voiced a duality that adverse events are unexpected, yet they can happen any given day during one's professional career:

Ob-Gyn 1, Focus group 2: (…) I remember the first time I heard a physician telling about an intrapartum death he had been involved in and he was obviously upset, and I thought 'how lucky I am because it hasn't happened to me', because it might as well happen on the first day on duty as any other day …

It seems that any day at work holds the potential to detach the HCPs from their previous identity, and that the latent strategy to aspire to be the ever competent and capable clinician leaves the HCP very vulnerable after an adverse event. Within a few moments or hours, the HCPs could find themselves separated from their preceding social status as a 'potentially infallible HCP', facing a new identity as a 'potentially fallible HCP'. Seen from a liminality perspective, the separation stage abruptly moves the HCP towards the liminal stage, and since there has been no preparation for this, there are no guided direction or rituals to follow.

4.2. Indefinite rituals provide unclear transitional guidance

The focus group participants had many different experiences of the immediate aftermath of the adverse event—some experienced tremendous support and guidance from either peers or management, while others felt abandoned and insecure. All mentioned debriefings as an integrated part of the organizational response to adverse events. The debriefings can be seen as forming part of a kind of ritual process helping the HCP to cope and make a good transition to the 'potentially fallible HCP'. Therefore, this paper considers the debriefing to be the formal, institutionalized ritual targeting HCP after an adverse event. Peer support is considered an equally important, though informal ritual.

4.2.1. Debriefing – the formal rite after adverse events

4.2.1.1. Unclear structure and leading of the ritual. The debriefing seems to be the institutionalized response to adverse events, and thus, could be seen as a rite of incorporation; yet it is associated with great insecurity in terms of *whether* and *when* it is conducted *for whom* and *by whom*.

Many reported unclear or random trigger points for a debriefing to take place, which resulted in either too few or too many debriefings.

Ob-Gyn 5, Focus group 1: And I also think that, well, sometimes a lot of debriefings are conducted, though it might not be necessary. Because some midwife is sitting in a corner crying. Because some words have been said. (Small giggle).

OG3: Yes, but … No, it's true, you do experience that it [the concept of debriefing] may become a bit diluted.

OG5: Debriefing for the sake of debriefing …

It was repeatedly mentioned that not all employees involved in the event actually participated in debriefings because for some it would coincide with their clinical work, some of them were not invited to participate and some of the invited did not feel a need to participate. Apparently, this non-participation of some of the employees was not acted upon by the organization, and the participants found this inconsistency problematic. In cases where the organization did not provide a debriefing as standard ritual, the potential vulnerability of the HCPs would impede them from seeking support or guidance, therefore prolonging the phase of liminality. This could be due to fear of further exposure:

Midwife 1, Focus group 4: The situation I was in, where someone died, ehm … I told my husband of course. But apart from that I didn't tell anyone. Because … I spent the next fortnight waiting for a headline in the newspaper. […] I figured that a maternal death in this day and age would definitely make the headlines. So, I was waiting to get exposed or bashed in the media at some point.

The midwife described that due to confidentiality, she felt unable to disclose anything to her friends and family, making her more dependent on workplace support. Unfortunately, the workplace failed to provide this support; the management assessed the midwife's role to be minor and invited her "only by coincidence" to a debriefing. Another example of being abandoned – or wrongfully assumed to not need any support – was given by a consultant who had delivered a severely asphyxiated child by C-section. The woman's uterus had ruptured during labour, and the doctor had acted according to the clinical guidelines. Still, she felt that no one paid attention to her needs in the aftermath of the stressful event. The doctor wondered whether her senior position (consultant) prevented offers of support, as both peers and management did not deem it necessary.

Ob-Gyn 5, Focus group 1: So, basically, I hadn't done anything wrong, but I still think that I needed a talk afterwards. And nobody did that. A few of the junior doctors said that it was a strenuous or hard case, right? And then I spoke to another consultant the day after. But otherwise … nothing.

Another trait of the senior position of consultants is that they were expected to conduct the debriefings after events in which they had not been involved.

Ob-Gyn 3, Focus group 1: Somehow, it seems wrong that we are the ones conducting these debriefings, because we don't have the tools.

OG5: It sure is! Completely wrong! It's only because we are good at talking to people, right? (…)

OG3: We should be getting some sort of coaching on how to conduct them, right?

OG5: Yes.

OG3: Some sort of training or education …

OG5: Exactly.

(…)

OG5: Because I think about it very often, when I'm sat there conducting a debriefing, and I have done that *many* times, I can assure you.

(…) I do believe that a lot of people get over it by talking it through. But we don't catch them all. People, including myself, may hide behind a brave face, right?

Those who had been charged with doing the debriefing, the consultants, mentioned that the lack of training and systematic tools put them in a vulnerable position. Consequentially, debriefings were considered being of very different quality leading to different outcomes depending on the person conducting the debriefing, and this added to the participants' uncertainty of what to expect:

Midwife 6, Focus group 3: Last week I went to this debriefing on the first event, and tomorrow I am going to a debriefing on the second event. The first debriefing was really good and proper, and of course I am hoping that the one tomorrow will be the same. (…) I have attended debriefings before, where I felt it turned into some sort of mudslinging. And you definitely don't need that in a situation like that. But the other day it was very proper, and I sure hope it will be the same tomorrow. Because it does help you get through it then.

4.2.2. Three types of debriefing rituals

We have identified three types of debriefings, which either facilitate learning, offer care or invoke blame. These categories are not necessarily mutually exclusive; a debriefing may include elements from all categories.

4.2.2.1. A ritual intended to promote learning. Participants mentioned that the debriefing was a time for reflection and learning and to identify preventative steps to avoid similar adverse outcomes in the future. Generally, the participants engaged in the learning aspects of the debriefing and found value and use in it. An open learning culture was described as an integral element of the organizational culture in which most felt obliged to take part. However, some of the participants discussed whether 'learning' was a priority or even a possibility in the immediate aftermath of the event where the involved HCP may feel vulnerable and distressed.

Midwife 4, Focus group 4: … I think that it is really important to consider the timing after the event. Because in the immediate aftermath … I wonder whether you need *to learn* right there … I reckon that you need comfort and care.

The timing of the debriefing seemed essential to achieve this goal of learning. Emotional turmoil and a great sense of vulnerability in the immediate aftermath of the event was experienced to impede the ability to learn, because the immediate focus was on self-protection. Also, the fine line between learning from mistakes and pointing out culprits or errors was discussed.

Ob-Gyn 2, Focus group 1: And I have experienced from both myself and my colleagues, that it quickly turns into … well, looking for someone's errors or mistakes rather than … well, I think it is a fine balance between the fact that this is a very serious business with razor sharp decisions and high standards … but you become … well, it is a learning process as well, right? (agreement in the group). So, it's no use to just criticize or crush someone. And just find the mistakes.

Regardless of the timing of the debriefing to facilitate learning, the participants agreed that learning can only take place in a psychologically safe setting.

4.2.2.2. A ritual providing care. Some participants emphasized the supportive atmosphere of the debriefings they had attended, and that they had left the room feeling much better than when they entered it. Such debriefings were described as focused on HCPs' experiences of the events.

Yet, participants mentioned that the "one size fits all" model of the debriefings precluded a focus on the individual HCP and hindered honest talks about the emotional impact of the event.

Ob-Gyn 5, Focus group 1: And there might be 20 people sitting around the table. It's not exactly the place where you would expose yourself in any way. (agreement in the group). I think that you have to know each other really well to pick up on anything there, right?

Although debriefings were intended as a resource for the employees and as an act of support after adverse events, the participants were unconvinced that the debriefings provided them with psychological or emotional support.

Midwife 4, Focus group 4: Sometimes the debriefings seem very formal, and we go through the course of events. Whether mistakes have been made or we could have done anything differently. And I miss the dimension of … *how are you doing*, like …

…

Ob-Gyn 2, Focus group 1: Yes. But it was … it was more of a general debriefing, it wasn't *me* in focus, how was *I* doing …

4.2.2.3. A ritual invoking blame. Although all participants shared the understanding that the purpose of a debriefing is not to allocate blame, some had experienced just that, either explicitly or in more subtle manners. Some participants disclosed how debriefings had turned into discussions about *who* should have done *what* during the event. One participant stated: *And that's not okay. It turns into mudslinging then* (M3, FG3). Everybody agreed that such arguments should not take place at a debriefing. A few reflected that the most disturbing experiences were usually due to poor communication obstructing the teamwork. In particular, harsh or condescending comments during emergency situations made lasting imprints. The same was said about the debriefing, where an atmosphere of blame was described to be both counterproductive and hurtful.

Midwife 6, Focus group 3: I walked out of there [the debriefing] and thought 'what did I get out of this?'. Other than … that at least somebody wanted to point in my direction and say that I hadn't done my job properly. Or at least, that's how I felt. And it kind of confirmed this sense of … what do people think of my professional skills?

The uncertainty of whether one is being blamed silently by colleagues and management was described as very uncomfortable and left the person feeling insecure and perhaps even distrustful when going back to work. *Does everybody know? What have they been told? What do they think about me?* Such questions seemed to appear even in seemingly supportive environments.

A few participants had experienced that, by way of creating a cohesive narrative, the debriefing had become a place to strategically counter a potential patient complaint.

Midwife 5, Focus group 4: (crying voice) Well, it was because we had this debriefing… and it was a bit like … we had to split the bill … the blame, in some way … I got a bit of spanking for writing in the patient's record that I didn't agree with the doctor, and… the doctor had missed some things, but that wasn't mentioned at the debriefing at all.

Such debriefings were not considered to be *proper debriefings*. It was generally expected that debriefings should create a setting where people felt safe and supported, yet the participants felt that they never knew exactly what to expect.

4.2.3. Peer support – the informal rite after adverse events

While we consider debriefings to be the formal, institutionalized ritual targeting HCPs after an adverse event, we consider peer support as an equally important, though informal ritual, which is the final subtheme of 'transition through indefinite rituals'. Rituals are performed by members of the community – they guide you back into the community with a healed or transformed identity – hence peer support may represent an informal ritual.

All participants were inclined to consult their colleagues about the adverse event, predominantly colleagues of the team immediately involved in the event. The main purpose of these talks was to go through the course of events, to ask (senior) colleagues for professional advice on specific obstetric issues and to evaluate clinical decision making. Generally, the participants expressed that the people who would

understand the situation best were their colleagues. They would know all obstetric complications, possible dilemmas in clinical decision making and they would be aware of the potential vulnerability in the aftermath of an adverse event.

Despite this overall positive presentation of peer support after an adverse event, a more nuanced picture unfolded in the focus groups:

Ob-Gyn 4, Focus group 1: I reckon that there are several aspects here, right? Because your colleagues can be really, really good to talk with if you are sad or upset. But I also think that sometimes colleagues can make you feel … that you have made the wrong decision. (agreement in the group). At a time where you may feel quite vulnerable.

Some peer-interactions were not perceived as supportive, for example handover situations. Seemingly small comments could have a great impact and some participants described feeling exposed when colleagues initiated a professional discussion scrutinizing the course of events. Such discussions would often cause defensive positioning, , hampering the learning potential of the individual.

Despite the need for support in the aftermath of the adverse event, many participants described having to consider carefully the extension of their emotional disclosure:

Ob-Gyn 2, Focus group 1: So, there is a fine balance between how much you dare to expose yourself and how much you are in need of support, and do you know each other well enough to risk this exposure? Because it is an *immensely* vulnerable and personal thing. And at the same time, it's a professional thing.

How much to disclose was depending on who the individual preferred to confide in. Some participants, mostly midwives, expressed a sense of being surrounded by supportive colleagues whom they would always be able to talk to in an open and honest manner about their emotional reactions after the event. Others, however, had a more hesitant approach, carefully reading their colleagues' reaction before disclosing further information:

Ob-Gyn 4, Focus group 1: Because it takes a while before you … some of us are not so expressive … we have to warm up a bit. And I find that people rarely engage in such talks.

Another strategy was to confide in a trusted colleague with whom one already had a close and trustful relationship:

Ob-Gyn 5, Focus group 1: I would go talk to my colleague who had been involved in the incident with me. But also … not just any other colleague, one I chose myself. One I would confide in.

4.3. Re-entering the society is a lonesome accomplishment of the individual

According to Turner, re-entering the society is a relatively stable state where the liminal persona is expected to behave in accordance with the norms and standards of the system having now acquired the same rights and obligations as other members of the community (Turner, 1969). As described above, the institutionalized debriefing ritual was perceived as unpredictable, loosely structured, without fixed requirements or provisions, no clear membership and varied experiences of support from colleagues (*older* members of the community). This indicates that for those having gone through an adverse event, the final phase of re-entering society is not facilitated by the community but must be accomplished by the individual.

The questions of uncertainty described above - *Does everybody know? What have they been told? What do they think about me?* – adds further pressure on the person seeking reincorporation. Not knowing whether and what the society knows about the adverse event may lead to further concealment of the emotional impact and falsely confirm that the HCP has successfully re-entered the society. The focus group discussed the implicit expectation that one should be able to carry on working after the event.

Ob-Gyn 4, Focus group 1: But we also contribute to this culture by accepting it. (…) I think there is an implicit expectation. Get back on your bike, sort of thing. (…) you are expected to be resilient.

Some of the younger midwives deliberately attempted to fight this expectation and openly communicated their need for more supervision in the aftermath of the event, and they generally felt that the charge midwives tried to accommodate these needs. This would usually only happen if they notified the charge midwife at the beginning of the shift, so that she would be attentive to them and offer them assistance.

Generally, more senior HCPs found it easier to go through the entire process than their younger colleagues, because they could rely on previous experiences:

Ob-Gyn 3, Focus group 2: In many ways, it has gotten easier, right? Because you have tried it a few times, right? And then you know (…) that it will pass … in time, right? But the first couple of times, you think it will never pass. But then you realize that it does. And you move on. And you realize that it happens to others too.

Senior HCPs also described the advantages of having accumulated a certain repute over time, so that their qualities and competences had become established in the community before the incident.

Midwife 6, Focus group 4: Well, that's what my manager said to me after that baby died. "I'm glad it happened to you." (laughs). And don't get me wrong, I knew what she meant. It would have been terrible if it had happened to one of the young midwives, because … how would you ever believe in yourself again? (agreement in the group). If it happened during your first year.

The midwife continued to tell about an experience where she had moved to a different hospital and that, despite having a high level of seniority, she would have felt very vulnerable in case of an adverse event, not having established her position as a competent midwife in the new community. This perspective is corroborated by a young midwife in another focus group:

Midwife 4, Focus group 3: But I also thought about whether the department would continue to believe in my abilities. (agreement in the group).

Moderator: Who did you talk to about that?

M4: Ehm. I didn't talk to anyone. Because … I think I am only becoming aware of this aspect right now talking to you all. That it was important to be in a department where they all knew you and knew your usual level of performance.

Similarly, many participants reflected on the impact of openly sharing experiences in the focus groups, and that such supervised forums with peers would facilitate both personal development and a more compassionate culture towards each other after adverse events.

5. Discussion

Globally, supporting and addressing the needs of second victims have become a major concern for healthcare organizations. Several studies in the USA, UK, Belgium, Switzerland, Sweden, Italy and Denmark have acknowledged the second victim phenomenon, and have suggested methods to support HCPs following an adverse event (Edrees et al., 2016; Rinaldi et al., 2016; Schrøder et al., 2016a; Schwappach and Boluarte, 2009; Ullstrom et al., 2014). Despite these efforts, few healthcare organizations have assessed the need for and availability of emotional support services for second victims (Edrees and Wu, 2017). In Denmark there are no organizational services with the sole purpose of supporting the HCP after adverse events.

According to Turner, critical life stages, and the acquisition of new social roles herein, are shared experiences between the liminal individual and their community (communitas), institutionalized through rites of passage (Turner, 1969). Structural and cultural processes give an outward and visible form to an inward and conceptual process (Turner, 1967), and liminality may need to be facilitated and channelled if the potential chaos is to be fruitful and develop into order (Bigger, 2010). In this paper we have made an analogy between the adverse event happening to HCPs within a Danish labour ward and a rite of separation. Due to the unpredictable nature of clinical work and the lack of educational preparation for adverse events, the separation happens

abruptly without prior anticipation.

The liminal rite (rite of transition) is interpreted to be both formal and informal debriefing rituals that the HCPs may partake in, in the aftermath of an adverse event. These represent the action taken and support offered within the HCP's work organization/community. Our findings suggest that many HCPs find this ritual to be inadequate; the inconsistency and uncertainty regarding the level of support contributes to the chaos and liminality experienced by the second victim, the liminal person. The unclear purpose of the debriefing (learning, providing care or invoking blame) makes it ineffective as a transitional ritual. Liminal states suggest danger and threat, as the previous identity is replaced by ambiguity and separation (Dowling and Pontin, 2017; Turner, 1969); this lack of clear transition rituals and support may put further strain on the HCP as a second victim with the associated psychological and social distress of being a person that has undergone failed attempts of reincorporation into their community.

Many reflected on the setting of the debriefing as an impediment for disclosing emotional distress often accompanied with a general reluctance to genuinely share the experienced impact of the event. In Goffman's words this is a dramaturgical discipline where all team members show intellectual and emotional involvement in the activity they are presenting, but they must be affectively dissociated from their presentation. The disciplined performer is someone with "self-control", and "actual affective response must be concealed and an appropriate affective response must be displayed." (Goffman, 1959, p. 217). The setting of a debriefing invites the participants to take positions as disciplined performers suppressing emotional response to the adverse event. Since many of the participants in the debriefing may not know each other very well, one may expect them to "tighten their front" and careful or circumspect performance will be performed (Goffman, 1959). From this perspective, the debriefing should not stand alone as a rite of transition, as its primary purpose might not allow for a safe setting for emotional disclosure. This lacking element may cause the person 'betwixt and between' social worlds and statuses, to not feel incorporated in their community. Personal relations are crucial in this context, and the ability to have private, non-judgmental and unguarded conversations with colleagues appears to be the most important factor in the clinicians' recovery process (Berlinger, 2005).

If given this opportunity, HCPs do want to discuss incidents of adverse events, their own role herein, and associated emotions (Leferink et al., 2018; Seys et al., 2013a). In all the focus groups, participants noted that the empathic and non-judgmental atmosphere of the focus group facilitated an open communication within a shared, mutual understanding. Community spirit was reinforced through storytelling in the focus groups, and this emergence of humility, homogeneity and comradeship could be related to Turner's *communitas*. Communitas refers to an unstructured or rudimentarily structured state in which all members of a community are equal, allowing them to share a common experience (Turner, 1969). A systematic review has showed that talking to medical colleagues after adverse events is the preferred way of seeking (social) support (Seys et al., 2013b). However, it has been found that only 48% of Danish midwives and ob-gyns felt that their colleagues provided meaningful and sustained support after an adverse event (Schrøder et al., 2018). It seems that the liminal state can be unsettling not only for those in it, but also for the people around the liminal person (Dowling and Pontin, 2017). Franks and Meteyard (2007) pose the question: "How does one walk with someone who is experiencing the dislocation of liminality?" (p. 220), and they suggest that the key to true companionship in *liminality* is to stay with the person without withdrawing or trying to fix what is wrong. Such comradeship is easier provided by those who have experienced the fracture of liminality themselves (Franks and Meteyard, 2007). Modern healthcare organizations should explore how to facilitate and qualify communication between colleagues about adverse events as a part of organizational support programs (Edrees and Federico, 2015; Seys et al., 2013a) and the concept of facilitating *communitas* may be useful in establishing formalized peer support programs.

In Western countries, there is a high expectation of perfection in medicine and medical errors are often viewed as a personal failure of the HCP involved (Busch et al., 2019). Wears and Wu have expressed that *We live in an age in which the only universally acceptable cause of death is decapitation – all else is considered reparable* (Wears and Wu, 2002, p. 345). Infallibility might form part of HCPs' consciousness to a greater or lesser extent. However, socialization into a biomedical paradigm and a strong patient safety culture are solid socio-cultural factors that will constantly bring this awareness and the associated behavior to the front stage, maybe as a part of an identity building as a professional that can be abruptly ruptured when adverse events happen.

Midwives and obstetricians consider the general public to have an expectation that childbirth is a jubilant event, and the possibility of harm to either the baby or the mother may be met with incredulity (Cauldwell et al., 2015; Nuzum et al., 2014). This view of the general public may reinforce the capability identity as they transpose their expectations onto the HCP, adding to the pressure of maintaining a self-image as the infallible and capable HCP. Following this, there is an innate conflict of interest in the transition from 'the potentially infallible HCP' to 'the potentially fallible HCP', because society in general – as well as the HCPs – want to preserve the illusion of infallibility. Zinck Pedersen (2013) argues that the current patient safety program is dominated by an organizational myth of failsafe systems. This general reluctance to acknowledge 'the inherent fallibility of medicine' may be one of the reasons why the debriefing in its current form seems to have an unclear purpose and hence is unsuccessful as a rite of passage.

Medical error and handling the aftermath of adverse events are not a part of the curriculum in Danish medical or midwifery educational programmes. Based on the findings of this study, we would recommend educating HCPs and students about the second victim phenomenon, as it would prepare them for the potential separation and transition of their professional identity. Furthermore, structured and consistent rituals would guide HCPs in the aftermath of adverse events and support them through this transition making the re-incorporation in the clinical society a less lonesome and individual process Considering the challenged or ruptured identity as "potentially infallible", the liminality and the need for structured transition rites within the work environment may prove useful when constructing adequate second victim support programs.

5.1. Methodological considerations and limitations of the study

Interviewing one's professional peers has several implications for the research process. It appeared that sharing a common knowledge about obstetrics and midwifery allowed the participants to talk freely, to use medical terminology and to address serious events, without the concern of disturbing a layperson. This mutual understanding contributed to the generation of open-hearted, honest and trustful accounts of experiencing a traumatic childbirth as a midwife or ob-gyn. However, there is the possibility of "conceptual blindness", whereby the insider perspective of the interviewer, or in this case the moderator, may govern the dialogue and dominate the process of data analysis and interpretation, which may be a hindrance to novel insights (Coar and Sim, 2006). This was addressed through a reflexive approach to the study and the interviews, through both active and conscious engagement with the participants and careful attention to facilitating focus group discussions between the participants with no moderator interference (Holstein and Gubrium, 1995). Furthermore, the co-authors (AJ and EAH) have backgrounds in sociology and psychology, and they have acted as critical investigators providing different theoretical sounding boards and encouraged reflection on interpretations as they emerged in the analytical process.

It may be a limitation to this study that the midwives and ob-gyns who chose to participate in the focus groups were representing a group of HCPs being particularly troubled by the organizational handling of adverse events. This limitation in the form of self-selection

bias is, however, not unique to this study, but to any study that includes self-selected participants.

6. Conclusion

In the aftermath of an adverse event, second victims may experience an identity transition from 'the potentially infallible HCP' to 'the potentially fallible HCP'. The findings of this study suggest that the inconsistency in the level of support in the aftermath of an adverse event contributes to the chaos that may be experienced by the second victim, the liminal person. The organizational structure does not provide rites of transition or any other ritual processes, except for debriefings that, in many cases, are experienced as deficient. Since liminal states suggest danger and threat, because the previous identity is replaced by ambiguity and separation, the lack of clear rituals and support may put further strain on the HCP who is left to him- or herself seeking re-incorporation in the society.

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