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Second Victims Need Emotional Support after Adverse Events – Even in a Just Safety Culture

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Second Victims in a Just Safety Culture

Second victims are healthcare professionals (HCPs) who are involved in an unexpected adverse event, in a medical error or a patient related injury, and become victimised and traumatised by the event. Second victims may experience psychological distress, fear, loss of self-esteem, feelings of guilt, anger, frustration, and fear of continued practice\(^1\). Since a just safety culture should provide a supportive working environment where mistakes can be discussed openly without criticism and punishment\(^2\), second victims should suffer less distress. Our argument is that although an open, system-based approach is preferable to finger-pointing and blame, a just safety culture per se, cannot alleviate the emotional impact on the second victim.

Denmark as an Example of Best Practice

Denmark was one of the first countries to pursue a just safety culture in healthcare supporting both the rights of patients and of HCPs. While 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 formalised reporting system\(^3\). The Danish Act on Patient Safety was enacted in 2004 and frontline personnel in hospitals and primary care were required to report adverse events in a National Reporting System. Since 2011, patients and relatives were encouraged to report adverse events to learn from mistakes, not to punish HCPs\(^3\)\(^4\).

The act protects HCPs from sanctions: “A frontline person who reports an adverse event cannot as a result of that report be subjected to investigation or disciplinary action from the employer, the Board of Health or the Court of Justice.”\(^4\)

Reports have risen substantially since initiation, suggesting that the health service is shifting towards a greater openness about mistakes. Similar to other Nordic countries, Denmark has implemented a no-fault compensation system, which provides fair, speedy and adequate compensation for victims of medical injury. This has shifted the duty to compensate from the wrong-doer to the community. However, although the reporting system is without sanction, HCPs who are in breach of duty, can still be punished\(^3\).
Compared to healthcare systems where emphasis is about establishing fault, the Danish system is a good example of a blame-free setting, benefiting both first and second victims, after adverse medical events. Our empirical research on second victims and adverse events in obstetric departments in Denmark may provide some insight into the setting of a just safety culture.

Struggling with Guilt, Even When There is no Blame

In a National study on how Danish midwives and obstetricians (n=1237) experience adverse events in childbirth, we found that: i) fear of being blamed by the patient, clinical peers or through official complaints, was of considerable concern to obstetricians and midwives, although few had experiences of such blame, and ii) feelings of guilt were reported by 50% of the respondents, which in the interview study was described as a psychological burden, even in cases where no blame was attached. These reports of feeling guilty without being at fault or experiencing blame indicates that a blame-free culture per se, does not relieve the HCPs of distress and guilt feelings that they may experience following an adverse event. Zinck Pedersen characterises the current Danish safety programme as training HCPs in ‘appropriate’ blame-free attitudes and in approaching adverse events as systemic. This approach may not be entirely helpful for the HCP involved, since the effort to keep the second victims blame free may also leave them in a state of uncertainty dealing with the emotional aftermath of the adverse event. Irrespective of the institutional and organisational measures to prevent future medical errors or adverse events, the individual HCP is faced with the predicament of being unable to undo what has been done, where a patient may have suffered severe injury or death. We should not underestimate the feeling of guilt for the HCP after an adverse event. In our interview study, painful accounts of feeling guilt were expressed:

You know, that feeling that I actually… maybe didn’t kill that child, but may have contributed to it. (Obstetrician)

…I think that, what makes it really hard, is the fact that (cries)… they [the parents] continue to have a disabled child and all that. It doesn’t go away. (Midwife).

This individual feeling of guilt deserves careful attention, even in healthcare systems devoted to a just safety culture. Merely targeting the system and the culture is not enough to support the individual clinician.
Guilt may become pathogenic or excessive

It may seem redundant to propose more support in a system that has attempted to abandon the “blame game” and pursued the disclosure and learning of a just safety culture. One might even pose the question, “if you were not blamed for the event, then why do you keep blaming yourself”? In our view, the individual’s discomfort that they have done something wrong is not necessarily related to the level of blame, and we have three arguments why second victim support should include a specific focus on how to cope with feelings of guilt following an adverse event:

Firstly, if HCPs feel that they have done something wrong, then “there is simply no consolation for them to be found in the thought that what they did was not really their fault”7, p. 124. Following this, it is essential that second victims experience acknowledgement of their guilt feelings, rather than futile attempts to take them away. Our data support the thoughts of Gamlund, that the HCPs will always entertain the thought that they could have done something differently and changed the outcome, regardless of being told that they did nothing wrong8.

Secondly, it has been suggested that empathy is closely related to guilt, so that more empathetic people are more likely to experience guilt than less empathetic people. Empathy-based guilt is necessary in many social situations, as it enables us to respond with empathy, and experience guilt when we have harmed someone else. HCPs are constantly exposed to situations that demand their empathetic abilities, and due to the close association between guilt and empathy, they are prone to experience empathy-based guilt9. However, empathy-based guilt becomes pathogenic when it leads to cognitive errors in understanding causality, which creates feelings of failure and wrongdoings as the cause of the adverse outcome9 10. Pathogenic guilt is commonly found in mental disorders such as depression and posttraumatic stress disorder10, and it is suggested that feelings of distress and guilt are key factors in understanding “burnout” among HCPs11.

Finally, it appears that HCPs may fail to recognise and express feelings of guilt, because it is not facilitated by the professional community. Mesel argues, that a poor focus on the need to make distinctions between concepts of responsibility, guilt, and shame, makes emotional coping more difficult for the second victim. Second victims may experience emotional guilt so overwhelming that it renders them unable to judge their own role. The emotion of guilt needs to be connected to the specific time and place in history where the event took place, and it needs to be calibrated to the event itself. Reviewing the medical records with a trusted colleague is an important step in this calibration to avoid excessive (pathogenic) guilt11. Indeed, the ability to have private, unguarded conversations with colleagues, in which HCPs can discuss their role in adverse events.
Second Victim Support Programmes Benefit Both Staff and Patients

Educating HCPs and students about the second victim phenomenon and arranging a peer support program for second victims is essential in a modern safety-culture, although few such programs have been implemented. In 2015, the Royal College of Physicians published a report entitled “Work and wellbeing in the NHS: why staff health matters to patient care”, in which the inextricable link between HCPs and their patients was established. A systematic review of the impact on physicians involved in medical errors, suggested that personal distress and self-reported error were related reciprocally, where feelings of responsibility for a serious medical error provoked “burnout”, depression and reduced empathy. This in turn would often result in suboptimal patient care and a greater risk of future errors. Accordingly, investment in second victim support programmes may prove to be an investment in safer and better patient care. Furthermore, a cost-benefit analysis of a peer support program demonstrated substantial hospital cost savings. We would like to acknowledge the impact of guilt in second victims, even in seemingly blame-free cultures, and we suggest that similar programs should be developed and implemented in other European healthcare systems.

Disclosure of interests

The authors declare that they do not have any conflict of interest in regard to this article. Completed disclosure of interest forms are available to view online as supporting information.

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KS, RFL, JSJ and NCH all contributed to the writing of this commentary.

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