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THE ROLE OF FORGIVENESS IN DISCLOSURE AND VICTIM SUPPORT AFTER A PATIENT SAFETY INCIDENT.

Carla Martos Algarra

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Supervisors:

Dr. Maria Fernández-Capo

Dr. Priscila Giraldo Matamoros

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A ellas

"Sometimes an apology releases a part of you that you didn't even know was caged ...

and forgiveness destroys that cage"

Sanjo Jendayi

"Forgive, that by forgiving you will have your soul in peace

and the one who offended you will have it"

Mother Teresa

Cover by: Christine Panagiotidis

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ABSTRACT

In the healthcare field, we know patient safety incidents are unfortunate events that occur. Two groups are affected by these incidents: Patients become first victims and the professionals involved turn into second victims. All of them need adequate support. The main objective of this dissertation is to determine if forgiveness can play a significant role in the aftermath of a medical error. To achieve this goal, three studies are presented. The first study is dedicated to the experience of forgiveness of the patient or their family members, after submitting a medical complaint, related to an adverse event. By means of a telephone survey, we explored whether they received an apology, as well as whether they forgave the professionals involved. The second study explores the need for forgiveness of professionals after a patient safety incident, using a quantitative methodology. Finally, the third study is a qualitative approach to the need for forgiveness in professionals who have experienced a patient safety incident. Results indicated that forgiveness contributes to patients' or relatives' wellbeing, as well as that of professionals. Knowing if the patients have forgiven helps professionals in their recovery process as second victims. These findings suggest that developing interventions, where forgiveness is facilitated between first and second victims, contribute to both parties' welfare.

KEYWORDS: Patient Safety Incident, Second Victim, Apology, Forgiveness, Medical Complaint, Mental Health.

RESUMEN

En el campo de la salud ocurren incidentes relacionados con la seguridad del paciente. Dos grupos se ven afectados por estos incidentes: los pacientes, quienes se convierten en primeras víctimas y los profesionales implicados, conocidos como segundas víctimas. Todos necesitan el apoyo adecuado. El objetivo principal de esta tesis doctoral es determinar si el perdón puede tener un rol significativo en el periodo posterior a un error médico. Para lograr este objetivo, se presentan tres estudios. El primer estudio está dedicado a la experiencia del perdón del paciente o de sus familiares después de presentar una reclamación relacionada con un evento adverso. A través de una encuesta telefónica exploramos si recibieron disculpas, así como si perdonaron a los profesionales involucrados. El segundo estudio explora la necesidad de perdón de los profesionales después de un incidente de seguridad del paciente desde un enfoque cuantitativo. Finalmente, el tercer estudio es una aproximación cualitativa a la necesidad de perdón en profesionales que vivieron un incidente de seguridad del paciente. Los resultados indicaron que el perdón contribuye al bienestar de los pacientes o familiares, así como al de los profesionales. Saber que los pacientes los han perdonado contribuye a su recuperación como segundas víctimas. Estos resultados sugieren que el desarrollo de intervenciones en las que se facilita el perdón entre la primera y la segunda víctima favorece al bienestar de ambas partes.

PALABRAS CLAVE: Evento Adverso, Segunda Víctima, Disculpa, Perdón, Reclamación Médica, Salud Mental.

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STATEMENT OF THE PROBLEM

The present dissertation presents a review about how patient safety incidents can affect patients, healthcare professionals and organizations. The analysis suggest that the approach in its management is insufficient when it comes to disclosure and support.

Errors in medical care have always existed and can affect all of us. They are actually the third cause of death in the United States (Makary & Daniel, 2016), but it is only after the report "*To err is human*", published by Kohn et al. in 2000, that attention was brought to this situation. The focus, since then, is to alleviate the incidence and consequences of the problem.

One of the outcomes of this situation is how the patients and the professionals involved are affected, how organizations manage the situation and how patients are taken care of emotionally in the aftermath of the incident. There are existing disclosure programs that seek to meet patients' needs (McVeety et al., 2014), but are they sufficient in order to help patients recover? Also, there are professional-adressed support programs to apply once and error is known, but what happens with the healthcare professionals who err with no consequences for the patient and, therefore, do not share the emotional effects they carry along? Previous literature has highlighted that forgiveness can contribute to restoring relationships (Karremans & Van Lange, 2008) as well as contribute to mental health (Berry et al., 2001). Therefore, can forgiveness play a role in hospital environment after a patient safety incident? Do professionals need forgiveness? Can it contribute to both patients' and professionals' recovery?

The reader will find below a comprehensive theoretical framework. The first chapter includes a review of the concepts that have to do with patient safety incidents and the different parties involved in them. In the second chapter, aspects related to disclosure, difficulties and elements that it should include, such as apologies, and the potential role of forgiveness in the field

are presented. In the third chapter, different support procedures and programs for patients and professionals are exposed.

The empirical research includes three studies. The first study puts the emphasis on the patient's experience of apologies and forgiveness after filing a complaint in the aftermath of a patient safety incident. On the other hand, studies two and three focus on healthcare professionals and their need for forgiveness and support after these types of incidents.

PART I: THEORETICAL FRAMEWORK

CHAPTER I

PATIENT SAFETY INCIDENTS

In the context of a hospital, errors that directly jeopardize patient safety and lead to patient safety incidents may occur, even when there are several preventive measures, protocols and qualified professionals (Edrees & Wu, 2011).

The following sections will provide information, clarifying different terms related to patient safety incidents, and a review of the context in which they take place as well as the victims they affect.

1.1. Terminology

Patient safety initiative is a critical public health policy for all healthcare systems. This is: "*A framework of organized activities that creates cultures, processes and procedures, behaviors, technologies, and environments in health care that consistently and sustainably: lower risks, reduce the occurrence of avoidable harm, make error less likely and reduce its impact when it does occur*" (World Health Organization, 2020).

Beneath the term patient safety incident (from now on PSI), there is also a wide range of terms used as adverse event, near miss, incident, or negligence. For example, if the PSI did not affect the patient, we would have a *near miss*, this is "*an incident that did not reach the patient (e.g., a unit of blood being connected to the wrong patient's intravenous line, but the error was detected before the transfusion started)*" (World Health Organization, 2010, 2020). If the PSI reaches the patient, in the best of cases, we would be facing a *no harm incident*: "*one in which an event reached a patient, but no discernable harm resulted (e.g., if the unit of blood was transfused, but was not incompatible)"*. If the PSI *"reaches the patient and results in harm to a patient (e.g., the wrong unit of blood was transfused, and the patient died from a hemolytic reaction)"*, then we

are defining a *harmful incident*. Referring to prevention, we have an *adverse event* and, if it is not preventable, it would be an *adverse reaction*. The definitions presented above are related but have different nuances that may lead to confusion, therefore a table including some terms that the World Health Organization offers about the international classification of patient safety can be found in annex 1.

The concept patient safety incident (PSI) will be used throughout this dissertation to adopt the wide range of incident types.

1.2. Conceptualization

PSI's have always occurred in healthcare, but it was not until the 70's that the first studies were carried out on the subject. In 1991, the Harvard Medical Practice published one of the most relevant studies (Brennan et al., 2004) but it was not until the publication of "To err is human: Building a safer health system" (Kohn et al., 2000) that awareness was established in healthcare centers around the visibility of this report. This report highlighted that between 44.000 and 98.000 people die each year in the United States due to medical errors, being the eighth cause of death at that moment.

Several years later, Makary and Daniel, (2016) pointed out medical errors as the third cause of death in the United States. They refer to medical errors as events that cannot be eliminated, but yet they state that it is necessary to measure the problem properly, as well as to design safer systems to alleviate the incidence and consequences.

A patient safety incident can appear in any medical specialty, though data from the psychiatric service is often left out (Brennan et al., 1991; Wilson et al., 1999; De Vries et al., 2008). PSIs can appear in different forms and shapes: They can be found as errors in diagnostic, assessment of the patient's general condition, related to patient's monitoring or nursing required, nosocomial infection, surgical interventions, medication or water balance, resuscitation maneuvers,

and others (ENEAS, 2006). Other studies classified the type of event as: Surgery-related, drug-related, diagnostic, therapeutic, procedure, fall/fracture, postpartum/obstetric, anesthesia-related, neonatal, system/other, ward management, discharge or other clinical management (De Vries et al., 2008). Aranaz-Andrés et al. (2012) affirmed that the most contributing factors of adverse events are related to medication, communication, and how the process care was delivered. Data reveal that a quarter of European PSIs are related to hospital acquired infections while the remaining are medication errors, surgical errors, diagnostic errors, medical device failures or failure to act on test results (European Commission, 2014). On primary care, more than half (55.5.%) of the adverse events are related to medication; almost one fifth (17%) was attributed to a worsening of the clinical course of the underlying disease; complications, deriving from a medical procedure, represented 7.8%; health care-related infections were 7.4%; and 6.1% stemmed from problems with the care dispensed (e.g., wound cures, catheter care). The predominant clinical outcome was the aggravation of an underlying disease, but other causes reported by the professionals as contributing factors of adverse events were: medication-related, communication problems and how care was delivered. Finally, the consequences derived from adverse events in primary care, were mainly temporary injuries where only minor health care was involved, such as observation or surveillance in primary care (Aranaz-Andrés et al., 2012; Hartwig et al., 1991).

PSIs can also be categorized according to the degree of harm or severity: None or minor disability (resolved within 1 month), temporary disability (resolved within 1 year), permanent disability, death or unknown (De Vries et al., 2008; Hartwig et al., 1991).

No healthcare professional escapes the probability of being involved in an incident. This includes physicians, nurses and even pharmacists. No one is free of being at risk of becoming, what Wu (2000) called, a second victim, defined as a “health professional involved in an unanticipated adverse patient event, medical error and/or a patient related injury”.

Although there is a current tendency towards a non-blame or blame-free culture, the most frequent is the self-blame approach, especially in the medical community (Collins et al., 2009). Conditions in the system often enable the adverse event to occur (Kohn et al., 2000; Mendonca et al., 2019; Rafter et al., 2015). In this sense, Reason (2000) put the focus on how the system develops to understand what barrier or safeguard failed and triggered the error. He explained how errors happen, despite the possible barriers that could limit them. Reason refers to these barriers as slices in a Swiss cheese. Each slice has a few holes that are constantly moving, opening and closing. Usually, the existence of holes in one slice does not normally cause a bad outcome. Unsatisfactory consequences appear when several holes line up and, therefore, there is "space" for the error to exist. The holes are a combination of, on one hand, "active failures", understood as *"the unsafe acts committed by people that are in direct contact with the patient or system"* and on the other hand, "latent conditions" which are *"the inevitable "resident pathogens" within the system. They emerge from decisions that are taken by different agents (i.e., designers, builders, procedure writers and top-level management)"*. Latent conditions, summed up with active failures and local triggers, create the accident opportunities, but these conditions may be identified and tackled before an adverse event occurs (Reason, 2000). Some explanations for errors have to do with human factors. For instance, Al-Ahmadi et al. (2020) find that emotional stress, lack of motivation, workload, poor communication and overlooked patient information on the information system are human factors that may explain medication errors.

Also, a substantial proportion of adverse events are seen as preventable (Bates et al., 2003; Classen et al., 2011; Soerensen et al., 2013). Yet there is a repeated need to clarify what has happened, in order to avoid the PSI from happening. In fact, there are testimonies of victims of a PSI who state that they reported what had happened, in order to force the review of different protocols and, thereby, prevent it from happening again (Levine, 2002). In this line, Hannawa and Roter (2013) created the TRACE tool that allows a comprehensive analysis of the human action

across different clinical-practice circumstances, a check-list before healthcare processes the PSI. Basically, it is an instrument to prevent these situations and a database that aims to improve the quality of the processes.

1.2.1. Victims

A patient safety incident involves victims. In the following sections a description of the different victims affected after a PSI occurred is explained.

1.2.1.1. First Victims. The existence of a first victim: the patient. The person direcly affected from the PSI is generally considered the first victim, however, if the patient passed away or if a minor, then their family or relatives is. This group of victims may be affected due to direct harm and/or secondary consequences, as the result of how the event is handled (Vincent, 2003).

Patients' initial reactions after an adverse event included fear, loss of trust and isolation (Vincent, 2003). Not only may they suffer from the physical consequences of the incident but they may also be psychologically affected (Vincent et al., 1993). Ottosen et al. (2019) and Massó-Guijarro et al. (2009) found that patients and family members may suffer psychological (e.g., anger, loss of trust, grief, self-blame, psychological scars such as depression or suicidal thoughts), social or behavioral (e.g., altered health seeking behaviors, altered life/view of self), financial (e.g., physical disabilities led to lose their job) and physical long-term impact after an adverse event. Southwick et al. (2015) added the fact that follow-up surgery or therapy was required, as well as the specific impact on the family of the patient, including the perception of loss of lifestyle and stress over caregiving, gathered from a patient-initiated voluntary online survey.

According to Tomás et al. (2010), in Spain, there were 12.650 deaths annually derived from an adverse event. Research showed that 1 in 7 patients were involved in an adverse event (Clancy, 2012; Classen et al., 2011). Complementarily, European data indicated that between 8 and 12% of hospitalized patients had suffered an adverse event (Agra-Varela et al., 2015; De Vries et al., 2008).

Also, in 2015, Rafter et al. found that around 10% of hospital admissions were associated with adverse events.

Classen et al. (2011) and Classen et al. (2016) pointed out that the number of incidents registered was underestimated due to the instruments used to register them. Because of that, they proposed the global trigger tool to measure the impact and gather data properly. Results provided using its tool reported ten times more confirmed serious events.

First victims emphasize the importance of actively participate in decisions regarding their care (Southwick et al., 2015). Patients are a reliable source of information and thus their collaboration contributes to a patient-centered care (Massó Guijarro et al., 2009). It has been demonstrated that patients are capable of identifying these events before harm is done (Weissman et al., 2008). If their participation was taken into account, it would be possible to decrease the incidence or harm of the events (Weingart et al., 2005). Zhu et al. (2011) pointed out that patients provide valid information that, most of the time, is not possible to gather from other sources. Despite this, only few studies reported a routine that includes gathering information from patients after a medical error (Harrison, et al., 2015).

There is also literature that pointed out that there is not a unique definition of adverse event expressed by patients, but rather a range of quality and safety concerns that are included in the definition, as seen in the systematic review of Harrison et al. (2015). The definitions of adverse events, reported by healthcare professionals, are more specific than the ones patients provide. Information, gathered through patients, reports data regarding need of continuity of care, medication errors and communication problems between staff and patients (i.e., Daniels et al., 2012, Kaboli et al., 2010). Sometimes, patients refer to episodes that have to do with communication as adverse events. This concept then differs with professionals' definition of adverse event. (e.g., Davis et al., 2013, Friedman et al., 2008). Patients acknowledge the need for more healthcare

professionals, as well as the need to improve training in patient-professionals communication (Adams et al., 2009; O'Hagan et al., 2009).

Even though there are some doubts regarding the reliability of the information patients can provide on adverse events, as part of the solution to avoid these events and enhance patient safety culture, first victims should be involved in medical errors research projects and healthcare commissions, in order to improve procedure guidelines. Initiatives, such as studies where they are giving voice to patients and families involved in care errors may help improve care quality (Moore et al., 2019).

1.2.1.2. Second victims. As previously pointed out, in the adverse event scenario there is more than one victim. Different healthcare professionals are involved in, or at least witness, adverse events (Wahlberg et al., 2016) and therefore might be suffering from the experience. Narratives such as the one offered by Hilfiker (1984), can help to understand the situation and agony experienced by a professional who realizes that he or she has erred, and how this healthcare provider can question the care offered and become a second victim. According to Wu (2000), the second victim is a "health professional involved in an unanticipated adverse patient event, medical error and/or a patient related injury." Scott et al. (2009) added that: "These professionals become victimized in the sense that the provider is traumatized by the event". Frequently, second victims feel personally responsible for the unexpected patient outcomes and consider they have failed their patient, second-guessing their clinical skills and knowledge (Denham, 2007; Scott et al., 2009; Wu, 2000). Scott et al. (2009) described what is known as the "Second victim phenomenon", even when no error has occurred, but the patient has experienced an unfavorable outcome concerning the relationship between the patient and the professional. According to Lewis et al. (2015), only observing an adverse event may trigger anxiety and secondary traumatic stress in some healthcare providers. The term second victim is now well established in the healthcare system; although there is a controversy in terms of its suitability, it can be seen as insensitive to the patient (Wu et al.,

2017), as well as potentially dissipating the professional identity of the healthcare professional (Tumelty, 2018), and even Wu et al. (2017) have recently acknowledged concerns about its use. However, for now, no other term meets the needs so well.

Regarding the number of professionals affected, Lander et al. (2006) reported the lowest value of professionals afflicted (10.4%), followed by Scott et al. (2010), who point out 30%, and Wolf et al. (2000), who indicated that there are 43.3% of professionals affected. Joesten et al. (2015) and Mira, Carrillo, et al. (2015) found that between 73 and 94% of healthcare professionals experienced the second victim phenomenon. Scott et al. (2009) refer to a survey that found that 1 in 7 healthcare professionals experienced problems, due to their experience in a PSI. Also, Martens et al. (2016) carried out a study with mental health inpatient care professionals. They found that 73.2% of the participants had been involved in an adverse event at some point during their career. Finally, according to Mohamadi-Bolbanabad et al. (2019), 90% of healthcare professionals report experiencing at least one physical or psychosocial second victim symptom.

Female gender and spending more than 75% of healthcare professional time working as a clinician are risk factors towards becoming a second victim (Schelbred & Nord, 2007). According to a systematic review the symtpoms of the second victim phenomenon include: troubling memories, anxiety/concern, anger toward oneself, regret/remorse, distress, fear of future errors, embarrassment, guilt, frustration, anger, fear, feelings of inadequacy, reduced job satisfaction, concern regarding colleagues' reactions, symptoms of depression, fears of repercussions/official consequences, sleeping difficulties, anger toward others, loss of confidence, concern regarding patients' reactions and self-doubts (Busch et al., 2020; Harrison et al., 2014; Joesten et al. 2015; Wahlberg et al. 2016). Complementarly, Von Arx et al. (2018) and Vanhaecht et al. (2019) added injustice, humiliation, shame, flashbacks, feeling dejected, doubts about knowledge and skill, and avoiding risks in their daily practice as other related symptoms. All these symptoms could fit in the symptoms described by Van Gerven, Deweer et al. (2016) that have to do with the ones that have an

effect on the personal life of the involved clinician, which are subdivided in 3 categories: (a) personal emotional responses (e.g., feeling down, guilt, self-blame), (b) personal mental responses (e.g., flashbacks, depression, burnout) and (c) personal physical responses (e.g., illness, insomnia, vomiting), which would be what Rinaldi et al. (2016) described as psychosomatic symptoms that include extreme fatigue, muscle tension, increased respiratory and blood pressure, and tachycardia.

In line with Scott et al. (2009), Busch et al. (2020) suggested there are several symptoms that fit with a Post-Traumatic Stress Disorder (PTSD). Waterman et al. (2007) added that not only is there a posttraumatic stress disorder, but also: (a) doubts about informing patients; (b) fear of legal consequences of adverse events and (c) concerns about a loss of reputation.

Another group of symptoms, for Van Gerven, Deweer, et al. (2016), are those that have an effect on the professional life of the involved clinician: (a) Professional physical responses (e.g., shaking over entire body, not being able to perform profession anymore, switch jobs) (b) Professional mental responses, divided in positive (e.g., higher awareness of responsibility, being more careful, attention for prevention measures) and negative responses (e.g., loss of concentration, fear for the future), and (c) Professional emotional responses (e.g., decreased resilience, loss of self-confidence, stress, isolation). There are concerns regarding the professionals' performance at work after a PSI (Kable et al., 2018; Scott et al., 2009; Seys, Wu, et al., 2012; Ullström et al., 2013). In fact, almost half of the physicians said that being involved in an adverse event increases stress in their work place (Donaghy et al., 2018). Factors, such as gender, also imply differences when it comes to coping with this stressor (Hu et al., 2012; Seys, Scott, et al., 2012), but there does not seem to be differences in coping with the adverse event according to health care profession (Hall & Scott, 2012), but Finney et al. (2021) does point out the need of paying special attention to nurses because they constitute the highest proportion of hospital staff and provide the majority of direct patient care. Specifically, they refer to nurses that work in obstetrics and gynaecology. Also, Van Gerven, Vander Elst, et al. (2016) found that the professionals, involved in a PSI, had a higher

proportion of problematic medication use, risk of burnout, work-home interference, and higher intention levels of leaving the profession. All this is exacerbated if, eventually, there is also a malpractice claim (Vizcaíno-Rakosnik et al., 2020). Moreover, second victims are in higher risk of practicing defensive medicine (Panella et al., 2016), which is the professionals deviation from evidence-based medicine that may include ordering unnecessary tests, procedures, visits, and hospital admissions, as well as the possibile avoidance of high-risk patients, procedures or medical services. The final objective is to avoid medical malpractice lawsuits (Cunningham & Wilson, 2011).

Among all the consequences, positive outcomes are also found. For example, the attention of the professionals may become more acute and they are able to pay more attention to details, even anticipating future incidents, as well as asking for more advice from colleagues or supervisors (Van Gerven, Deweer, et al., 2016). Also, Christensen et al. (1992) pointed out some positive changes in practice, resulting from the mistake: modifications in diagnosis and the therapeutic approach the professionals carry out, even including being more precise when checking allergies and carrying out more screening tests; regarding practice management, closer supervision of practitioners and fewer number of new patients accepted into the practice; and, in addition, variation in the perception of other doctors, including lowering judgements towards other doctors. Being involved in a mistake made these professionals more accepting and understanding, as well as less critical. In addition, increased resilience, supporting fellow professionals, leading patient safety initiatives and educating colleagues on the second victim phenomenon have been found as positive outcomes (Finney et al., 2021).

Health care students may also turn into second victims (Seys, Scott, et al., 2012) and, therefore, it would be convenient to help them get familiar with the second victim topic during their studies, so that they normalize discussing about events and solutions (Van Gerven, Deweer, et al., 2016).

The concept “medical error” is full of negative connotations, but it is also a good learning opportunity with pedagogical and diagnostic benefits (Eva, 2009).

When it comes to healthcare professional trainees, learning about failures in simulation contexts has positive results (Goldberg et al., 2015). In 2006, Engel et al. found that learning from the error was a coping strategy by residents, interviewed regarding medical mishaps and near misses. The education on these incidents is essential, because the possibility of being involved in an adverse event in healthcare professionals becomes a day-to-day possibility, with the inherent personal and professional consequences, and should be included in any health care-related studies (Schiess et al., 2018).

If the error is seen as a learning opportunity, physicians could learn powerful lessons from medical errors (Robertson & Long, 2018; Shepherd et al., 2019). In fact, patient safety initiatives should be carried out in interprofessional teams in order to harmonize outcomes and enhance teamwork, as all the professionals can benefit from it (Castel et al., 2015).

1.2.1.3. Third victims. Research has revealed that unsafe acts are not isolated from the system in which they take place (Rafter et al., 2015; Reason, 2000). This situation leads to the existence of a third victim after a PSI which is the organization where the adverse event occurred (MacLeod, 2014).

The management outcomes from the PSI affecting the organization are related to effectiveness (McVeety et al., 2014; Scott et al., 2010; Ullström et al., 2013) image and reputation (McVeety et al., 2014; Mira, Lorenzo, Carrillo, Ferrús, Pérez-Pérez, Iglesias, Silvestre, Olivera, Zavala, Nuño-Solinís, et al., 2015), people’s trust in the institution (Clancy, 2011; Seys, Scott, et al., 2012); and legal (Ullström et al., 2013) and financial issues (McVeety et al., 2014). Beyond that, an adverse event may generate an organizational crisis, developing long-term business difficulties (Conway et al., 2010).

Healthcare organizations are considered part of the problem as third victims, but also part of the solution. Possible systematic prevention of consequences in first and second victims would have a positive impact on the patient safety culture (Liukka et al., 2020), and the organization is responsible for this.

1.2.1.4. Fourth victims. The condition in which the professionals remain after the patient safety incident if they do not receive the care they need, can lead them into a vicious cycle including more adverse events, burnout, and definitely poor quality of care (Schwappach & Boluarte, 2009; Scott et al., 2009). Also, the skills of the professional to assist another patient after a PSI are affected as well. This must be taken into account, because of the increased risks for the health care offered to other patients (Gazoni et al., 2011). If there is a new patient affected (new first victim) by these unsupported professionals (second victims), he or she would hypothetically become a fourth victim (Ozeke et al., 2019).

CHAPTER II

DISCLOSURE OF ADVERSE EVENTS

It is expected that, after a patient safety incident, the patient affected will be informed of what occurred (Manser & Staender, 2005). According to Gallagher et al. (2003), patients receiving a disclosure regarding errors was ethically imperative from healthcare professionals' point of view, however this is not always the case and in many occasions patients are not informed (Mira-Solves et al., 2017).

The following section includes information about the need for disclosure, what errors should be disclosed, barriers towards disclosing, elements that should be considered when disclosing, and support needed in order to perform disclosure.

2.1. Need of disclosure

Experts, such as scholars in medicine, ethic, and health law, have reached quite a consensus regarding the need for disclosure after errors in health care (Gallagher et al., 2007; Mira-Solves et al., 2017). Some of the reasons to disclose adverse events are: the strengthening of patient-physician relationship; disclosure may be an opportunity for forgiveness and reconciliation after an adverse event; a good disclosure practice makes effective reporting and learning more likely (Gallagher et al., 2003). However, the structure, timing, and content of this communication has been left to a private matter (Kohn et al., 2000).

This great consensus from international experts is far from the real situation. Lamb et al. (2013) found that there is a frequency of 24.6 disclosures per year across all respondent hospitals, this is a mean of 7.4 disclosures per 10,000 admissions. The same study found that different measures have been taken to change this situation. One in three hospitals had board-approved disclosure, and almost 50% had initiated the process of developing disclosure policies. Despite this,

Hannawa and Frankel (2018) found that disclosure was still rare after an incident. One in four patients experienced an adverse event, but only a third received a disclosure (this data was collected in several healthcare settings, not just hospitals). Also, Giraldo et al. (2017) showed how disclosure of and apology for medical errors is not a frequent practice, even after a situation of medical malpractice policy.

2.2. Errors that should be disclosed

A dilemma that comes up frequently after a medical incident, is to specify what errors should be disclosed (Gallagher et al., 2007). They found that physicians agreed on disclosing any incident that caused harm to patients. Also, some professionals responded that errors that did not cause harm should also be reported if follow-up testing was required. Against this, Lezzoni et al. (2012) found that one third of the physicians who answered their survey did not completely agree on the need to disclose all serious medical errors. Moreover, they found differences according to medical specialties. For example, surgeons and pediatricians were more in favor of disclosing all serious medical errors (American college of physicians, 1993), *versus* cardiologists and psychiatrists, who were less likely to report these incidents. There are studies that have found equal reasons for not disclosing within nurses and physicians, such as Blendon et al. (2002) and Gallagher et al. (2003), while Castel et al. (2015) found no differences in fear of disclosing between them, nor fear associated to age, gender or tenure. These findings are based on surveys and theoretical answers, in cases of adverse events and based on information gathered afterwards. Iedema et al. (2008) and Varjavand et al. (2012) discovered that most practitioners do not disclose errors to their patients, especially when their actions caused no harm.

If the data, regarding the type of harms disclosed, is provided by the institutions rather than from the professionals, Lamb et al. (2013) found that 65% of the hospitals that participated in their study answered they always disclosed if the outcome included death or serious injury. A smaller proportion answered that they disclosed in the case of serious, short-term harm. Also, Gallagher et

al. (2003) found that physicians go through situations in which they would not disclose an error, for instance, if the harm was trivial or the patient was unaware an error had occurred. Regarding near misses, the tendency was also not to disclose.

On the one hand, physicians believed that patients would not want to know about these errors and that informing about them would only affect their trust in the medical professionals. Only a few physicians expressed they would discuss near misses with the patients. On the other hand, when the patients are asked, they do not have a clear opinion regarding wanting to know about near misses. Some patients have expressed they would be alerted towards what situations they must watch out for, others thought knowing about a near miss would make them fearful (Gallagher et al., 2003). As for preventable serious and minor harms, the general tendency is to disclose them less often than the non-preventable harms of equal severity (Leone et al., 2015). Therefore, we can see that not all adverse events are fully and honestly disclosed to patients (Gallagher et al., 2006; Hickson, 1992), though healthcare professionals must be able to speak to the patient and even apologize (Wears & Wu, 2002).

2.3. Barriers to disclosure of adverse events

According to Gallagher et al. (2003) some of the reasons for these differences in the decision whether to disclose the error or not were: fear of affecting the relationship, fear of loss of reputation or damage in the professionals' career progression, lack of institutional support, absence of training on how to conduct disclosure conversations, and the emotional impact of adverse events on clinicians. Also, poor publicity and distancing from peers (Blendon et al., 2002); being negatively affected by the adverse event (the professional becoming a second victim) (Bohnen et al., 2019; Coughlan et al., 2017); the event being preventable; and the existence of a punitive culture (Elwy et al., 2016; Mira-Solves et al., 2017). In the latter studies, the medical specialists also expressed that discussing prevention and recurrences could suggest blame.

Another reason why physicians do not disclose is fear of liability and having doubts about the consequences (Detsky et al., 2013), and increased costs (Gallagher et al., 2003). Lezzoni et al. (2012) found that one fifth of the physicians of their sample had not fully disclosed mistakes to the patients for fear of being sued. In fact, Ock et al. (2020) found that more than half (57%) of the participants (general Korean population) in their study believed that disclosing patient safety incidents would increase medical lawsuits. Waterman et al. (2007) pointed out that the perception of a possible litigation already has emotional negative effects on practicing.

It is important to explore whether these fears are reasonable, considering they hold back communication. Literature indicates that disclosing properly is not linked to responsibility (Giraldo, Corbella, et al., 2016), and it does not exacerbate financial or legal risk (Boothman et al., 2009; Kachalia et al., 2010). According to the Harvard medical practice study, only 3 to 5% actually sue after being injured by negligent care (Mello et al., 2003). Kachalia et al. (2003) suggest that, sometimes, patients sue in order to get more information. Also, Witman et al. (1996) found in their study that patients were more likely to sue when the physician did not acknowledge the mistake, and that it was more likely that a patient would seek for legal advice according to the severity of the injury (Mazor et al., 2004).

In this sense, the communication between medical practitioners and patients also influences suing probability. In fact, Vincent et al. (1994) found that patients or families may decide to take legal actions, influenced by poor communication and insensitivity when handling the error. According to Hannawa et al. (2016), patients would rely on physicians' non-verbal communication to make inferences about the error, the professionals' competence and the implications of the error on their health and medical care. Moreover, Iedema et al. (2011) found practitioners face legal threats, due to the fact their organizations present an unsupportive culture, absence of clear guidelines and lack of experience disclosing.

2.4. Elements to consider when disclosing

Once the decision to disclose is taken, there is a need to organize how the disclosure will take place, who will participate, and what information will be provided, amongst other aspects (Mira, Lorenzo, Carrillo, Ferrús, Pérez-Pérez, Iglesias, Silvestre, Olivera, Zavala, Maderuelo-Fernandez, et al., 2015).

A gap has been detected between the patients' expectations of what a disclosure would entail and what they really receive and experience (Espin et al., 2006; Gallagher et al., 2003, 2006; Gallagher & Lucas, 2005; Kaldjian et al., 2007; Myren et al., 2020). Furthermore, O'Connor et al. (2010) concluded that knowledge on how to deliver disclosures is limited among healthcare professionals. Additionally, in their review, Myren et al. (2020) found several studies (e.g., Harrison et al., 2017; Iedema et al., 2008) pointing out the need that patients have for constant communication. At an interpersonal level, they appreciate sincerity, openness, and non-verbal communication. They expect incident disclosure to be a respectful and responsive dialogue, with the focus centered on the patient, in order to promote healing, learning and safety. They also wanted to include a discussion on how to increase patient safety (Conway et al., 2010). In fact, a good communication process reduces psychological trauma and increases trust in the healthcare professional (Massó Guijarro et al., 2009). Several authors (Blendon et al., 2002; Gallagher et al., 2003; Gallagher & Lucas, 2005; Mazor et al., 2005; Ock et al., 2020) found that patients want to be told about harmful medical errors, even near misses (Hobgood et al., 2002; Mazor et al., 2005; Ock et al., 2020; Witman et al., 1996). In fact, patients have expressed that they want to know how the event occurred (not only that it happened), why the error happened, how recurrences will be prevented, as well as receive an apology (Duclos et al., 2005; Espin et al., 2006). Myren et al. (2020) pointed out that patients specifically want to know what actions will be taken and what the professionals have learnt from the experience. In the same line, Gallagher et al. (2003) detected that patients want to know what implications the error has on their present and future health.

Gallagher and Lucas (2005) advised on some practical considerations, in order to disclose medical errors to patients (i.e., (1) get help, (2) plan the disclosure conversation carefully, (3) asses the patient's knowledge about the error; (4) provide basic information about the error; (5) apologize, (6) plan follow-up, (7) offer support and referral as needed). Moreover, they emphasize the great value of receiving help from a trusted colleague.

The elements that constitute a disclosure are: an explanation, an undertaking to investigate the incident, an apology, and acknowledgement of harm (Lamb et al., 2003). The Australian Commission for Safety and Quality in Health Care (2008) added an expression of regret and the potential consequences and steps being taken to manage the event and prevent recurrence.

When the disclosure is carried out, it is important to be able to adapt the communication towards the patient's needs. It is paramount to pay attention to what is disclosed and how it is done. This includes showing empathy, as well as using comprehensive vocabulary and listening carefully. The context in which disclosures take place is also a variable that affects outcomes for patients, family members, as well as healthcare institutions (Hannawa, 2017; Hannawa et al., 2016; Wu et al., 2013). Using a proper physical space and giving hope are also important aspects (Ferreira Da Silveira et al., 2017; Witt & Jankowska, 2018). These elements might involve the fact that providers include proximity and physical contact. Interpersonal adaptability is a critical skill in the context of medical disclosures that constitutes competent error disclosure (Hannawa, 2017).

Amongst the skills needed to perform a proper disclosure there is communication. In the study carried out by Hannawa (2011), physicians used friendly non-verbal disclosure styles when communicating with their patients. How this communication took place led to observe differences that were associated with sex. For instance, the female physicians smiled more and were more sensitive towards their patients, compared with males, and there were more friendly facial expressions toward angry female patients than toward angry male patients. There was also more physical contact at the beginning and at the end of the communication.

As seen previously, how the disclosure is carried out is essential in order to meet patients' needs. For this, there are communication and resolution programs (CRPs). According to Mello et al. (2014), the most effective is to apply full programs, rather than applying separate elements of communication and resolution approach. Using full programs involves a higher degree of institutional commitment to disclosure, apology and compensation, even when not supported by insurers. Just mentioning a compensation/restitution by the transgressor in the apology has the ability to impact on forgiveness-related behaviors (Jeter & Brannon, 2018). These programs also need training of staff, adequate marketing, time, and resources (Mello et al., 2014).

Prentice et al. (2020) concluded the need to implement CRPs with a comprehensive communication approach that (1) acknowledges the long-term impacts of the error, (2) provides supports for long-term impacts, and (3) facilitates long-term care continuity to address the physical, emotional and healthcare-related behavioral consequences of the error. Open communication is not useful for all the outcomes of a PSI as it could leave anxiety symptoms, the avoidance of medical care in general, and the loss of trust in healthcare unattended. Apology seems to help with the first two outcomes, but does not help the loss of trust.

2.5. Support needed in disclosure

In order to be able to disclose correctly, professionals need more support. Nurses, for instance, have an important role when it comes to emotional support at the ward, but do not feel free to speak openly during disclosure (Jones et al., 2019; Shannon et al., 2009). They also seek for more assistance from physicians and their manager, in order to improve in the completion of their task. Sometimes, they are investigated, regarding what has occurred after an incident, and they lack information about the causes, as well as about procedures (Kable et al., 2018). In addition, healthcare professionals prefer to disclose as a team, because these encounters provide moral and informational support, which is highly valued by them (Jones et al., 2019). Unfortunately, the

physician who committed the adverse event was included in the communication only in half of the occasions (Hannawa, 2019).

Most professionals affirm the need for more training and guidelines to carry out disclosures (Gallagher et al., 2003; Mira, Carrillo, Lorenzo, Ferrús, Silvestre, Pérez-Pérez, Olivera, Iglesias, Zavala, Maderuelo-Fernández, et al., 2015; Mira, Lorenzo, Carrillo, Ferrús, Pérez-Pérez, Iglesias, Silvestre, Olivera, Zavala, Nuño-Solinís, et al., 2015; Ock et al., 2020). The review of university trainings of future healthcare professionals is also needed to include tools and instruction regarding adequate and effective communication (Giraldo et al., 2015; Myren et al., 2020). This is even more important, knowing that the elements of non-verbal communication can be taught, learned, assessed and put into practice, with the support of the revised MEDC guidelines (Hannawa & Frankel, 2018).

All this needs to be carried out in a favorable working environment as it is very important when it comes to the interaction between patients and physicians after an adverse event (Myren et al., 2020; Report, 2009; Wu et al., 2013).

CHAPTER III

FORGIVENESS

Disclosing adverse events, including apologies, goes in favor of forgiveness (Ahadi, 2009; Fehr & Gelfand, 2012; McCullough & Worthington, 1995; Riek & Mania, 2011). Understanding what forgiveness is, what variables are associated to it and its benefits, will allow to comprehend its relevance in the patient safety context

3.1. Definition of forgiveness

It is not easy to reach a unique definition of forgiveness (McCullough, 2000; Toussaint & Webb, 2005). However, some authors do agree on some aspects of the term: It is understood that forgiveness (a) is a voluntary choice based on a decision (Goertzen, 2003; Kaminer et al., 2000), (b) is a possible response to an injury or wrongdoing by another person (Kaminer et al., 2000), (c) can require letting go of a negative response (Recine et al., 2007) and could involve giving a positive one to the offender (McCullough, Fincham & Tsang, 2003; Mullet et al., 2004), (d) implicates identifying both the offense and the painful consequences (Goertzen, 2003), and (e) is considered a process that takes time (Gordon & Baucom, 2003; McCullough et al., 2010).

There is more agreement in delimiting what forgiveness is not. Enright and The Human Development Study Group (1991) considered that forgivness should be set apart from legal pardon; pardoning, understood as release from punishment (Worthington, Witvliet et al., 2007); justifying, such as giving a reason why (Enright & Fitzgibbons, 2014b); condoning, this is accepting that the other's behavior was legitimate; exonerating, like absolving from blame or fault; excusing, as the action of lessening the blame by explaining the reasons of why the offender acted that way; forgetting, as to cease remembering the hurt (Cehajic et al., 2008); forbearing, such as abstaining from acting when provoked; and reconciling, which is restoring the relationship with the offender (Enright, 2001; Worthington, 2005).

North (1987) defined forgiveness as a process of foregoing the victim's right to feel resentment and anger against the offender, and feeling benevolence and compassion instead, recognizing that the transgressor has no right to this. Subsequently, Enright and The Human Development Study Group (1991) added that forgiveness is the change of negative affect, behavior and judgement into positive ones, as a response to a deep and unfair hurt.

Subkoviak et al. (1995) defined forgiveness as *"a response toward an offender that involves letting go of negative affect, cognitions, behavior and may involve positive responses toward the offender"* (p. 642). They take into account both positive and negative dimensions.

In a context of valued relationships, victims focus on both, first reducing the negative feelings and then (if possible) increasing positive feelings towards the valued person. Only after reaching a positive stage, the victims consider forgiveness completed (Worthington, 2005).

McCullough (2000) advocated for the social aspect and defined the term as *"a prosocial change in the motivations to avoid or to seek revenge against a transgressor."*

3.1.1. Types of forgiveness

According to McCullough et al. (2002), forgiveness includes the forgiver (victim and offended) granting forgiveness and the transgressor (offender) seeking forgiveness. We can differentiate between *episodic* forgiveness, where forgiveness can be assessed as a response to a particular offense; *dispositional* forgiveness, understood as personality disposition to forgive; and *dyadic* forgiveness which would be the general tendency to forgive within a specific relationship (McCullough, Worthington, 1999).

There is also the differentiation between *trait* and *state* forgiveness, though Kim and Enright, (2016) argue that the disposition to forgive (*trait* forgiveness) cannot exist if specific offenses are not forgiven. They affirmed that there is actually only a unique concept, comprehended

as mature forgiveness, which is a developmental continuum that leads to a maturity in the practice of the virtue, and therefore no difference between *state* and *trait* forgiveness.

In addition, McCullough (2001) found that the tendency to forgive is linked to personality traits. He found that friendliness, perspective taking, and trait forgiveness seem to demonstrate a positive association with the tendency to forgive (Fehr et al., 2010; Riek & Mania, 2011). In their systematic revision, Fehr et al. (2010) found that neuroticism (the tendency to respond with stress to life events) has been negatively associated with forgiveness. Also, emotional intelligence, understood as the ability to manage emotions on interpersonal forgiveness, leads to a self-protective mechanism of avoidance, instead of the use of revenge (Rey & Extremera, 2014).

3.1.2. Benefits of forgiveness

Research has demonstrated that forgiveness is a process with several potential benefits. One of the areas where this is manifest, is in restoring interpersonal relationships after a conflict (Karremans & Van Lange, 2008; Toussaint & Webb, 2005; Tsang et al., 2006). There are also benefits on mental health (Berry et al., 2001; Exline & Baumeister, 2000; Toussaint et al., 2001; Toussaint & Webb, 2005; Wilson et al., 2008). It reduces anger and grief (Coyle & Enright, 1997), and decreases anxiety and depression (Freedman & Enright, 1996; Lin et al., 2004; Reed & Enright, 2006; Rye & Pargament, 2002; Toussaint et al., 2008). Forgiveness lowers stress, and this has a positive repercussion on physical health (Toussaint et al., 2016), as well as positively influences life satisfaction (Harris & Thoresen, 2005; Karremans et al., 2003; Webb et al., 2011). Also, according to Ingersoll-Dayton and Krause (2005), being forgiven may contribute to the change of the transgressors' self-evaluation into a more positive one, leading to a feeling of relief and, therefore, make them feel better.

Therefore, facilitating forgiveness in hospitals is an effective strategy in order to make the clients (in this case the patients) of healthcare feel better after a transgression (for example a patient

safety incident). This forgiveness may moderate the impact on their health and help them recover (Allan & McKillop, 2010).

3.1.3. Variables associated to forgiveness

There are several variables that affect the forgiveness process. Those associated to episodic forgiveness are presented.

Related to the offended. One of the variables associated is empathy, understood as the ability to perceive the thoughts of others and feel their emotions (Kimmes & Durtschi, 2016). Related to forgiveness, empathy would contribute to replacing avoidance and revenge by benevolence (McCullough, Fincham & Tsang, 2003). Also, rumination of the offense, which is the repetitive focus on all the negative and hurt of the offense (Skinner et al., 2003), is negatively associated with forgiveness, since it amplifies the negative view of the transgression (Fehr et al., 2010).

Inevitably, the offended assigns attributions to the offender. These will determine the likelihood to forgive. If the attributions are positive, for instance, non-malicious intent, forgiveness increases, although, if attributions are negative, such as a malicious intent under the offense, it is less probable that forgiveness is shown (Fehr et al., 2010).

Another important feature in forgiveness, when looking at the offended, would be the value he or she gives to the relationship that is at stake, and the quality of the relationship (McCullough et al., 1998). The more value, the higher the motivation to preserve it (Ahadi, 2009). Also, the association between commitment and forgiveness has been demonstrated (Finkel et al., 2002).

There are also demographic variables of the offended that can affect forgiveness. Though not all researchers found the relation between forgiving and gender or between forgiving and age to be significant (Fehr et al., 2010), there are some exceptions: Miller et al. (2008) found that women forgive more than men, and Riek and Mania (2011) detected that age acts as a moderator in forgiveness relationships.

Related to the offense. Those offenses that are severe and hurtful are likely to be more difficult to forgive (Ahadi, 2009), because of the less reversible consequences they have, compared to non-severe offenses.

Related to the offender. One of the biggest influences on forgiveness is the presence of an apology (Ahadi, 2009; Fehr & Gelfand, 2012; McCullough & Worthington, 1995; Riek & Mania, 2011). When the offender demonstrates remorse, anger is reduced in the offended (Riek & Mania, 2011), and the idea of recidivism decreases (McCullough, Pedersen et al., 2014; Tabak et al., 2012). In fact, according to Jeter and Brannon (2017), the most effective apology is the one that expresses a wish to recompense the offense.

3.1.3.1. Apology in healthcare disclosure. Including apologies in the disclosure after a PSI may remedy part of what open communication does not fulfil. Cohen (2000) found that error disclosure involves both communicating information to patients as well as handling their upset emotions that appear after the error. The way in which an apology is communicated has important effects on the patients and their relationship with the healthcare professionals involved. Expressing empathy, providing accurate information, as well as taking responsibility and learning from the event, are crucial aspects for the apology process (Liukka et al., 2020). Moreover, Hannawa et al. (2016) also highlighted the importance of the professional's non-verbal communication.

As for the explicit information, received from the professionals, once they express they are sorry, these words may have different interpretations. It may be understood as an expression of regret, an apology of responsibility, or the acknowledgment of the professionals' implication in the injury. Allan et al. (2015) found that patients prefer an apology where acknowledgement, remorse and reparation are included. Also, patients' pursuit of a lawsuit does not vary after a verbal apology. In order to protect healthcare professionals when apologizing, apology laws have been enacted. These prohibit physicians' apologies to be used as evidence in a medical lawsuit (Saitta & Hodge, 2012). Giraldo, Sato, et al. (2016) outlined there is an effect on disclosure of medical errors and

information provided in countries where these apology laws exist, and differs from the one, given in countries without these laws. With all the healing qualities that come from apology, together with the rest of elements that help recover from a PSI, it is essential that healthcare professionals use apologies effectively and honestly in their interactions with patients and colleagues (Lazare, 2006). Furthermore, Allan and McKillop (2010) found that, if the disclosure incorporates apology and admission of responsibility, an expression of regret and some action to deal with the needs of the patient, it will more likely promote forgiveness with the associated positive health outcomes.

If apology is linked to such good results, answering why professionals might not apologize is a core issue, especially taking into account that it is positive for both, physicians and patients (Heaton et al., 2016). Moreover, Lane and Roberts (2020) found that reasons for physicians not to apologize can be found in the way they rationalize the error. This approach can unfortunately result in a loss of context and, therefore, make the apology perceived as unempathetic. Nevertheless, Lane and Roberts (2020) also found that, when physicians were aware of the error, their reasoning changed. Physicians insist on thinking that apologizing implies accepting responsibility for what happened, but this is an incorrect perception (Giraldo, Corbella, et al., 2016). What studies reveal actually happens is that, when full apologies (the ones that include regret and responsibility acceptance) were offered, the majority of the sample accepted settlement, *versus* the ones who received no apology, or the ones who only received the expression of regret (partial apology). This last situation has little effect on the willingness to accept an offer (Robbennolt, 2003).

Prentice et al. (2020) found that apology was more common when communication was more extensive (included more elements of open communication). However, only 45% of the sample in the highest tier of *open communication* received an apology. Elements such as apologies, whether the event was preventable, and discussing possibilities of prevention, are not commonly included in the communication (Elwy et al., 2016). In the majority of disclosures, studied by Prentice et al. (2020), the offer to ask about the error was present, as long as there was lack of

acknowledging the error as one. Apart from that, more than a third of the participating patients were able to receive information in an open and truthful way, and were even given the chance to express feelings. These researchers concluded open communication was linked to lower emotional impact, as well as to lower healthcare avoidance.

In order to work in the line of reconciliation between parties, Moore and Mello (2017) indicated different areas that could evolve in order to better serve patients' needs in this process: (1) ask, rather than assume, what patients and families need from the process and recognize that, for many patients, being heard is important and should occur early in the reconciliation process, (2) support timely, sincere, culturally appropriate and meaningful apologies, avoiding forced or tokenistic quasi-apologies, (3) choose words that promote reconciliation, (4) include the people who patients want involved in the reconciliation discussion, including practitioners involved in the harm event, and (5) engage the support of lawyers and patient relations staff as appropriate. Also, they encourage institutions to pay more attention to apology, culture and terminology as elements that work in favor of reconciliation with emotional intelligence.

A core element of successful reconciliation is apology (Australian Commission on Safety and Quality in Health Care, 2013). Timing and who offers these apologies are very important (Lazare, 2006). Consistent with legal (Taft, 2005) and empirical research (Leape, 2012; Mazor et al., 2013; McVeety et al., 2014), patients consider that apologies, provided by the involved clinician, are more authentic. This authenticity invites the party harmed to extend forgiveness (Taft, 2005). Nonverbal, uninvolved expressions will probably include higher malpractice risk, and they are less likely to promote healthy reconciliations (Hannawa et al., 2016). Yet, non-verbal communication, adjusted to the situation that transmits true remorse, is more important than expressing feeling sorry (Hannawa, 2019).

Taking all this into account entails an important challenge for both healthcare providers and patients. As noted, patients need custom-made approach that meets their expectations for

information and recognition, as well as to express their emotions and concerns (Myren et al., 2020). This highlights the importance of face-to-face interactions and how written apologies are poorly received (Heaton et al., 2016).

CHAPTER IV

SUPPORT AFTER AN ADVERSE EVENT

In the patient safety strategy of any healthcare organization, the management of the aftermath of an adverse event should be established. It is essential that the parties involved (e.g., patients, healthcare professionals, managers) are all attended and supported, starting with the first victim and continuing with the rest (Manser & Staender, 2005). In the following section, information regarding different support alternatives for first and second victims is provided.

4.1. Support for first victims

One of the things that is widely taken for granted by the patients, involved in the adverse event, is open disclosure (Manser & Staender, 2005). Regardless of the severity of the medical incident, patients and relatives expected the acknowledgment of the error. This action lowers the chances of punitive actions (Witman et al., 1996). In contrast, non-disclosure is related to lower patient satisfaction, loss of trust in the physician and higher negative emotional response, as seen in Mazor et al. (2005), when surveying 958 adults. One of the main reasons patients litigate after an adverse event, is their need for explanations, as found by Vincent et al. (1993). Other reasons found were accountability, standards of care, and compensation. In fact, open disclosure is not associated with a higher number of lawsuits, as pointed out by Giraldo, Corbella, et al. (2016) and Lamb et al. (2003).

There are several recommendations, highlighted by McVeety et al. (2014), in their systematic review for healthcare providers to meet the needs of patients and relatives (e.g., increase awareness of the complexity of the experience and its personal costs; the need for a listening ear and validation of their concerns; facilitate open disclosure and support incident debriefing). There is a necessity to undertake a case-by-case study to personalize the attention after living this unwanted experience. This is very clear when referring to patients who are minor. There is an increased need to pay

attention to family environment, and to inform in order to provide the adequate support (Koller et al., 2019). Also, Mira et al. (2017) highlight the double approach that first victims need. On the one hand, patients should be taken into account in the analysis of the incidents and participate in the generation of solutions and alternatives in order to reduce risks. On the other hand, the emotional impact that may remain after the adverse event, with all the concerns and fears, also needs to be handled. Therefore, it is also important to open lines of communication to work on the re-establishment of trust, starting by listening without interrupting to patients and relatives.

4.2. Support for second victims

Second victims need support, in order to be able to cope with the different symptomatology they may develop, as well as with the eventual trauma they might face after a PSI (Scott et al., 2009). Dekker (2014) stated that second victims are not automatically traumatized, yet can eventually become traumatized if they do not receive the adequate support. It is even likely for them to become more stressed (Waterman et al., 2007) and feel worse psychologically (Scott et al., 2009; Sirriyeh et al., 2010), as well as suffer a higher risk of burnout and turnover with the corresponding higher financial annual cost (Tumelty, 2018). In fact, Mira, Lorenzo, Carrillo, Ferrús, Pérez-Pérez, Iglesias, Silvestre, Olivera, Zavala, Nuño-Solinís, et al. (2015) found that, in Spain, there are still institutions which do not have a program around second or third victims. One of the core elements of this support should be education on second victim phenomenon among health care professionals, because lack of this information is explicit (Busch et al., 2021; Finney et al., 2021; Mokhtari et al., 2018). Fortunately, some studies reveal that there are organizations that provide satisfactory assistance, though the percentage is far from desirable. Organizations should be fully prepared to offer support (Van Gerven et al., 2014). In fact, Grissinger (2014) reinforced the idea that the organization should have a management plan that includes how to support second victims, before it is actually needed. For example, Scott et al. (2009) found that only 35% of the professionals who

experienced emotional distress received adequate support from the organization, and Edrees and Wu (2011) found a higher percentage (52%) in their research.

The vast majority of organizations fail to provide this support (Conway et al., 2010; Schwappach & Boluarte, 2009). In 2009, McCready and Russell found, in their study with obstetric anesthetists from the United Kingdom, that 60% of 29 who were involved in maternal death, received no support.

Sometimes, the support is available, but the professional ignores its existence (Joesten et al., 2015). In the same line, McCready and Russell (2009) found 65% of participants did not know the resources they had access to, and only a minor sample (5%) answered they had information regarding availability of support from the institution. According to Gallagher et al. (2003), Hu et al. (2012) and Scott et al. (2009), healthcare professionals may not always know where to look for assistance after the event. Therefore, a structured program and organizational education, regarding this aspect, is very important (Scott et al., 2010), as well as the subsequent promotion of the resources available, and the creation of awareness of the value of emotional support for second victims (Edrees et al., 2016).

Support characteristics

Support must start right away after a potential emotional distressing event occurs, and should remain available for as long as necessary (Rassin et al., 2005). Obviously, second victims must be open to receive this support. They have the right to be treated with respect in a learning culture, supported by their peers and leaders (Denham, 2007). Regarding the rights caregivers have when approaching the second victim phenomenon, Denham (2007) pointed out five: (a) treatment that is just, (b) respect, (c) understanding and compassion, (d) supportive care (e) transparency and opportunity to contribute. Support provided must be able to respect these rights, while accompanying the affected through the different phases the second victim is going to confront.

Scott et al. (2009) described a 6-stage recovery: (1) chaos and accident response, (2) intrusive reflection, (3) restoring personal integrity, allowing the caregiver to tell their story, (4) enduring inquisition from others, wondering about the impact of the error, (5) obtaining emotional first aid, (6) moving on, dropping out, surviving, or thriving.

After a loss in our daily lives, we have culturally accepted rituals that help us grieve and recover. When a professional loses a patient, generally, it is only accepted to conduct a presentation at morbidity and mortality meeting, or maybe a minute of silence, in order to grieve and heal. It seems to be "part of the job", but it is important not to ignore the impact the second victim phenomenon has on mental health. Each professional, as the person he or she is, has resources to cope with the situation, but not all are healthy. Therefore, the system must be alert to detect professionals that may be struggling (Bohnen et al., 2019). Depending on the type of adverse event experienced and the perceived personal responsibility, the emotional outcome will be different, which is important to take into account, because different support will be needed (Engel et al., 2006; Sirriyeh et al., 2010). Thus, even if patient safety is promoted, an organizational culture of supporting second victims is needed (Bohnen et al., 2019; Mira, Lorenzo, Carrillo, Ferrús, Pérez-Pérez, Iglesias, Silvestre, Olivera, Zavala, Nuño-Solinís, et al., 2015; Rinaldi et al., 2016).

Elements that are seen to be effective when it comes to supporting second victims are: reassuring their professional competences (Scott et al., 2009, 2010), prompt debriefing, information about processes after incidents, and guidance and mentoring by senior colleagues (Pinto et al., 2012) For instance, Herring (2020) finds that open review and discussion begin the healing process.

Other possible sources of support with pros and cons (i.e., Risk managers and legal defense team providing emotional support; critical incident stress management (debriefing); physician support groups; referral to employee assistance program; referral to colleagues; referral to professional counselor or psychiatrist) are gathered by White et al. (2008).

Burlison et al. (2017) outlined (a) a respected peer to discuss the details of what happened (Conway et al., 2010); (b) a discussion with my manager or supervisor about the incident: (c) a specified peaceful location that is available to recover and recompose after one of these types of events: (d) the ability to immediately take time away for a little while (Joesten et al., 2015): (e) an employee assistance program that can provide free counselling to employees outside of work (Mira, Lorenzo, Carrillo, Ferrús, Pérez-Pérez, Iglesias, Silvestre, Olivera, Zavala, Nuño-Solinís, et al., 2015). (f) The opportunity to schedule a time with a counselor at my hospital to discuss the event: and, (g) a confidential way to get in touch with someone 24 hours a day to discuss how the experience was. Also, professional reassurance and recognition of their actions and collegial trust are especially important for nurses (Kable et al., 2018). Some professionals refer that talking about the error at a morbidity and mortality meeting is very helpful (Gallagher et al., 2003). It is seen this resource is specially useful as educational learning, though they have to improve to really imply progress in quality and safety (George, 2016).

One of the sources of support that seems to be very appreciated by the health care professionals is peer support (Burlison et al., 2017; Gazoni et al., 2011; Hu et al., 2012; Joesten et al., 2015; Scott et al., 2010; Seys, Scott, et al., 2013), even if it is in an informal format (Burlison et al., 2017; Seys, Scott, et al., 2012; Ullström et al., 2013), as well as non-judgmental colleagues (Ullström et al., 2013). Peer support is highly appreciated, but it is important it is kept authentic and there is no blaming, gossiping or silence (Lewis et al., 2013). Peer supporters can be adequately trained to be able to accomplish their task (Kobe et al., 2019). In fact, peer support is the first aid emotional support of Scott et al. (2010) FORYOU program. It is estimated that aproximatly 60% of second victims will receive sufficient support at this first level. Second support level is also provided by peers, though they are specially trained and they can refer second victims to internal resources when necessary. Around 30% of second victims find the support they need at this level.

The remaining 10% are assited by the third level that is professional counseling support and guidance.

How peers should address towards second victims includes: outreach call; invitation/opening; listening; reflecting; reframing; sense-making; coping; disclosing; and resources/referrals (Shapiro & Galowitz, 2016). Most physicians agree on sharing what has occurred in the adverse event with a trusted colleague (Jones et al., 2004). Being able to review the medical records with a reliable colleague helps to avoid the pathogenic guilt (Mesel, 2013), and becomes one of the most important coping responses (Harrison, Walton, et al., 2015). Being able to discuss the role of the professional in the adverse event, as well as the emotions that appear, is seen as a central factor when it comes to forgiving oneself (Berlinger, 2005). When the event impacts multiple professionals, it can be useful to debrief as a team with a facilitator (Tanabe & Janosy, 2020). The use of peers as one of the most important pillars of support after an adverse event appears explicitly in Scott et al. (2010) in their three-tiered model for second victims in their FOR YOU team support program. The Resilience Education Support Training (REST) offers debriefing facilitation, immediately after the unexpected event. In order to normalize talking and learning about adverse events, it is important to have peer review meetings routinely and seek to provide clear information regarding what happened and what to do (Van Gerven, Deweer, et al., 2016).

Formal support resources

At the time this literature review took place, there were twelve formalized second victim support resources described in scientific literature. All of them have been implemented between 2006 and 2017 (Busch et al., 2021). In order of implementation, there are The Healing Beyond Today (Neonatal Intensive Care Unit at the Riley Hospital for Children of the Methodist Hospital Indianapolis, Indianapolis, USA) (Roesler et al., 2009); Peer Support Team (Brigham and Women's Hospital, Boston, USA) (Van Pelt, 2008); ForYOU Team (University of Missouri Health Care Columbia, Missouri, USA) (Scott et al., 2010); MITSS: Medically Induced Trauma Support

Services Tool Website (Pratt et al., 2012); Swaddle (Scott & White Healthcare, Central Texas, USA) (Trent et al., 2016); RISE (John Hopkins Hospital, Baltimore, USA) (Edrees et al., 2016); Care for the caregiver program (Ten – hospital Health System, Columbia, USA) (Morales & Brown, 2019); YouMatter Program (National Children's Hospital, Columbus, USA) (Krzan et al., 2015); Washington University School of Medicine Peer Support Program (Barnes-Jewish Hospital, St. Louis, USA) (Lane et al., 2018); Second Victim Support Program (no specific name) (Bali International Centre Hospital Kuta and Nusa Dua, Bali, Indonesia); MISE Website (Mira et al., 2017); Surgery-specific second victim support program (no specific name) (Department of surgery at Massachusetts General Hospital, Boston, USA) (El Hechi et al., 2020).

In all these programs, support by internal peers is offered, except in the Healing Beyond Today. In general, this support was available in the immediate or short-term aftermath of the event, and was voluntary and confidential. They all considered offering higher levels of support if necessary. All of the programs offered one-on-one and/or group support (Busch et al., 2021). The main objective of these programs is to identify and reduce the negative impact patient safety incidents generate on second victims, and some of the programs focus on promoting and improving their coping strategies (El Hechi et al., 2020; Lane et al., 2018; Morales & Brown, 2019).

The abovementioned is considered short-term support. But support may also be needed in the long run. Long-term support became important, following the suicide of two anesthetist professionals of the University of Colorado (Tanabe & Janosy, 2020). Previously, Shanafelt et al. (2011) found that only 26% of surgeons with suicidal ideation looked for help. From then on, psychologists are included in the communications that take place after an adverse event. Also, they contact the professionals affected, 1 or 2 weeks after the incident, to offer support and guidance.

In order to speed up clinicians' recovery process, proactive actions must be taken by the organization. Liukka et al. (2020) carried out an integrative literature review, and highlight different measures that should be implemented at an organizational level. First, an organizational strategy

and infrastructure (Lewis et al., 2013; Seys, Scott, et al., 2012; Ullström et al., 2013) that include an post-adverse-event action plan (Mira, Carrillo, et al., 2015; Scott et al., 2010; Van Gerven, Bruyneel, et al., 2016), personnel (Burlison et al., 2017; Iedema et al., 2008; Lewis et al., 2013; Mira, Lorenzo, Carrillo, Ferrús, Pérez-Pérez, Iglesias, Silvestre, Olivera, Zavala, Nuño-Solinís, et al., 2015; Van Gerven, Bruyneel, et al., 2016) and processes (Mira, Lorenzo, Carrillo, Ferrús, Pérez-Pérez, Iglesias, Silvestre, Olivera, Zavala, Nuño-Solinís, et al., 2015; Ullström et al., 2013; Van Gerven, Bruyneel, et al., 2016).

Organizational culture

One of the situations nurses face is the embarrassment when there has been a medication error. This can lead to keeping silence about what has occurred, because of fear of losing their jobs (Grissinger, 2014; Rassin et al., 2005). Organizations providing counselling for these nurses reduce emotional stress among the staff and, therefore, keep future patients safer (McMeekin et al. 2017).

In order to prevent blame-related stress, leaders should train staff on how to debrief after a PSI with a non-blame approach, promoting an environment of performance improvement rather than punishment (Davidson et al., 2015). This training is also important to acknowledge the potential devastating emotional impact on healthcare providers (Wu, 2000). For example, giving information on what happened, what to do next, and extra guidance in the workplace, is positively associated with the impact of the incident. When the clinicians have the feeling they have received correct guidance, it translates into a significant difference in the impact of event scale scores (Van Gerven, Bruyneel, et al., 2016).

Meanwhile, reaching a just blame-free culture is not easy. Schrøder et al. (2018) expose a Danish good practice, not focused on sanction, that seeks this type of organizational culture, benefitting both first and second victims, and focused on learning from mistakes, using a formal reporting system (Svansoe, 2013) that aims to learn from mistakes, rather than punish healthcare

professionals. It is a no-fault compensation system that offers fast, fair and suitable compensation for victims of medical injury. Despite this, those professionals who do not meet their professional expectations can be punished (Svansoe, 2013). But a blame-free culture is not enough for healthcare professionals to feel relieved from distress and guilt feelings, implying a psychological burden (Schrøder et al., 2016).

Support improvement

In order to continue improving support for second victims and, therefore, patient safety, the SVEST tool is available to be used before and after the implementation of a support program (Burlison et al., 2017). For instance, Krzan et al., (2015) found that, 5 months after the implementation of the program, 3 respondents had used the source and 11 had directed a coworker towards a peer supporter. Results in another direction were found by Quillivan et al. (2016), where different scenarios that organizations can provide in order to learn, communicate and improve future performance after an incident, seem to have lower impact on personal distress or professional vulnerability. At an individual level, it is possible that the support enrichens the way the professional copes, but there is no change in the way the organization handles the situation. Findings that motivate implementing changes in the existing support programs, such as the possibility that some staff are being left unsupported, was found by Wolf et al. (2021) also using the SVEST tool. The need to reach out to all health care specialties and professionals is obvious, and specific research on the topic has been done, for example, the completion of a study of second victim support structures in anesthesia (Nijs et al., 2021).

In the literature review carried out by Liukka et al. (2020), it is concluded that the approach towards the support, needed after an adverse event, is complex. The need for an integrative holistic action plan exists, where all victims are assisted and interaction between them as part of the process is highly recommended, in order to lead to positive outcomes for all parties involved. It is essential to handle the phenomenon as a whole. Communication stands as a core tool for this to become

reality, and has to flow between all parties. This can promote professionals to openly discuss the events with the first victim, because they feel the support from the organization, and are able to carry out full disclosures that contain full apologies, which will eventually encourage first victims to forgive. This process will, in the end, bring benefits to all parties, including health and healing benefits. All of this should take place in a blame-free learning culture that seeks to alleviate the suffering that comes from unwanted, yet impossible to fully eradicate – due to the human nature of actions – patient safety incidents.

After the review of the literature, the absence of forgiveness in the aftermath of a PSI has been found. The process after an incident would start with the organization being aware of what occurs, followed by providing support for first and second victims, and also a context in which a full disclosure takes place. This includes discussing the event and apologies, as well as enabling learning from the adverse event, and elaborating improvements to be implemented in the future. This entire process would help healthcare organizations to transform their image, which may be negatively affected by the adverse event, into one that seeks to recover the trust of future patients. After the review of types of support, currently available after an adverse event, a gap has been found regarding the lack of seeking forgiveness, which has potential benefits for both the patient and the healthcare professional involved, as well as the type of support that healthcare professionals need when the adverse event has no visible consequences for the patient and, therefore, it is decided not to communicate the incident.

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PART II: EMPIRICAL RESEARCH

CHAPTER V

PURPOSE AND HYPOTHESIS

The main objective of the dissertation is to study the experience of forgiveness in hospital environment after a patient safety incident occurred, focusing on the patients' experience as first victims, and on the professionals' experience as second victims.

Considering the existing literature, regarding forgiveness and the first and second victim phenomenon, the insertion of forgiveness in the aftermath of a patient safety incident will contribute to a better healing process for all parties involved. To accomplish the main goal, three exploratory studies will be presented:

The first study is dedicated to the experience of forgiveness of the patient or their family members after submitting a claim related to an adverse event. By means of a telephone survey, we explored whether they received an apology, as well as if they forgave the professionals involved. The second study explores the need for forgiveness of professionals after a patient safety incident, using a quantitative methodology, and the third study is a qualitative approach to the need for forgiveness in professionals who have experienced a patient safety incident.

STUDY 1: THE IMPORTANCE OF AN APOLOGY IN FORGIVENESS AND PATIENTS' MENTAL HEALTH AFTER A MEDICAL ERROR

Purpose

The purpose of this study was to explore whether using an apology letter or direct apologies enable forgiveness from patients and family relatives after an incident, as well as to verify the impact of forgiveness on health.

Specific objectives

- *Objective 1.1:* To determine if an apology letter enables forgiveness
- *Objective 1.2.:* To determine if face-to-face apologies enable forgiveness
- *Objective 1.3:* To explore if forgiving contributes to mental health.
- *Objective 1.4:* To explore if forgiving contributes to higher life satisfaction

Hypothesis

- *Hypothesis 1.1:* An apology letter does not enable forgiveness.
- *Hypothesis 1.2:* Face-to-face apologies facilitate forgiveness.
- *Hypothesis 1.3:* Forgiving increases mental health, specifically depression and anxiety.
- *Hypothesis 1.4:* Forgiving increases life satisfaction.

STUDY 2: THE ROLE OF APOLOGY AND FORGIVENESS IN SECOND VICTIMS AFTER MEDICAL ERROR.

Purpose

The aim of this study was to describe the symptoms that second victims suffer, their need for forgiveness and the professional consequences of being involved in a PSI.

Specific objectives

- *Objective 2.1:* To explore the symptoms that second victims suffer.
- *Objective 2.2.:* To determine if second victims have a need for forgiveness.
- *Objective 2.3:* To find out the professional consequences of being involved in a PSI.

Hypothesis

- *Hypothesis 2.1:* Second victims suffer negative symptoms (e.g., guilt, anxiety, insomnia).
- *Hypothesis 2.2:* Second victims have a need for forgiveness.
    - *Hypothesis 2.2.1:* Second victims want to know if the patients have forgiven them.
    - *Hypothesis 2.2.2:* Second victims will feel better if they know the patient has forgiven them.
    - *Hypothesis 2.2.3:* Second victims experience feelings of regret if they did not apologize to the patient.
    - *Hypothesis 2.2.4:* Second victims are capable of learning from the experience.
- *Hypothesis 2.3:* Second victims experience professional consequences after a PSI.

STUDY 3: A DEEPER LOOK INTO HEALTHCARE PROFESSIONALS' NEED FOR FORGIVENESS AND SUPPORT AFTER A PATIENT SAFETY INCIDENT.

Purpose

The purpose of this study was to explore in-depth the need for forgiveness that second victims have, and examine what support they receive and what they would need to feel supported, as well as to apologize and therefore promote forgiveness.

Specific objectives

- *Objective 3.1:* To find out the type of support second victims receive after a PSI.
- *Objective 3.2.:* To determine what support second victims need in the aftermath of a PSI.
- *Objective 3.3:* To explore the feelings of not being able to apologize if the professional wished to.
- *Objective 3.4:* To determine facilitators that will encourage apologizing.
- *Objective 3.5:* To find out what lessons second victims draw from the experience.

Hypothesis

- *Hypothesis 3.1:* Second victims do not receive the adequate support for their needs after a PSI.
- *Hypothesis 3.2:* Second victims need peer and organizational support in the aftermath of a PSI.
    - *Hypothesis 3.2.1:* Second victims need peer support
    - *Hypothesis 3.2.1:* Second victims need professional support or guidance
- *Hypothesis 3.3:* If the professionals want to apologize but are not able to, feelings such as regret appear.

- *Hypothesis 3.4:* Team and organizational support encourages apologizing.
- *Hypothesis 3.5* Professionals always learn something from a PSI experience.

CHAPTER VI

METHOD

Study 1: The importance of an apology in forgiveness and patients' mental health after a medical error.

In the current study we explore what apology format enables forgiveness when responding to a complaint filed by patients or relatives in the aftermath of a patient safety incident. Also, we verify the benefits of forgiving in this population.

Participants and procedure

The study was conducted with patients and patients' family relatives who had submitted a complaint to the main patient advocacy department in a tertiary hospital in Spain between January 2017 and December 2018. Whenever there is any unsatisfactory situation (including medical errors), this hospital offers the patient the possibility of filing a complaint with the patient advocacy department. The procedure that this department follows, in response to a complaint, includes answering with a letter that contains an explanation of what occurred, a review of the patient's clinical history, and an apology. The objective is to restore the confidence that may be jeopardized after the incident. Also, some of the people who file a complaint receive a face-to-face apology from the professionals, involved in their medical care.

The complaints, selected for this study, were the ones related to health care, these are the ones corresponding to the quality of care and treatment, provided to a patient (e.g., improper performance of procedures), and healthcare provider behavior (e.g., violation of rights). All complaints from medical services were included, except for the psychiatry service.

We used two information sources: the complaints and a telephone survey. A total of 408 complaints were selected for their inclusion in the study. All the claimers were contacted and

invited to participate in a phone survey on the spot, between January and April 2019. A final sample of 144 participants agreed to complete the survey (response rate: 35.3%), which was adapted to whom the claimer referred to as the respondent (e.g., one professional). Of all participants, 74.1% (106) were patients, and 25.9% (37) were relatives. 25.2% (36) were men and 74.8% (107) were women, with an average age of 47.43 years (*SD*=15.17). As for their educational level, 1.6% (2) had none, 22.8% (29) had primary studies, 40.9% (52) had secondary and 34.6% (44) had tertiary studies. After receiving and recording their consent, the survey was completed. If they still had anything to add to the complaint, or they had any request that had not been taken care of, the patient advocacy department was informed.

The Ethics Committee of the Universitat Internacional de Catalunya granted approval for this study (CBAS-2018-19) (annex 2), and verbal informed consent was obtained from all participants.

Measures

Complaint. This is a document facilitated by the head patient advocacy department of the hospital where we gathered the sample. Any patient or relative can fill in order to express non conformity with the care received, including medical errors. The document contains information about the type of medical error (i.e. related to healthcare or healthcare provider behavior), information about medical specialty (i.e., medical, surgical, emergencies) and year of the complaint.

Telephone survey. Information collected during the survey is described below but the full protocol can be found in annex 3.

Demographic Information. Information about age, gender and maximum level of studies completed was collected.

***Respondent characteristics*.** Participants provided information regarding who they considered was the claimed (i.e., a specific professional, a whole unit service, the hospital or more than one of the previous options).

***Painfulness*.** We used a single item to assess the degree of pain that the medical error had generated using a 5 point Likert-scale ranging from 0 (*nothing at all*) to 5 (*extreme*).

***Apology*.** Participants were asked if they remembered receiving a face to face apology and/or a letter that included an apology from the hospital or healthcare professionals.

***Satisfaction with apology*.** Satisfaction with the letter that included an apology and satisfaction with face to face apologies were also rated using a 6-point Likert scale from 0 *(no satisfaction)* to 5 *(very high satisfaction)*

Single item of forgiveness. The extent in which participants had forgiven the claimed was measured using a 6-point response option ranging from 0 (*none*) to 5 (*completely*).

***Rye Forgiveness Scale; (Rye et al., 2001)*.** The scale consists of 15 items answered using a Likert-type scale ranging from 1 (s*trongly disagree*) to 5 (*strongly agree*). Due to length issues, we selected the 4 items with higher factor loadings. Two of them are items that belong to the factor that describes presence of positive thoughts, feelings, and behavior towards the wrongdoer, these are "I want good things to happen to the person, service, institution that took care of me" (from now on, Rye's good things item) and "I feel compassion for the person, service, institution that harmed me" (from now on, Rye's compassion item). The other two items describe the presence of negative thoughts, feelings and behavior towards the wrongdoer, these are "I can't stop thinking about how I was hurt by this person, service, hospital" (from now on Rye's thinking item) and "the harm that this person, service, institution caused has deprived me from enjoying life" (from now on Rye's deprivation item). Also, a total forgiveness score was used by summing all four Rye items (From now on Rye's total forgiveness score).

Satisfaction With Life Scale (SWLS); (Atienza et al., 2000; Diener et al., 1985). The SWLS is an instrument designed to assess global cognitive judgments of one's Satisfaction With Life. It is comprised by 5 items with a 7-point response option that goes from 1 (*strongly disagree*) to 7 (*strongly agree*).

Brief Symptom Inventory 18 (BSI-18); (Derogatis, 2013). The Depression and Anxiety subscales of the *BSI-18* were used. Both subscales include statements that are responded using a 5-point Likert scale from 0 (*not at all*) to 4 (*extremely*) and that asked about the level of distress during the previous seven days. The depression dimension is composed of 6 items and the anxiety dimension is composed of 3 items. Higher scores indicate higher levels of both variables.

Data analysis

Descriptive analyses including means and standard deviations regarding characteristics of the complaint, claimed, claimant, apologies, degree of forgiveness and mental health variables were carried out. Normal distribution of the data was assessed through the Kolmogorov-Smirnov and Levene tests and the exploration of the histograms.

In order to control the effect of type of complaint, offender, profession and medical specialty on forgiveness dimensions independent samples t-test and one-way ANOVAs were applied.

Also, two-way analyses of variance (ANOVA) were used to assess the main effects of receiving a letter including an apology and receiving a face-to-face apology on the forgiveness single item, Rye's total forgiveness score and Rye's items. If the interaction effect was found to be significant, Tukey post hoc comparisons were performed.

Pearson correlations were used to explore the association between all the forgiveness variables and mental health and satisfaction with life. In those cases where normal distribution was

not found, non-parametric (i.e., Spearman correlation) tests were applied. SPSS Statistical Package version 21 was used for all the analyses.

Study 2: The role of apology and forgiveness in second victims after a medical error

Participants and procedure

A descriptive cross-sectional study was carried out, taking advantage of a survey that a tertiary hospital in Barcelona (composed of two hospitals, a mental health center and a healthcare-social center), was going to perform. In total, the consortium has 3511 healthcare professionals, 1000 beds (400 acute care beds) and 19 operating rooms in Barcelona. This online, self-administered survey was carried out from February to June 2018. An experienced pollster was hired and in charge of informing all different departments about the research, sending the survey and collecting the data. The pollster insisted on those departments where no surveys were completed, by visiting these departments and offering to answer the survey on the spot, using an electronical device, ensuring confidentiality. The Ethics Committee of the Universitat Internacional de Catalunya granted approval for this study (CBAS-2018-19) (annex 2), and written informed consent was obtained from all participants.

A total of 423 healthcare professionals completed the survey. From all the participants, only the ones who had experienced a patient safety incident were taken into consideration (n=273).

Measures

The survey (annex 4) aimed to gather information regarding the profile of second victims, symptoms they experienced from a subjective point of view, professional consequences and need for forgiveness. The items, related to symptoms and professional consequences, were based on the items, presented in the Hospitals professionals' questionnaire, created by the Spanish Second and Third Victims group (Mira, Carrillo, et al., 2015), that were created by consensus among the research team after reviewing different recommendations and interventions. The internal

consistency of the implementation subscale was 0.94 and 0.98 for the utility subscale. Legibility and acceptability of the questions were tested before starting the field trial. This same protocol was followed in all 8 regional health services when assessing the impact of adverse events in primary care and hospitals in Spain on second victims. Also, four specific questions, regarding the need for forgiveness, were added for the purpose. Four items of the need for forgiveness were attached to this survey.

Hospitals professionals' questionnaire

***Demographic information*.** Participants provided demographic information, including their age, gender, health specialty and years of practice.

***Symptoms*.** The symptoms measured were: feeling dazed/confusion/difficulty concentrating, guilt, sadness, tiredness, anxiety, insomnia, having the feeling of re-experiencing the event, anger and mood changes at work and at home, doubts about what to do and whether their clinical decisions were correct, worries about loss of reputation among colleagues or loss of reputation among patients, and doubts about continuing in the profession. Every symptom was measured with a 3-point Likert-scale rating 0 (*never*), 1 (*sometimes*), 2 (*almost always), and 3 (always*), with higher scores indicating a higher presence of the symptom.

***Professional consequences*.** Three professional consequences of going through a PSI were measured: The professionals or a colleague needed time off, or needed a change in their unit, or abandoned their career. All were measured, using a dichotomous answer response (*yes/no*).

Items of need for forgiveness

We measured the need for forgiveness, using four questions, inspired by the idea of willingness to be forgiven (Enright, 2001): (1) Would you like to know if the patient has forgiven you? and (2) Knowing that the patient has forgiven you would help you feel better? Both questions were answered by means of a dichotomous response (*yes/no*). The third question was: (3) Do you

regret not having apologized personally to the patient? This question had three response options (*yes/no/I did apologize*). A last question was added (4), regarding whether they had learnt anything positive from the experience, measured using a dichotomous answer response (*yes/no*).

Data analysis

Frequencies or means and standard deviations were calculated for all the variables, included in the study. Chi-square tests were used to determine whether the profession (i.e., physician, nurse, health assistant, other) was independent of the outcomes on the need for forgiveness measurements (i.e., four items) and the professional consequences questions (i.e., three items). Chi-square tests were also used to asses the relation between need of forgiveness and gender. A total of 13 one-way ANOVAs applying Bonferroni correction were conducted between subjects to compare the effect of the profession on each symptom (i.e., 13 symptoms). In cases where statistically significant results were found, we computed a Tukey post-hoc test.

We conducted an independent samples t-test, to assess differences in each symptom, regarding the need for forgiveness (as measured for each of the four items). SPSS Statistical Package version 21 was used to do all the descriptive and statistical analyses

Study 3: A deeper look into healthcare professionals' need of forgiveness and support after a PSI

The following is a pilot study carried out by using in-depth interviews to make a qualitative approach towards the need for forgiveness and support that professionals, who have experienced a patient safety incident, require.

An interpretative phenomenological approach was used to explore professionals' experiences, need for forgiveness and support in the aftermath of an adverse event. A reflexive hermeneutic process was followed to arrive at an understanding and interpretation of the phenomenon.

Participants and procedure

The study sample was collected by contacting the person responsible for second victims of a pediatric hospital in Barcelona from March to September 2021, and a total of 5 participants were included. There were four doctors and a nurse with specialization in pediatrics. All of them had 6 to 19 years of experience in their profession and had experienced an adverse event in the past 5 years. Three of them did not result in consequences for the patient, while the other two cases did (permanent harm and death). All of the participants referred the event had caused them some personal o professional impact and in none of the cases apologies were offered to the patient or relatives.

Potential participants were informed of the opportunity of participating in the study and information about it was provided. Those who agreed to participate voluntary, received a screening survey (annex 4) by e-mail to sift participants and see if they met sample inclusion criteria.

Inclusion criteria was (a) to be a physician or nurse with studies completed, (2) having experienced an adverse event in the past 5 years that caused personal or professional impact (c) not having apologized for the adverse event (d) be willing to participate as a volunteer in an interview, and (e) having Spanish or Catalan as mother tongue.Those who meet the criteria received and e-mail with the date of the interview as well as the full informed written consent (annex 5) to be signed and returned. The interviews had a duration of between 30 and 60 minutes.

Measures

The semi-structured interview schedule was divided into four blocks (annex 7). First of all, it included an invitation to talk about the adverse event they referred to in the screening survey, as well as their feelings, impact, and how they thought it could have been avoided. Secondly, they were asked about the first support they received (e.g., who they spoke with; what support they received). Thirdly, how the communication with the patient or relatives took place, if it happened,

and questions related to apologies and forgiveness (e.g., why were apologies not offered; what feelings remained after not offering apologies; are there benefits to being forgiven?) and finally, what would they recommend for someone who goes through the same experience (e.g., what external support would they have needed) communication with the patient.

Data analysis

All the recordings were transcribed and can be found in annex 8. Content analysis was carried out using ATLAS.TI, version 9. Meaningful statements were marked and codified through line by line analysis. Codes that stood for similar meanings were classified under the same category and from there the emerging topics were extracted. The names of these topics try to reflect as much as possible the content they stand for.

Ethical considerations

At the beginning of the research, participants were informed about the purpose of the study, as well as notified that all information acquired would be kept anonymous, and only used for research purposes. Approval from an ethics committee was obtained before initiating the research. The Ethics Committee of the Universitat Internacional de Catalunya granted approval for this study (CBAS-2018-19) (annex 2), and written informed consent was obtained from all participants.

CHAPTER VII

RESULTS

Study 1: The importance of an apology in forgiveness and patients' mental health after a medical error

Characteristics of the complaint, respondent, claimant and apologies

Table 1 shows the relative frequencies regarding the complaint, respondent, claimant and apology variables, and table 2 shows means and standard deviations of the claimer, forgiveness and mental health variables.

Table 1. *Descriptive statistics of the main variables*

			N	%
Complaint	Type	Health care	119	82.6
		Behavior healthcare provider	25	17.4
	Year	2017	77	53.5
		2018	67	46.5
Respondent	Professional	Specific professional	90	63.8
		Care unit	26	18.4
		Institution	9	6.4
		More than one	16	11.3
	Medical specialty	Medical	71	49.3
		Surgical	59	41
		Emergencies	14	9.7
Claimant	Who	Patient	106	74.1
		Family relative	37	25.9
	Gender	Male	36	25.2
		Female	107	75
	Education level	None	2	1.6
		Primary	29	22.8
		Secondary	52	41
		Tertiary	44	35
Apology	Letter that includes an apology	Yes	68	47.6
		No	75	52.4
	Face-to-face apology	Yes	32	24.8
		No	97	75.2

Table 2. *Characteristics of the claimant, forgiveness and health*

	Mean	SD
Claimant		
Degree of pain	4.67	.71
Age of the claimant	47.43	15.17
Months between survey and the medical error	29.07	10.95
Forgiveness		
Single item	2.10	2.05
Rye's thinking item	3.00	1.73
Rye's deprivation item	2.42	1.79
Rye's compassion item	2.45	1.66
Rye's good things item	4.38	1.12
Rye's total forgiveness	10.98	4.12
Health		
Satisfaction with life	21.86	6.62
Depression	5.27	5.80
Anxiety	2.51	3.23
Satisfaction		
Letter that includes an apology	2.67	1.77
Face-to-face apology	2.69	1.98

Effects of the types of apologies on forgiveness

Results only showed a significant effect of type of complaint on Rye's thinking item ($M_{health\ care}$ = 2.08; $M_{behaviour}$= 3.22; t=-3.06; p = .003) and an effect of medical specialty on the item of compassion (F(2,122)=3.30; p = .04). We controlled the effect of time since the offense happened by including it as a covariate on the main analyses, however results showed a non-significant effect and thus it was excluded. Distribution of the sample, according to the type of apology, is shown in table 3. A two-way analysis of variance (ANOVA) was conducted to compare the main effects of receiving a letter that included an apology, and receiving a face-to-face apology on all forgiveness variables. Table 4 shows the results obtained for every criterion.

Table 3. *Cross tabulation between Apology letter and Face-to-face apology*

	Face-to-face apology N(%)		
Letter with apology	No	Yes	Total
No	61 (47.7)	10 (7.8)	71 (55.5)
Yes	35 (27.3)	22 (17.2)	57 (44.5)
Total	96 (75)	32 (25)	128 (100)

Regarding single item of forgiveness scores, only the effect of the face-to-face apology was statistically significant at the .05 significance level, indicating that those who received a face-to-face apology presented higher scores on the single item of forgiveness (M = 3.13, SD = 1.84) than those who did not receive any (M = 1.81, SD = 2.03).

All the effects of the Rye's total forgiveness score model were statistically significant, except for a letter that includes an apology. The main effect of the face-to-face apology indicated that there were significant differences on Rye's total forgiveness, depending on whether they had received a face-to-face apology (M = 12.29, SD = 3.05) or they had not (M = 10.41, SD = 4.30). Since the interaction effect was significant, Tukey post-hoc comparisons were performed to assess simple effects. Results showed that those who received a face-to-face apology significantly forgave more than those who did not, when a letter including an apology had not been received (p = .12). On the other hand, no significant differences were found between receiving a face-to-face apology or not, when they had received the apology letter (p = .99). Means and standard deviation of each group can be found in table 5.

Table 4. *Fixed-Effects ANOVA results using forgiveness variables as the criterion*

Criterion	Predictor	Sum of Squares	*df*	Mean Square	*F*	*p*
Single item of forgiveness	(Intercept)	546.45	1	546.45	139.49	.00
	Letter	1.50	1	1.50	.38	.54
	Face-to-face	42.24	1	42.24	10.78	.00
	Interaction	10.57	1	10.57	2.70	.10
	Error	454.42	116	3.92		
Rye's total forgiveness score	(Intercept)	11160.50	1	11160.50	719.55	.00
	Letter	2.42	1	2.42	.16	.69
	Face-to-face	84.72	1	84.72	5.46	.02
	Interaction	96.45	1	96.45	6.22	.01
	Error	1814.73	117	15.51		
Rye's thinking item	(Intercept)	709.71	1	709.71	249.27	.00
	Letter	.00	1	.00	.00	.99
	Face-to-face	.01	1	.01	.00	.95
	Interaction	10.80	1	10.80	3.79	.05
	Error	333.12	117	2.85		
Rye's good things item	(Intercept)	1609.33	1	1609.33	1237.63	.00
	Letter	.91	1	.91	.70	.41
	Face-to-face	3.55	1	3.55	2.73	.10
	Interaction	.01	1	.01	.00	.95
	Error	145.64	112	1.30		
Rye's deprivation item	(Intercept)	348.00	1	348.00	116.80	.00
	Letter	.51	1	.51	.17	.68
	Face-to-face	27.54	1	27.54	9.24	.00
	Interaction	8.21	1	8.21	2.75	.10
	Error	342.64	115	2.98		
Rye's compassion item	(Intercept)	521.84	1	521.84	187.13	.00
	Letter	.78	1	.78	.28	.60
	Face-to-face	1.21	1	1.21	.43	.51
	Interaction	10.18	1	10.18	3.65	.06
	Error	298.38	107	2.79		

Table 5. *Means and standard deviation for forgiveness variables as a function of a 2 (apology letter) X 2(face-to-face apology) design*

		Face-to-face Apology	
		No	Yes
	Apology Letter	*M (SD)*	*M (SD)*
Single item of forgiveness	No	1.64 (2.03)	3.80 (1.69)
	Yes	2.09 (2.04)	2.81 (1.86)
Rye's total forgiveness score	No	9.78 (4.19)	14.00 (2.54)
	Yes	11.61 (4.32)	11.48 (2.98)
Rye's thinking item	No	3.31 (1.67)	2.60 (1.35)
	Yes	2.58 (1.86)	3.33 (1.59)
Rye's good things item	No	4.36 (1.13)	4.80 (.63)
	Yes	4.17 (1.34)	4.57 (1.03)
Rye's deprivation item	No	2.92 (1.87)	1.10 (.32)
	Yes	2.43 (1.83)	1.90 (1.48)
Rye's compassion item	No	2.24 (1.64)	3.22 (1.86)
	Yes	2.77 (1.74)	2.29 (1.55)

About the Rye's forgiveness items, only the main effect of receiving a face-to-face apology was significant for the Rye's deprivation item, indicating significant differences between receiving a face-to-face apology (M = 1.63, SD = 1.27) and not receiving it (M = 2.75, SD = 1.86) in the deprivation levels. Meanwhile, the interaction effect for the Rye's thinking item and the Rye's compassion item was marginally significant, and thus, post-hoc comparisons were performed. However, no significant differences were found between any of the groups.

Association between forgiveness, mental health and satisfaction with life

Table 6 includes the correlations between forgiveness variables and apology formats, satisfaction with life and health variables

Positive and significant correlations were found between depression and Rye's thinking and deprivation items. Negative and significant correlations were found between depression and Rye's good things item, Rye total forgiveness and satisfaction with life.

Positive and significant correlations were found between anxiety and Rye's thinking and deprivation items, as well as with degree of pain and depression, and negative and significant correlations were found with Rye's thinking item and satisfaction with life.

Table 6. *Association between forgiveness variables and apology formats, satisfaction with life and health variables*

	1	2	3	4	5	6	7	8	9	10	11
1.-Forgiveness	1										
2.- Satisfaction with direct apology	.52**	1									
3.- Satisfaction with apology letter	.28	.68**	1								
4.- Rye's thinking	-.38**	-.38	-.36	1							
5.- Rye's deprivation	-.26**	-.34	-.30**	.41**	1						
6.- Rye's compassion	.22*	.33	.03	-.08	-.20*	1					
7.- Rye's good things[a]	.32**	.19	.19	-.04	-.07	.13	1				
8.- Degree of painfulness[a]	-.24**	-.09	-.22	.37**	.26**	-.11	.09	1			
9.- Rye's total forgiveness	.47**	.59**	.31**	-.61**	-.73**	.60**	.33**	-.31**	1		
10.- Satisfaction with life	.04	-0.9	-.01	-.17*	-.17	.06	.11	.02	.12	1	
11.- Depression	-.16	-.25	-.08	.26**	.24**	-.05	-.19*	.16	-.23**	-.58**	1
12.- Anxiety	-.16	.19	-.09	.29**	.20*	-.13	-.10	.18*	-.28**	-.41**	.64**

Note: ** Correlation is significant at the 0.01 level (2-tailed); * Correlation is significant at the 0.05 level (2-tailed); [a] Spearman correlation.

Study 2: The role of apology and forgiveness in second victims after a medical error

While conducting this study, the opportunity arose to offer the physician community the isolated results, referred to physicians (Martos et al., 2019). The full editorial can be found in annex 9.

Characteristics of the professionals

Descriptive analyses for all the variables, included in the study, can be found in table 7 and table 8. The final sample of 273 professionals was composed of physicians (29.7%), nurses (50.9%), health assistants (neither physician nor nurse) (12.1%) and others (7.3%) (e.g., medical students). They belonged to different units: medical unit (38.8%), surgical unit (13.6%), central unit (3.3%), and intensive-care unit (14.3%). The majority were women (75.8%). More than half of the healthcare professionals (56%) were between 30 and 51 years old, 32.2% were aged between 51 and 70, and 11.7% less than 30. Almost all the participants (92.7%) had more than 3 years of professional experience.

Table 7. *Means and standard deviations of the healthcare professionals' symptoms*

	N (%)	Mean	SD
Guilt	251 (91.9)	1.87	.85
Anxiety	244 (89.4)	1.41	.87
Insomnia	216 (79.1)	1.26	.83
Re-experiencing the event	232 (85.0)	1.32	.90
Tiredness	233 (85.3)	1.27	.84
Doubts about what to do and whether the decisions made were correct	237 (86.8)	1.14	.75
Feeling dazed/confusion/difficulty concentrating	238 (87.2)	1.10	.84
Sadness	236 (86.4)	1.00	.87
Anger at home	182 (66.7)	.86	.74
Anger at work	223 (81.7)	.78	.74
Doubts about the profession	227 (83.2)	.53	.69
Fear of loss of reputation among patients	209 (76.6)	.59	.75
Fear of loss of reputation among colleagues	230 (84.2)	.61	.71

Table 8. *Frequencies of need for forgiveness and occupationa impact items*

	Yes N(%)	No N(%)	No answer N(%)
I would like to know if the patient or family relatives have forgiven me	219 (80.2)	18 (6.6)	36 (13.2)
I learnt something positive from the experience of a PSI	230 (84.2)	13 (4.8)	30 (11)
Knowing the patient has forgiven me would make me feel better	215 (78.8)	34 (12.5)	24 (8.8)
I regret not having apologized personally to the patient or family relatives[a]	90 (33)	57 (20.9)	126 (46.2)
The professional involved or a colleague needed a transfer to another service after a PSI	21 (7.7)	199 (72.9)	53 (19.4)
The professional involved or a colleague needed time off after a PSI	26 (9.5)	195 (71.4)	52 (19)
The professional involved or a colleague abandoned the profession after a PSI	1 (.4)	231 (84.6)	41 (85)

[a]There was also the option to answer: "I did apologize" but the response rate was 0%

Main variables and profession

Most frequently reported symptoms were guilt, anxiety, feeling dazed/confusion/difficulty concentrating, doubts about what to do and whether the decisions made were correct, and sadness. Over 85% of the participants reported these symptoms, and every symptom included in the survey was reported by at least 66.7% of participants. Furthermore, those who reported symptoms most frequently reported suffered them almost always. No differences in gender were found on the measured variables (*p* values ranged between: .057 and .917).

Chi square tests of independence were performed to examine the relation between gender and need of forgiveness. No significant relation was found between these variables, χ^2 (3, N=273) = 1.96, p=.376. Chi-square tests of independence were also carried out to assess the relation between

profession and need for forgiveness. The results of the chi square tests, used to examine the association between profession and professional consequences, can be found in table 9. None of the relationships between these variables were significant, meaning that the need for forgiveness is independent from the profession. The relationship between profession and the need for time off after a PSI was significant, χ^2 (3, N=221) = 16.44, $p < .001$; assistants need more time off after a PSI than other health professionals. The relationship between profession and abandoning their career was also significant, χ^2 (3, N=232) = 12.70, $p < .001$; meaning that professionals, other than physicians, nurses and assistants, presented a higher rate of abandoning their profession (or knowing someone who did) than the remaining professions.

Association between symptoms and professional characteristics

Results from the different one-way ANOVAs to test the differences between symptoms according to professional groups are presented in table 10. There were significant profession-related effects on guilt [F(3, 247) = 7.38, $p < .001$], re-experiencing the event [F(3, 228) = 3.71, $p = .01$], and fear of loss of reputation among colleagues [F(3, 226) = 5.24, $p = .002$] for the four professions.

Table 9. Need for forgiveness and occupational consequences in healthcare professionals after a PSI

Need for forgiveness in healthcare professionals after a PSI		Profile of healthcare professionals N (%)					χ^2	df	p
		Physi-cians	Nurses	Assis-tants	Others	Total			
I would like to know if the patient or family relatives have forgiven me	No	4 (5.6)	10 (8.3)	2 (7.4)	2 (10.5)	18 (7.6)	.72	3	.87
	Yes	67 (94.4)	110 (91.7)	25 (92.6)	19 (89.5)	237 (92.4)			
I learnt something positive from the experience of a PSI	No	2 (2.7)	7 (5.7)	2 (7.7)	2 (10)	13 (5.3)	2.24	3	.52
	Yes	73 (97.3)	115 (94.3)	24 (92.3)	18 (90)	230 (94.7)			
Knowing the patient has forgiven me would make me feel better	No	13 (16.9)	14 (11.2)	4 (14.3)	3 (15.8)	34 (13.7)	1.40	3	.71
	Yes	64 (83.1)	111 (88.8)	24 (85.7)	16 (84.2)	215 (86.3)			
I regret not having apologyzed personally to the patient or family relatives	No	16 (45.7)	24 (31.6)	10 (43.5)	7 (53.8)	57 (38.8)	3.83	3	.28
	Yes	19 (54.3)	68.4 (76.0)	13 (56.6)	6 (46.2)	90 (61.2)			
Occupational consequences in healthcare professionals after a PSI									
The professional involved or a colleague needed a transfer to another service after a PSI	No	75 (96.2)	88 (87.1)	20 (83.3)	16 (94.1)	199 (90.5)	5.90	3	.12
	Yes	3 (3.8)	13 (12.9)	4 (16.7)	1 (5.9)	21 (9.5)			
The professional involved or a colleague needed time off after a PSI	No	74 (94.9)	89 (89)	17 (65.4)	15 (88.2)	195 (88.2)	16.44	3	.00
	Yes	4 (5.1)	11 (11)	9 (34.6)	2 (11.8)	26 (11.8)			
The professional involved or a colleague abandoned the profession after a PSI	No	78 (100)	112 (100)	25 (100)	16 (94.1)	231 (99.4)	12.7	3	.00
	Yes	0	0	0	1 (5.9)	1 (0.4)			

Table 10. Symptom scores by healthcare professionals

Symptoms	Healthcare professional Mean (SD)				F	df	*p*
	Physician	Nurse	Assistant	Others			
Guilt	1.88 (.77)	2.05 (.85)	1.42 (.92)	1.37 (.68)	7.38	3	.00
Anxiety	1.44 (.79)	1.44 (.93)	1.33 (.76)	1.16 (.96)	.69	3	.56
Insomnia	1.4 (.82)	1.25 (.84)	1.18 (.82)	.88 (.70)	1.97	3	.12
Re-experiencing the event	1.35 (.89)	1.44 (.90)	1.17 (.97)	.71 (.47)	3.71	3	.01
Tiredness	1.26 (.71)	1.35 (.88)	1.03 (.89)	1.22 (.90)	1.17	3	.32
Doubts about what to do and whether the decisions made are correct	1.19 (.65)	1.19 (.81)	.90 (.70)	1.00 (.79)	1.53	3	.20
Feeling dazed/confusion/difficulty concentrating	1.15 (.80)	1.00 (.85)	1.03 (.81)	1.12 (.99)	.45	3	.72
Sadness	1.05 (.81)	1.05 (.91)	.83 (.87)	.81 (.75)	.85	3	.47
Anger at home	1.00 (.69)	.816 (.69)	.85 (1.00)	.50 (.52)	2.18	3	.09
Anger at work	.90 (.70)	.74 (.76)	.75 (.84)	.56 (.62)	1.32	3	.27
Doubts about the profession	.57 (.71)	.60 (.74)	.30 (.47)	.28 (.46)	2.30	3	.08
Fear of loss of reputation among patients	.47 (.64)	.52 (.57)	.24 (.44)	.24 (.44)	1.73	3	.16
Fear of loss of reputation among colleagues	.46 (.63)	.78 (.78)	.52 (.57)	.24 (.44)	5.24	3	.00

Post-hoc analysis revealed significant differences between the various professions. Specifically, nurses experienced significantly more guilt than assistants ($p < .01$) and others ($p < .01$). Physicians had significant higher levels of guilt than assistants ($p = .04$). Regarding re-experiencing the event, physicians had higher scores than others ($p = .04$), and nurses had higher scores than others as well ($p < .01$). As for fear of loss of reputation among colleagues, nurses had higher fear levels than physicians ($p = .01$) and others ($p = .02$). Means and standard deviations can be seen in table 11.

Table 11. *Means and standard deviations of significant symptoms between professions*

Symptom	Profession	N	Mean	SD
Guilt	Physicians	78	1.88	.77
	Nurses	123	2.05	.85
	Assistants	31	1.42	.92
	Others	19	1.37	.68
	Total	251	1.87	.85
Re-experience the event	Physicians	72	1.35	.89
	Nurses	114	1.44	.90
	Assistants	29	1.17	.97
	Others	17	0.71	.47
	Total	232	1.32	.90
Fear of loss of reputation among colleagues	Physicians	72	0.57	.71
	Nurses	110	0.60	.74
	Assistants	27	0.03	.47
	Others	18	0.28	.46
	Total	227	0.53	0.69

Need for forgiveness and symptoms

Independent-samples t-tests were conducted to compare self-perceived scores of symptoms regarding the four questions of need for forgiveness after a PSI (table 12). Differences in the scores of guilt for regretting not having apologized (M=1.98, SD=.87) and not regretting not having apologized (M=1.62, SD=.84) conditions were found; $t(131) = -2.54$, $p = .02$. Significant differences in the scores of doubts about the profession and the question regarding having learnt something positive out of the experience of a PSI (M=.51, SD=.67) and not learning something positive out of the experience (M=1.09, SD=.94) conditions were also found; $t(209)=2.75$, $p=.00$.

Table 12. *Independent samples t-test comparing symptoms and forgiveness item*s

	I would like to know if the patient or family relatives have forgiven me				I learnt something positive from the experience of a Patient Safety Incident				Knowing the patient has forgiven me would make me feel better				I regret not having apologized personally to the patient or family relatives			
	Mean (SD)		t	*p*	Mean		t	*p*	Mean		t	*p*	Mean		t	*p*
Symptoms	Yes	No			Yes	No			Yes	No			Yes	No		
Guilt	1.89 (.86)	2 (.79)	.51	.61	1.90 (.86)	1.69 (.95)	-.83	.41	1.89 (.86)	.88 (.86)	-.09	.93	1.98 (.87)	1.62 (.84)	-2.32	.02
Anxiety	1.41 (.88)	1.71 (.77)	1.33	.18	1.43 (.86)	1.62 (.96)	.74	.46	1.45 (.89)	1.45 (.75)	.03	.98	1.46 (.86)	1.37 (.84)	-.59	.55
Insomnia	1.28 (.80)	1.37 (.88)	.45	.65	1.28 (.82)	1.44 (.88)	.61	.55	1.28 (.81)	1.41 (.87)	.84	.40	1.29 (.72)	1.08 (.78)	-1.52	.13
Re-experiencing the event	1.37 (.93)	1.44 (.81)	.30	.76	1.34 (.90)	1.59 (.79)	.93	.36	1.36 (.92)	1.38 (.83)	.09	.92	1.40 (.89)	1.18 (.82)	-1.45	.15
Tiredness	1.30 (.82)	1.19 (.75)	-.54	.60	1.29 (.81)	1.42 (.1.00)	.51	.61	1.31 (.83)	1.16 (.77)	-.96	.34	1.25 (.82)	1.31 (.85)	.36	.72
Doubts about what to do and whether the decisions made are correct	1.16 (.76)	1.24 (.83)	.38	.70	1.14 (.73)	1.50 (1.09)	1.12	.28	1.19 (.76)	1.00 (.66)	-1.46	.70	1.18 (.84)	1.14 (.64)	-.27	.79
Feeling dazed/confusion/difficulty concentrating	1.1 (.83)	1.19 (.83)	.40	.69	1.07 (.83)	1.27 (1.00)	.79	.43	1.09 (.83)	1.09 (.86)	.02	.99	1.12 (.84)	1.04 (.85)	-.50	.62

Sadness	1.02 (.86)	1.19 (1.05)	.73	.47	1.04 (.87)	.80 (1.03)	-.84	.40	1.03 (.88)	1.09 (.82)	.40	.69	1.13 (.85)	1.02 (.85)	-.73	.47
Anger at home	.90 (.75)	.67 (.78)	-1.07	.32	.86 (.73)	1.11 (.93)	.98	.33	.90 (.75)	.82 (.73)	-.47	.64	.87 (.78)	.84 (.69)	-.23	.82
Anger at work	.79 (.77)	.80 (.68)	.04	.97	.78 (.73)	.91 (.94)	.57	.57	.83 (.78)	.69 (.60)	-.75	.46	.69 (.74)	.76 (.75)	.48	.63
Doubts about the profession	.51 (.68)	.57 (.76)	.30	.76	.51 (.67)	1,09 (.94)	2.75	.00	.53 (.71)	.57 (.63)	.38	.15	.51 (.64)	.48 (.58)	-.24	.81
Reputation among patients	.60 (.73)	.91 (1.22)	.82	.43	.59 (.73)	.63 (1.19)	.08	.94	.60 (.72)	.67 (.96)	.43	.67	.56 (.74)	.63 (.75)	.50	.62
Reputation among colleagues	.62 (.71)	1.00 (.96)	1.79	.08	.57 (.68)	.91 (1.04)	1.06	.32	.62 (.71)	.70 (.76)	.59	.56	.64 (.72)	.61 (.67)	-.29	.77

Study 3: A deeper look into healthcare professionals' need for forgiveness and support after a patient safety incident

In the following, we present the emerging topics of the interview.

Conceptualization of the adverse event

The participants interviewed did not have a clear definition of what an adverse event is, the attempts were vague and unprecise. The different explanations given to make the error understandable had to do with absence of effective communication between colleagues during medical assistance, this communication seems to be unclear, non-precise, and leads to misunderstandings; procedure mistakes, related to failing to carry out the usual protocols (e.g., using the computer to register data, labeled syringes); the concatenation of different events, some of the participants referred to the error as being everybody's and nobody's fault at the same time; overload of things to do and excess of distress; the hour the erratic procedure takes place, due to the fact that, at some times, there is less staff, which may affect decision-making, and also the number of hours the professionals have been working previously. Also, there was lack of profound reflection on ethics and on owning the errors, which is expressed in all the interviews as the need to justify that we are all humans, and humans make errors, therefore errors exist.

One of the participants referred to the need to complete an information session, previous to the interventions, with a realistic and wide vision of the possible outcomes of the procedure.

> *"Before administrating medication, I always double-check. I have to say that I am quite a calm person and I try not to obsess with these things. I have a couple of colleagues who go through similar things and, sometimes, become obsessed. But I… well, there is an error, and errors exist and that's it, it's the way it works"*

Consequences of the error

The outcomes that the professionals faced, after the experience of an adverse event, affected them personally and professionally. In the personal area, participants expressed different emotional responses, such as frustration, fear, shame, anger, guilt, sadness and panic, because of the bad outcomes that may affect the patient. At a cognitive level, feeling worried, stupid, lonely and acknowledging the impact that erring had caused them, surfaced during the interview. One of the participants even took behavioral measures and called the day after the error, in order to know the medical status of the patient.

In a professional area, being more cautious the weeks after, avoiding cases that were similar to the one they erred in, and double-checking the decisions and actions taken, described the weeks after the error. Also, one participant announced that, if the error had caused major harm to the patient, she thought she would leave the profession.

> *"Especially when you finish the night shift, you are mentally burned-out, the truth is, you go to sleep, thinking about the whole issue. The truth is, it lasted long, in fact, the next day, I called to check if the child was okay and there was no problem. And I was more or less calm because she was okay, and that's it, medication was administered, and she went to the inpatient floor, and everything okay. But yes, it's true that you reconsider a lot, what impact could come from it, what could have happened. […] Yes, it was on our minds for several days"*

Coping with the medical error

A dilemma that came up throughout the interviews was: what errors should be communicated, all of them or only those that cause potential harm to the patient? The professionals justified the non-communication of their errors with the fact that there were no consequences for the patients and the situation was kept under control, though one of the participants highlighted a

general feeling that physicians cover each other's back. Participants agreed that, in the case there was some negative outcome for the patient, then they did express the need of the patient to be informed.

Who should carry out this communication, in case it was considered appropriate, implied two answers: those who considered that this communication should be carried out by the professional who erred, because of the trust that had been deposited in him; others preferred that another professional carried out this task.

A modulator of communicating the error was the previous experience of the professional when communicating. One of the participants shared a bad experience, in which she was shouted at and received negative compliments that even made her doubt her professionalism.

One of the first and main things all participants needed, in the aftermath of the medical error, was to share the experience, to talk about what had happened, to be able to analyze, understand and let go all the tension they had gone through when realizing they had been part of this unwanted outcome. Generally, they were comforted most when sharing with their peers, though they also talked to their partner, friends and supervisor. The participants referred to the need of contacting someone who had experience in the field and knew how to handle errors, who answered rapidly, provided action guidelines and emotional follow-up. In the medium-term after the medical error, participants also mention that a good option could be to count on professionals, such as coaches and psychologists, as an extra support.

> *"No, it wasn't disclosed. The child was okay and it was not necessary. One thing is that, if there had been consequences, then yes, it would have been commented, I think. "Look, this has happened", but in this case, since the child was okay and there were no consequences, it was not disclosed."*

Apprenticeship from the error

The professionals referred to the error as an opportunity to learn and to question their performance in the field. Some of the errors were described as plausible, such as medication confusion because of similar packaging or labeling. The experience, gained in the health field, modulated the probability of erring, due to the fact that early professionals tend to ask less questions when faced with a doubt than veteran professionals. This is linked to the stage of education, reached by the professional at the moment of the error. Medical residents tend to take higher risks than veterans who have seen more consequences of their own and their colleagues' actions, as well as more patients in general, with all the casuistry related. Also, these experienced professionals pointed out that residents are sometimes afraid to ask when they have doubts.

Regarding what can be learnt from the error, the participants also point out the importance of not being afraid of the error, but integrate it as human and, therefore, express the need to carry out the procedures in which a mistake has been made and gain more practice.

Some changes had already been made in the medical and nursing procedures, such as the obligation to report all errors and, therefore, be able to review them and change protocols if necessary; at present, all syringes in surgery must be labeled correctly; one of the professionals went back to carrying along his calculator and small notebook with medication doses.

> *"What solutions can be given at the time. And then, well, probably that it is disclosed and he/she will feel better, that it is disclosed to professionals, to the family, to whom it should be disclosed, the involved, and then, to apologize, yes."*

Forgiveness

The recommendation for the professionals who will face an error in the future, was to communicate to all the people involved and to apologize for the event. The need and desire for forgiveness was manifest in the testimonies. According to one of the participants, apologizing

consists in acknowledging the error, this generates a negative feeling and motivates you to ask for forgiveness, in order to be free from that discomfort.

None of the participants apologized for the error. Three out of five referred to the fact they lost track of the patient and/or relatives and, therefore, had no opportunity to apologize or even communicate about the error committed. Also, in three of the participants, the error had no consequences for the patient. The fourth participant said she was so affected by what had happened that she was not able to do anything anymore with that patient or family. She also thought that the family never really understood that an error had been made. Since then, when this patient goes to the hospital, she never wants to be the one treating him.

Other factors that modulated the presence –or not– of communication and apologies were the severity and consequences of what had happened, along with the moral duty to confess what had occurred. When there were no consequences, no communication took place.

When exploring benefits of feeling forgiven, one of the participants argued that for her everything would have been easier knowing she had been forgiven, but she would not have had enough time to process. Besides, she expressed that thinking on the patients relatives, if the mother of the child was capable of forgiving, this would mean she was in a very constructive stage of recovery and therefore the participant would be very happy for her.

> *"I think it depends on each person, but I think it's important to be able to say 'yes, I made a mistake', rather than someone else. I don't know exactly how they should carry it out, but I think it's important to apologize and for yourself […] if you go through one of these things and then, it can be a big burden, so being able to apologize and the family, well, in the end…"*

"I would apologize so that I can forgive myself, no longer looking for the other one to understand. […] So, I can say I have done everything in my hands, I have apologized, even though the other might not forgive."

"Thinking about how the mother is feeling. If a mother is capable of forgiving, it means she has carried out a personal process, working hard on her grief, and she's on a path of recovery. I would be very happy for her. She was able to transform her suffering into a constructive experience for her."

CHAPTER VIII

DISCUSSION

After gathering the results from all three studies, the fact that health organizations should support patients and professionals in the aftermath of a patient safety incident, by conducting encounters where both parties can express themselves and facilitate the conditions for forgiveness, emerges.

In the following sections, a specific discussion about each study's results is provided.

Study 1: The importance of an apology in forgiveness and patients' mental health after a medical error.

The first study was focused on the patients' experience after filing a complaint in the aftermath of a medical error. The procedure of our study to respond to the complaints, received in the hospital, involved sending a letter that included examining the medical procedure, a review of the assistance, an explanation of the point of view of the professional, giving information regarding questions or doubts the claimant may have stated, and also contained an apology to those patients or relatives who had filed a complaint. The only literature found, related to the impact an institutional letter has on the complainants is, described by Van Pelt (2008) in his personal experience, where the patient refers to the letter as uncompassionate and only making her feel angry, and Haroutunian et al. (2017), who analyzed factors, contributing to patients' complaints in the emergency department, where the answer of several institutions included an apology letter and an explanation, but whose impact was not studied. As such, this study is innovative, because it analyzed the impact of this letter and whether or not it facilitates forgiveness, and whether this forgiveness had an effect on the complainant's mental health. Therefore, the objective of this study was twofold: first, to determine whether an apology enables forgiveness from patients and family relatives after a medical error, and second, to study the impact of forgiving on patients' mental health in victims of a medical error.

Regarding the effect of apology on forgiveness, our results suggested that face-to-face apologies were more related to forgiveness than receiving a letter that included an apology. This is in line with Heaton et al. (2016), who pointed out that the professionals who do not feel confident enough to carry out a personal conversation or miss the opportunity to have this on-site meeting with the patient and/or their relatives, and end up choosing a written format, were generally poorly received, compared to those who had a face-to-face conversation.

Also, in the scenario in which the participants had received an apology letter, no significant differences in forgiveness were found between receiving a face-to-face apology or not. It seems that receiving an apology letter may interfere with the process of forgiveness, as pointed out by Van Pelt (2008). He experienced how a patient, who had gone through a medical error he caused, admitted that receiving an administrative letter had made her very angry. It is possible that an administrative letter, although it includes apologies, may be excessively protocolary and impersonal. It may even include sentences that might not be perceived as sincere – such as "we are sorry for what happened" – and that, according to Lazare (2006), do not acknowledge the existence of an offense and are not considered apologies. Therefore, they do not facilitate forgiveness.

In contrast, the results suggested the format of the apology was essential in triggering forgiveness, when a letter that included an apology had not been received. This live interaction offered more sources of information for both parties, such as non-verbal communication, though it is important to highlight the significance of carefully carrying out this communication, as seen by Hannawa et al. (2016). They reported that the way in which the professional communicated had an important influence on forgiveness. This communication must be held in an emotionally involved way. In addition, Hannawa (2019) found that adequate non-verbal communication that transmits true remorse is more important than saying the words "I'm sorry". Therefore, this entire use of communication, which goes in favor of forgiveness, is only feasible in face-to-face apologies. Furthermore, it seems that giving the opportunity to the patients or relatives to speak and listen to

the professional, makes an important difference, compared to only being able to read a paper, even though it includes an apology. This idea is also supported by Moore et al. (2019), who found that, after going through a medical injury, the possibility for the patient and/or family relatives to speak to the professionals made the offended feel truly listened to, as well as ensured that measures would be taken in order to avoid the same situation affecting another patient.

As for the association between forgiveness and mental health, the results obtained confirmed previous findings (Berry et al., 2001; Exline et al., 2000; Toussaint & Webb, 2005; Wilson et al., 2008). For instance, Freedman & Enright (1996) empirically demonstrated this in their study, regarding the role of forgiveness as a treatment for incest survivors. They found forgiving was related to psychological health. Specifically, they measured the relation between forgiveness and anxiety and depression, finding that those who forgave had lower rates of anxiety and depression. In our research, higher rates of Rye's total forgiveness score were associated to lower depression levels, as found by Toussaint et al. (2008) in their research, where they explored what dimensions of forgiveness could be associated with hopelessness and major depression in American adults.

Moreover, we found that those who had less satisfaction with life had high scores on Rye's thinking item. This item can be understood as rumination, a variable that, according to Fehr et al. (2010), activates a negative view of the offense. This activation might explain the lower life satisfaction outcome. The fact that forgiveness was not entirely related to life satisfaction, but only to one of Rye's items, goes in the line of the weak relations also found by Muñoz et al. (2003), who indicated that forgiving an offense did not result in high satisfaction. One of the reasons may be linked to the study's limitation, related to the fact that the order of the questions may influence the answers, and asking about life satisfaction in the last place may lead to more negative responses in general. It would be interesting to randomize the order of the items in the survey, and see if there is a higher relation between forgiveness and life satisfaction.

This study has several limitations. First of all, sample size is low, mainly because there is reluctance towards talking about these emotionally sensitive topics, and also because the access to the participants was not easy. Secondly, there is a bias that derives from the data gathered, due to the fact that we worked with memory (i.e., remembering having received a letter that included an apology or a face-to-face apology), instead of working with objective events. In addition, we were not able to gather data regarding mental health at the time the medical error occurred and the complaint was filed. Also, we are aware that there are several situations that may be impacting on the current mental health of the patient at the time the survey was answered. However, since literature points out that forgiving is related to mental health, we wanted to explore if this relation was also found also after a medical error. Therefore, we asked about mental health during the survey, being aware that mental health at the time of the medical error was not contemplated, though this would be interesting to do in future studies. Thirdly, due to the context in which the survey was carried out (telephone survey), time was limited in order to avoid drop-outs. This forced the use of single items and shorter versions of scales. Furthermore, there is a time lapse between the medical error, the submission of the complaint and the phone survey, which may reduce the probability of true accurate details of the events.

The findings of the study suggest that, maybe, the current procedure is not sufficient when supporting patients and/or family relatives after a medical error. Only receiving a letter that includes an apology seems to be not enough to comfort the patient or family relatives, in order to promote forgiveness. However, it has been found that the probability of facilitating forgiveness is increased by a face-to-face apology, which will eventually promote forgiveness with all its benefits.

Study 2: The role of apology and forgiveness in second victims after a medical error

The second study presented had the focus on the professionals' experience after the medical error. The aim of this study was to describe the symptoms that second victims suffer, to explore their need for forgiveness and the professional consequences of being involved in a PSI.

The study reported multiple subjective negative feelings in healthcare professionals in the aftermath of a patient safety incident, as previously highlighted by Vanhaecht et al. (2019). The results confirmed that guilt, anxiety, and stress are the main symptoms that appear in second victims at a high frequency (almost always), as previously reported (Busch et al., 2020; Von Arx et al., 2018). Guilt and anxiety were the most frequently identified emotions by the respondents, with striking figures of 90% of the participants who had been involved in a PSI. Specifically, the results indicated that nurses suffered significantly more from guilt when compared to assistants and the category of other professionals. Also, both physicians and nurses re-experienced the event significantly more than the category of other professionals, and fear of loss of reputation was significantly more acute in nurses than in physicians. This may be explained because of the blame-culture healthcare still has, as exposed by O'Connor et al. (2010). After a PSI, healthcare professionals face the predicament of being unable to change what has happened, and painful feelings emerge. Probably, they will always entertain the thought that they could have done something different and changed the outcome. Furthermore, a posttraumatic symptom, such as re-experiencing the event, was present in 85% of those who had been involved in a PSI, underlining the victimization-traumatizing effect, included in Scott's definition of second victim concept (Scott et al., 2010).

In contrast with previous studies that reported that women are more exposed to experimenting second victim symptoms than men (Mira, Carrillo, et al., 2015; Waterman et al., 2007), no difference in gender was found in the present study, which could be related to the overall high reported frequency of symptoms and the vast predominance of women in our sample.

Regarding the need for forgiveness after a patient safety incident, unprecedented results were found, due to the fact that there is no previous literature on the topic. There was a need for forgiveness among healthcare professionals, regardless of their profession. In fact, almost all the professionals reported they wanted to know if the patient or their relatives had forgiven them, and

that having this information would make them feel better. Furthermore, higher levels of guilt were found in those who regretted not having apologized. This is in line with the findings of Ingersoll-Dayton and Krause (2005) in elder people, who pointed out that being forgiven may alter the transgressors' self-evaluation into a more positive one, and thus contribute to their relief and to making them feel better. Being able to apologize may contribute to letting go of this guilt and changing their self-evaluation, though regretting not having apologized appears in half of the sample. This may be explained by several different elements, such as the fact that maybe communication was no longer established with the patient or their relatives after the incident, and there was no opportunity for such an apology for instance. This supports previous data, concerning the small number of disclosures performed, despite the existence of medical malpractice policies that encourage them (Giraldo et al., 2017). Other reasons for a lack of apologies included the existence of a punitive culture inside the organizations, where the focus is put on finding a responsible person for what has happened (Ferrús et al., 2016), and therefore the incident was not even communicated to the organization or the first victim; the fact that the professional became a second victim and was not able to perform any further steps with the patient or their relatives, this condition has already been reported by Coughlan et al. (2017), maybe even being involved in unhealthy coping behaviors that entail risks, as seen by Bohnen et al. (2019) in their research among surgeons; or maybe there is the perception that the professionals do not have to apologize or do not know how to, as Heaton et al. (2016) discuss in their non-legal arguments in favor of medical apology. At the same time, more fear of loss of reputation among colleagues appeared in those who did not apologize personally to the patient or family relatives. This could be explained by the fact that, maybe, the professional considered that, if they apologize, they are acknowledging the error, which they prefer not to face by not apologizing, in concordance with Lazare (2006), who points out that professionals sometimes do not apologize adequately by not acknowledging the offense.

Another important finding of the present study was that 97.3 % of the sample answered they learnt something positive from the experience, which goes in line with Ferrús et al. (2016), who also detected the profile of learning-oriented professionals who were second victims or colleagues of these second victims. In those who did not learn anything positive from the experience, more doubts about the profession were reported, suggesting that, maybe, they were not satisfied with their profession and, therefore, it was difficult for them to continue learning from their daily practice. Being able to draw lessons from the experience is crucial for the apology process, as also pointed out by Liukka et al. (2020) in their review, regarding actions that should be taken after an adverse event.

The present sample referred to less job-related consequences in general terms, when compared to the results of Mira, Carrillo et al. (2015), who found a third of the participants needed time off after the incident. Moreover, when comparing these consequences between the different professions, some significant differences were found. The professional category of assistants needs more time off than the rest of professionals, maybe because physicians, for instance, do not have time to pay attention to their needs, or directly initiate healthy – or sometimes unhealthy – coping strategies, as pointed out by Bohnen et al. (2019). As for those professionals who abandoned their profession, the present study only found that other professionals, who were not physicians, nurses and assistants, showed significantly higher rates of abandoning their career. This contrasts with the findings of Scott et al. (2010), who highlighted that 15% of their entire sample, which included physicians, medical students, nurses and allied health professionals, without differentiating by groups, abandoned the chosen profession after an incident. These findings also contrast with the results of Mira, Carrillo, et al. (2015), where they found that, in hospitals, nurses needed more time off work and were being transferred more often to different departments/units, when compared to physicians. A possible explanation for this has to do with the fact that, maybe, the category of others is less committed to the task of patient care and, therefore, it is easier for them to change

their professional career. Also, physicians, nurses and assistants may feel completely lost in finding a new vocation, and may also be suffering all their doubts and needs in silence (White et al., 2008). This is interesting for studies in the future.

Although the sample size is small and mono-centered, and survey biases apply to the results, the study underpins the importance of designing and implementing interventions that involve forgiveness when supporting healthcare professionals in the aftermath of a PSI. The results confirm the relevance of guilt as a prevailing emotion in this context, and provide new evidence, regarding the wish of professionals to apologize and to be forgiven.

Study 3: A deeper look into professionals' need for forgiveness and support after a PSI

The high number of answers, pointing out the need for forgiveness professionals had after a patient safety incident, led to the suitability of a third study. In this case, a qualitative one, in order to explore the feelings, consequences and the need for forgiveness that second victims have, and examine what support they receive and what they would need in the aftermath of an adverse event, in order to facilitate apologizing and, therefore, promote forgiveness.

One of the first things that stood out is the fact that the professionals did not have a clear and unified definition of what an adverse event was. If they do not clearly understand what an adverse event is, it is quite likely they do not really know what a second victim is either. Therefore, it might be convenient for them to receive training on the topic, and a good starting point may be an awareness campaign on these concepts, similar to what Scott et al. (2010) propose in their tier 1 For You program, or the awareness campaign Scott et al. (2009) promote, in order to reach an open dialogue regarding the definition and prevalence of second victims. Van Pelt (2008) shares a personal experience of being involved in an adverse event, and how helpless he felt in the aftermath, having to deal with his own emotions, not knowing exactly how, and having the feeling that no one had ever prepared him to face and cope with the situation. These feelings were

somehow shared by the participants in the current study, especially when it came to feeling lost and alone, with the need to receive help.

The personal consequences, expressed by the participants after a medical error, included a range of feelings, such as guilt, sadness, anger, going to bed worried, that could eventually affect sleeping quality. Some of these symptoms, amongst others, have been seen by Mira, Carrillo, et al. (2015) and Van Gerven, Deweer, et al., (2016). Responses, such as frustration, fear, shame, anger, guilt and sadness, because of the bad outcomes that may affect the patient, were also reported, as found by Seys, Wu, et al. (2012). This goes in concordance with what Ullström et al. (2013) found, when one third of their sample reported that work became more difficult because of the emotional reactions. Another group of symptoms were those that can be considered cognitive, this is, feeling worried, stupid, lonely and acknowledging the impact that erring had caused. These types of symptoms were named "personal emotional responses" by Van Gerven, Deweer, et al. (2016). One of the participants even took behavioral measures, and called the day after the error, in order to know the medical status of the patient. This might be an outcome of the anxiety and intense feeling of responsibility and guilt for the incident. The duration of the symptoms of those cases in which there were no consequences for the patient lasted a few days after the incident. This might be explained by the fact that the incidents did not cause severe harm to the patients, in contrast with the symptoms that lasted even more than six months in the study of Vanhaecht et al. (2019), especially in the cases where harm was severe.

As for professional consequences, the participants referred to the need of double-checking their actions and medication administration, and being more cautious during the weeks after the incident. This goes in line with the study of Martens et al. (2016), where almost half of the interviewed paid more attention to details and anticipated future incidents, as well as with what Christensen et al. (1992) reported as changes in procedures, such as modifications in diagnosis and the therapeutic approach the professionals adopt. These would be the positive consequences of

going through an adverse event. Also, two of the participants pointed out they avoided the patient, and similar patients, during the following weeks. This same behavior was found in the samples of Seys, Scott, et al., (2012) and Van Gerven, Deweer, et al., (2016).

In order to cope with all these consequences, all the interviewed agreed on the need for support. This was also found by the majority, interviewed in the study of Martens et al. (2016), regarding serious events within inpatient health care, and its impact on healthcare professionals. In fact, participants referred to their need to share their experience with colleagues, superiors, friends and partners. The need for training and protocols, in order to cope with the error at all levels, emerged from the interviews, especially the need for peer support training, which would provide an informal but yet structured first support, as pointed out by Kobe et al. (2019). Colleagues were indicated as the ones who provided positive support in first instance, as also found by Martens et al. (2016) and Harrison et al. (2015).

Therefore, once the professional was emotionally taken care of, there was a decision to make, whether to disclose or not the event to the patient and/or family relatives. This dilemma emerged from the interviews, and the findings went in favor of not disclosing all errors, but only the ones that were severe or caused severe damage to the patient. This differs from what Gallagher et al. (2003) found in the interviews they carried out, where generally, the answer to the decision of whether or not to disclose was yes, meaning, to always communicate what has happened, obviously, with some exceptions.

Regardless of this dilemma, the general recommendation participants gave for the procedure after a medical error was to disclose what had happened to all the parties involved and also to apologize. This goes in concordance with Wears and Wu (2002), who expressed that healthcare professionals must be able to speak to the patient and, when appropriate, to apologize. Furthermore, they also needed to know what can be done to prevent future tragedies. Who should carry out this communication in case of being considerated appropriate implied two answers, those

who considered that this communication should be carried out by the professional who erred, because of the trust that had been deposited in him; others preferred that another professional carried out this task. In fact, Massó Guijarro et al. (2009) stated that a good communication process will reduce psychological trauma and increase trust in the healthcare professional. The professional in charge of disclosing was studied by Jones et al. (2019), though they referred to team disclosures as the most appropriate disclosure, including the professional who erred. This is also related to what Hannawa (2019) found in her research, where the professional who erred was involved in the aftermath communication, but only half of the times. In contrast, other participants preferred disclosure to be carried out by another professional. Moreover, in one case, one professional expressed she was not able to do this, due to the degree in which she was affected by the event and her condition as second victim.

In the study sample, none of the participants apologized for the error. Three out of five referred to the fact they lost track of the patient and/or relatives and, therefore, had no opportunity to apologize or even communicate about the error committed. Also, in three of the participants, the error had no consequences for the patient, so disclosure was not considered. One participant said she was so affected by what had happened that she was no longer able to interact with that patient or family, in line with the results, gathered by Seys, Scott, et al. (2012). This professional also thought that the family never really understood that an error had been made. Since then, when this patient goes to the hospital, she never wants to be the one treating him.

One of the aims when apologizing is to receive forgiveness. The need and desire for forgiveness was manifest in the testimonies. According to one of the participants, apologizing consists in acknowledging the error, identical to what it includes for the participants of the study of Allan et al. (2015), who also added remorse and reparation. Moreover, the interviewed mentioned that this recognition of error leads to a negative feeling and motivates you to ask for forgiveness, in order to be free from that discomfort. This emotional release is also mentioned by Van Pelt (2008),

when he explained his experience with an incident, and Gallagher et al. (2003) link it to the support needed after a medical error that includes receiving forgiveness for the error from the patient, other healthcare professionals, and themselves. In fact, one of the participants expressed she would have wanted to apologize, in order to be able to forgive herself. This highlights the need for self-forgiveness to be considered when supporting second victims.

One of the barriers that the participants found when facing disclosure, was their previous experience when communicating. One of the participants shared a bad experience, in which she was shouted at and received negative compliments that even made her doubt her professionalism. This fits with the conclusion, drawn by Kable et al. (2018), where the emotional impact of the events on the families contributed to the trauma nurses experienced. This emotional response from the families may include bad reactions towards the professionals, involved in the incident. Another factor that modulated the presence or lack of communication and apologies, is the moral duty to confess what has occurred, which was already taken into account by Wu et al. (1997).

These professionals interviewed faced the need to talk about what they had gone through, in order to share, analyze and receive the correspondent feedback. This is similar to the findings of Gallagher et al. (2003), where physicians found it helpful to talk about their errors at morbidity & mortality conferences. Openly discussing the situation experienced with people from the ward also opens the opportunity for the professional to receive support from the organization. One of the barriers towards receiving this support is not knowing the available resources in their organizations, which is one of the things that occurred to the interviewed, similar to what had also been found by Gallagher et al., 2003; Hu et al., 2012; Joesten et al., 2015; and Scott et al., 2009. Data that also corroborate this were found by McCready and Russell (2009), where 65% of the participants did not know the resources they could have had access to, and only a minor sample (5%) answered they had information regarding the availability of support from the institution.

Moreover, the participants referred to the error as an opportunity to learn and to question their performance in the field. This is consistent with the approach of Eva (2009) and Robertson and Long (2018) towards the error, which is seen as a learning opportunity. Giving errors this positive connotation contributes to somehow embrace them and to keep improving. It is factual that some of the errors in the interviews were described as plausible, such as medication confusion because of similar packaging or labeling. Errors within labelling medication can be considered human factors that contribute to medication errors and be added to the list of Al-Ahmadi et al. (2020).

The experience, gained in the health field, modulated the probability of erring due to the fact that early professionals tend to ask less questions when faced with a doubt than veteran professionals. This is linked to the stage of education, reached by the professional at the moment of the error. Medical residents tend to take higher risks than veterans who have seen more consequences of their own and their colleagues' actions, as well as more patients in general, with all the casuistry related. Also, these experienced professionals pointed out that residents are sometimes afraid to ask when they have doubts, though it is important to take into account, as seen by Seys, Scott, et al. (2012), that they may also become second victims with all their consequences (Schiess et al., 2018).

Learning from the incidents has led the participants to include changes, such as relabeling syringes, in line with what is described by Christensen et al. (1992), and different modifications professionals carried out after erring. Also, the obligation to report the errors was noted by one of the participants, following Rassin et al. (2005). In contrast with what Goldberg et al. (2015) found, the participants interviewed did not need to disclose the error to the patient, though they all learnt from the error.

As informed previously, this is a pilot study. Consequently, there are several limitations, such as the low number of participants that did not allow saturating on the different emerging topics, and also the low number of emerging topics. Further research is encouraged to continue this

research line, in order to gather more information and to be able to generalize conclusions and establish support that includes forgiveness.

After discussing the different results, found in each of the studies, what is concluded is that patients and professionals could both benefit from forgiveness after suffering the different consequences patient safety incidents generate.

In order to include forgiveness as part of the support, offered to patients, it would be recommended to generate encounters between the parties involved. In these meetings, both patients and professionals would have the opportunity to express themselves and feel listened to. Also, the professionals would be able to answer possible questions that may have appeared, deriving from the incident, share what they learnt, and what measures will be taken to avoid recurrences, as well as apologize. This would meet patients' needs and, eventually, facilitate forgiveness. For the patients, being able to forgive would also be very restoring and contribute to their emotional recovery. These sessions should preferably be conducted by psychologists and mediators, who can create the necessary atmosphere to make everybody feel cared for.

Also, in those cases where this encounter between parties is not possible, it is recommendable to help and guide healthcare professionals through self-forgiveness as an internal process that will help them recover. This would help them reach an emotional condition, closer to well-being, that would promote psychological recovery and allow them to continue their professional practice with better emotional and mental health.

All these procedures should be carried out taking into account that different professionals need different support systems, and these should be adapted to each collective, and that special attention must be drawn to residents and healthcare practitioners in general, because of their special needs regarding training, and in order to make the most of their learning period.

CHAPTER IX

CONCLUSIONS

Conclusions from study 1: The importance of an apology in forgiveness and patients' mental health after a medical error

- *Conclusion 1.1:* In the aftermath of a patient safety incident, when responding to complaints regarding medical care, an apology letter does not enable forgiveness.
- *Conclusion 1.2.:* Including face-to-face apologies after a patient safety incident does enable forgiveness.
- *Conclusion 1.3:* Forgiving contributes to mental health in patients or relatives who filed a complaint after a patient safety incident, specifically, in lowering depression and anxiety.
- *Conclusion 1.4:* Forgiving contributes to higher life satisfaction in patients or relatives, after filing a complaint in the aftermath of a patient safety incident.

Conclusions from study 2: The role of apology and forgiveness in second victims after a medical error

- *Conclusion 2.1:* The most frequent symptoms in professionals of a tertiary hospital in Barcelona after a medical error were guilt, anxiety, feeling dazed/confused /difficulty concentrating, sadness, doubt about what to do and whether the decisions made were correct.
- *Conclusion 2.2.:* Second victims do express having need for forgiveness, and would want to know if the patient or their relatives have forgiven them. Knowing they have been forgiven would make them feel better. Also, they are capable of learning from the experience, and the analysis of medical errors helps to avoid future recurrences.

- *Conclusion 2.3:* The most repeated professional consequence that professionals suffer, after being involved in a patient safety incident, is the need for time off.

Conclusions from study 3: A deeper look into healthcare professionals' need for forgiveness and support after a patient safety incident

- *Conclusion 3.1.:* Second victims do not know what support they have access to, and those professionals, involved in medical errors without consequences, do not receive any support.
- *Conclusion 3.2.:* The first need professionals have after a medical error, has to do with communication. There is a need to share the experience with peers in the first place, especially colleagues who know how to handle errors. Also, some professionals refer to the need for psychologists as extra support.
- *Conclusion 3.3:* Professionals, involved in patient safety incidents, do not feel the need to offer apologies if the medical error did not lead to consequences for the patient, although there are emotional (e.g., frustration, fear, shame), cognitive (e.g., feeling worried, lonely) and behavioral (i.e., calling the day after the medical error to know how a patient is feeling) symptoms.
- *Conclusion 3.4:* One of the facilitators among second victims to offer apologies is the fact that the medical error has consequences for the patient. When errors have consequences for the patient, professionals are more likely to offer apologies.
- *Conclusion 3.5:* Medical errors are perceived by second victims as opportunities to learn and improve protocols, and make the professionals aware of the need to double-check procedures.

CHAPTER X

GENERAL CONSIDERATIONS AND FUTURE RESEARCH LINES

A patient safety incident is a situation that we can all go through; therefore, it is important to continue learning and improving procedures and protocols, as well as the support, offered to patients and professionals. In this case, the conclusions led to the idea that reinforcing apologies in disclosure and facilitating the achievement of forgiveness constitutes good support for both patients and professionals, affected by the patient safety incident.

In order to continue with this line of research, on the one hand, it would be very interesting to design and evaluate effective interventions that should be carried out in the aftermath of a patient safety incident that has consequences for the patient. These procedures could include encounters between patients and professionals, where apology is a core element of disclosure.

On the other hand, to continue exploring the need for forgiveness in second victims, and structure and evaluate support programs that fulfill this need, paying special attention to what tools are necessary to accomplish self-forgiveness.

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ANNEXES

ANNEX 1: LIST OF TERMS AND DEFINITIONS RELATED TO PATIENT SAFETY INCIDENTS

Table 13. *List of terms and references definitions related to patient safety incidents*[a]

Accident	1. An event that involves damage to a defined system that disrupts the ongoing or future output of the system. 2. An unintentional and/or unexpected event or occurrence that may result in injury or death. 3. An unplanned, unexpected, and undesired event, usually with an adverse consequence. 4. An event that involves damage to a defined system that disrupts the ongoing or future output of system. 5. An adverse outcome that was NOT caused by chance or fate
Adverse event	1.An injury that was caused by medical management or complication instead of the underlying disease and that resulted in prolonged hospitalization or disability at the time of discharge from medical care, or both. 2. An undesired patient outcome that may or may not be the result of an error. 3. An event or omission arising during clinical care and causing physical or psychological injury to a patient. 4. A negative consequence of care that results in unintended injury or illness which may or may not have been preventable. 5. An injury that was caused by medical management and that results in measurable disability. 6. An injury caused by medical management (rather than by the underlying disease) which prolongs hospitalization, produces a disability at the time of discharge, or both; AEs are caused by drug complications, wound infections, and technical complications, and those due to negligence [caused by] diagnostic mishaps, therapeutic mishaps, and events occurring in the emergency room. 7. An untoward, undesirable, and usually unanticipated event, such as death of a patient, an employee, or a visitor in a health care organization. Incidents such as patient falls or improper administration of medications are also considered adverse events even if there is no permanent effect on the patient. 8. Adverse events are untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical center, outpatient clinic, or other facility. Adverse events may result from acts of commission or omission.

	9. An undesirable event occurring in the course of medical care that produces a measurable change in patient status. 10. An event that results in unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient. 11. An injury resulting from a medical intervention and not due to the underlying condition of the patient. 12. An unexpected and undesired incident directly associated with the care or services provided to the patient. 13. An incident which results in harm to a patient
Adverse reaction	Unexpected harm resulting from a justified action where the correct process was followed for the context in which the event occurred.
Error	1. The failure of a planned action to be completed as intended or use of a wrong, inappropriate, or incorrect plan to achieve an aim. 2. The failure of planned actions to achieve their desired goal. 3. Deviation in a process of care that may or may not cause harm to patients. 4. An unintentional deviation from standard operating procedures or practice guidelines. 5. An act of commission or omission that caused, or contributed to the cause of, the unintended injury. 6. A generic term to encompass all those occasions in which a planned sequence of mental or physical activities fails to achieve its intended outcome. 7. Failure to carry out a planned action as intended or application of an incorrect plan.
Health care	1. Services of health care professionals and their agents that are addressed at (1) health promotion; (2) prevention of illness and injury; (3) monitoring of health; (4) maintenance of health; and (5) treatment of diseases, disorders, and injuries in order to obtain cure or, failing that, optimum comfort and function (quality of life). 2. Care provided to individuals or communities by agents of the health services or professions for the purpose of promoting, maintaining, monitoring, or restoring health. Health care is broader than, and not limited to, medical care, which implies therapeutic action by or under the supervision of a physician. 3. Services received by individuals or communities to promote, maintain, monitor or restore health.

Incident	1. Involves damage that is limited to parts of a unit, whether the failure disrupts the system or not. 2. Something that happened to the patient, a clinical outcome probably with harmful or potential harmful effects. 3. An event that represents a marked negative deviation from the "standard of care" that occurs in a health care facility; … incidents include major substitution of medications or leaving a patient unattended for a prolonged period of time. 4. An event in the hospital that does not comport with the standards of the hospital or that is unexpected and undesirable … An incident report is completed for each incident to assist in quality management and risk management. 5. An event or occurrence that is usually unexpected and undesirable. 6. An event or circumstance which could have, or did lead to unintended and/or unnecessary harm to a person, and/or a complaint, loss or damage. 7. Any deviation from usual medical care that causes an injury to the patient or poses a risk of harm. Includes errors, preventable adverse events, and hazards. 8. Events, processes, practices, or outcomes that are noteworthy by virtue of the hazards they create for, or the harms they case, patients.
Medical error	An adverse event or near miss that is preventable with the current state of medical knowledge.
Near miss	1. An event that almost happened or an event that did happen but no one knows about. If the person involved in the near miss does not come forward, no one may ever know it occurred. 2. A deviation from best practice in health care delivery that would have led to unwanted harm to the patient or to the mission of the organization, but was prevented through planned or unplanned actions. 3. An event or situation that could have resulted in an accident, injury or illness, but did not, either by chance or through timely intervention. 4. Any process variation which did not affect an outcome, but for which a recurrence carries a significant chance of a serious adverse outcome. 5. A situation in which a medical error could have resulted in an accident, injury, or illness, but did not, either by chance or through timely intervention. 6. An error of commission or omission that could have harmed the patient, but serious harm did not occur as a result of chance… prevention… or mitigation. 7. An event that could have resulted in unwanted consequences, but did not because either by chance or through timely intervention the event did not reach the patient. 8. Unexpected or unplanned events in the provision of care that could have, but did

	not, lead to harm, loss or damage. 9. An incident that did not cause harm.
Negligence	1. Failure to exercise the skill, care, and learning expected of a reasonably prudent health care provider. 2. Care provided failed to meet the standard of care reasonably expected of an average practitioner qualified to care for the patient in question,(SP-SQS 2005) or that fell below the standard expected of physicians in their community. 3. Failure to use such care as a reasonably prudent and careful person would use under similar circumstances. 4. The failure (usually on the part of a physician or other health care professional) to exercise ordinary, reasonable, usual, or expected care, prudence, or skill (that would usually or customarily be exercised by other reputable physicians treating similar patients) in the performance of a legally recognized duty, resulting in foreseeable harm, injury; or loss to another; negligence may be an act of omission (i.e., unintentional) or commission (i.e., intentional), characterized by inattention, recklessness, inadvertence, thoughtlessness, or wantonness; in health care, negligence implies a substandard deviation from the "standard of medical practice" that would be exercised by a similarly trained professional under similar circumstances.
Patient safety	1. The avoidance, prevention, and amelioration of adverse outcomes or injuries stemming from the processes of health care. These events include "errors," "deviations," and "accidents." Safety emerges from the interaction of the components of the system; it does not reside in a person, device, or department. Improving safety depends on learning how safety emerges from the interactions of the components. Patient safety is a subset of health care quality. 2. Freedom from accidental injury; ensuring patient safety involves the establishment of operational systems and processes that minimize the likelihood of errors and maximize the likelihood of intercepting them when they occur. 1 3. Actions undertaken by individuals and organizations to protect health care recipients from being harmed by the effects of health care services. 4. Freedom from accidental injuries during the course of medical care; activities to avoid, prevent, or correct adverse outcomes which may result from the delivery of health care. 5. The identification, analysis and management of patient-related risks and incidents, in order to make patient care safer and minimize harm to patients. 6. The reduction and mitigation of unsafe acts within the health-care system, as well as through the use of best practices shown to lead to optimal patient outcomes. 7. The prevention and mitigation of harm to patients.

	8. Freedom, for a patient, from unnecessary harm or potential harm associated with healthcare
Patient safety incident	An event or circumstance which could have resulted, or did result, in unnecessary harm to a patient. *--referred to as an incident*
Potential adverse event	1. A serious error or mishap that has the potential to cause an adverse event but fails to do so because of chance or because it is intercepted. 2. An incident in which an error was made but no harm occurred.
Preventable event	An event that could have been anticipated and prepared for, but that occurs because of an error or other system failure.
Safety incident	An event that, under slightly different circumstances, could have been an accident
Unpreventable adverse event	An adverse event resulting from a complication that cannot be prevented given the current state of knowledge

[a]Adapted form World Health Organization (2009)

ANNEX 2: ETHICS COMMITTEE APPROVAL

APROVACIÓ PROJECTE PEL CER/ APROBACIÓN PROYECTO POR EL CER

Codi de l'estudi / *Código del estudio*: CBAS-2018-19
Versió del protocol / *Versión del protocolo*: 1.0
Data de la versió / *Fecha de la versión*: 09/05/18
Títol / *Título*: Forgiveness assessment in communication between health professionals and patients.

Sant Cugat del Vallès, 24 d'octubre de 2018

Doctorand/o/a: Carla Martos Algarra
Director: María Fernández-Capo

Títol de l'estudi / *Título del estudio*: Forgiveness assessment in communication between health professionals and patients.

Benvolgut/da,

Valorat el projecte presentat, el CER de la Universitat Internacional de Catalunya, considera que, el contingut de la investigació, no implica cap inconvenient relacionat amb la dignitat humana, tracte ètic per als animals ni atempta contra el medi ambient, ni té implicacions econòmiques ni conflicte d'interessos, **però no s'han valorat els aspectes metodològics del projecte de recerca degut a que tal anàlisis correspon a d'altres instàncies.**

Per aquests motius, el Comitè d'Ètica de Recerca, RESOLT FAVORABLEMENT, emetre aquest CERTIFICAT D'APROVACIÓ, per que pugui ser presentat a les instàncies que així ho requereixin.

Em permeto recordar-li que si en el procés d'execució es produís algun canvi significatiu en els seus plantejaments, hauria de ser sotmès novament a la revisió i aprovació del CER.

Atentament,

Apreciado/a,

Valorado el proyecto presentado, el CER de la Universidad Internacional de Catalunya, considera que, el contenido de la investigación, no implica ningún inconveniente relacionado con la dignidad humana, trato ético para los animales, ni atenta contra el medio ambiente, ni tiene implicaciones económicas ni conflicto de intereses, ***pero no se han valorado aspectos metodológicos del proyecto de investigación debido a que tal análisis corresponde a otras instancias.***

Por estos motivos, el Comitè d'Ètica de Recerca, RESUELVE FAVORABLEMENTE, emitir este CERTIFICADO DE APROBACIÓN, para que pueda ser presentado a las instancias que así lo requieran.

Me permito recordarle que si el proceso de ejecución se produjera algún cambio significativo en sus planteamientos, debería ser sometido nuevamente a la revisión y aprobación del CER.

Atentamente,

Dr. Josep Argemí
President CER-UIC

ANNEX 3: SURVEY USED IN STUDY 1

PROTOCOLO

Le llamo del Servei d'Atenció al Ciutadà de *l'Hospital del Mar-Parc de Salut Mar*, Barcelona.

Usted o un familiar presentó/aron una reclamación porque percibieron que la asistencia sanitaria o el trato recibido por el equipo asistencial del hospital no fue el adecuado y queríamos saber cómo se encuentra en estos momentos.

De hecho, estamos iniciando un estudio con personas que han presentado una reclamación y así poder mejorar.

¿Tiene tiempo ahora para contestar a unas preguntas?

¿Me da permiso para hacerle unas preguntas relacionadas con la reclamación que presentó? Comprende que su participación es voluntaria y que puede retirarse del estudio:

1º Cuando quiera.

2º Sin dar explicaciones.

3º Sin que esto repercuta en su atención médica.

¿Da libremente su conformidad para participar en este estudio y mi consentimiento para el acceso y la utilización de sus datos en las condiciones detalladas. Así como a que esta conversación sea grabada?

SI /NO

1. ¿Quién presentó la reclamación?

Paciente	Familiar

2.- Sexo: Hombre o Mujer

3.- Nivel de estudios máximo completado (primarios, secundarios terciarios (universitarios y FP superior))

4.- ¿Quién cometió la ofensa?

1.- Profesional
2.- Servicio
3.-Institución
4.-Profesional y Servicio
5.- Profesional e institución
6.- Servicio e institución
7.- Todos

5.- Mida el grado de dolor o en qué medida le ha herido el daño u ofensa recibida, puntuando del 1 al 5, siendo 1 (poco daño) y 5(daño extremo).

6.- ¿Recuerda haber recibido una disculpa por lo ocurrido?

Sí	No

7.- Si la respuesta es sí ¿Quién recuerda que realizó la disculpa? (MÁS DE UNA RESPUESTA POSIBLE)

1.- Médico
2.- Enfermera
3.-Otro personal sanitaria
4.- Recibí una carta por parte de la institución
5.- No sabría decirle

8.- Puntúe la satisfacción con la disculpa de 0 a 5, siendo el 0 totalmente insatisfactoria y el 5 totalmente satisfactoria

9.- Si contestan que no o a la pregunta 7 contestan del 1 al 3 ¿Recuerda recibir una carta de disculpa por parte del hospital?

Sí	No

10.- Si la respuesta es sí, puntúe la satisfacción con la carta de 0 a 5, siendo el 0 totalmente insatisfactoria y el 5 totalmente satisfactoria.

11.- ¿En qué medida ha perdonado usted al ofensor? Indique del 0 al 5 el grado de perdón, siendo el 0 No he perdonado y el 5 He perdonado totalmente

A continuación hay 4 preguntas a las que me tiene que contestar del 0 al 5 siendo el 0 Muy en desacuerdo y el 5 muy de acuerdo:

13.- No puedo dejar de pensar en cómo fui dañado por esta persona /servicio/institución

14.- Deseo que le ocurran cosas buenas a la personas/servicio /institución que me dañó

15.- El daño que cometió esta persona/servicio/institución me ha privado de disfrutar de la vida

Inventario Breve de Síntomas (BSI-18) Derogatis, 2000

A continuación hay una lista de problemas que las personas tienen algunas veces. Por favor, lea atentamente cada uno de ellos y señale la alternativa de respuesta que mejor describa EN QUÉ MEDIDA ESE PROBLEMA LE HA MOLESTADO O CAUSADO MALESTAR DURANTE LOS ÚLTIMOS 7 DÍAS INCLUYENDO EL DIA DE HOY. Señale sólo una respuesta para cada problema y no deje ninguno sin contestar.

Las alternativas de respuesta son:

0= nada
1= un poco
2= moderadamente
3= bastante
4= mucho

EN QUE MEDIDA USTED HA TENIDO PROBLEMAS A CAUSA DE:

16.- No sentir interés por las cosas	0	1	2	3	4
17.- Nerviosismo o temblor	0	1	2	3	4
18.- Sentirse solo	0	1	2	3	4
19.- Sentirse tenso o alterado	0	1	2	3	4
20.- Sentimientos de tristeza	0	1	2	3	4
21.- Sentir que usted no vale nada	0	1	2	3	4
22.- Sentirse sin esperanza frente al futuro	0	1	2	3	4
23.- Sentirse tan inquieto que no puede permanecer sentado	0	1	2	3	4
24.- Pensamientos de poner fin a su vida	0	1	2	3	4

SWLS

A continuación hay cinco afirmaciones con las cuales usted puede estar de acuerdo o en desacuerdo. Lea cada una de ellas y después seleccione la respuesta que mejor describa en qué grado está de acuerdo o en desacuerdo, teniendo en cuenta que:

1. **Fuertemente en desacuerdo**
2. **En desacuerdo**
3. **Ligeramente en desacuerdo**
4. **Ni de acuerdo ni en desacuerdo**
5. **Ligeramente de acuerdo**
6. **De acuerdo**
7. **Fuertemente de acuerdo**

25	En la mayoría de los aspectos, mi vida se acerca a mi ideal	1	2	3	4	5	6	7
26	Las condiciones de mi vida son excelentes	1	2	3	4	5	6	7
27	Estoy completamente satisfecho/a con mi vida	1	2	3	4	5	6	7
28	Hasta ahora, he conseguido las cosas más importantes que quiero en la vida	1	2	3	4	5	6	7
29	Si pudiera vivir mi vida de nuevo, no cambiaría nada	1	2	3	4	5	6	7

GRACIAS POR SU PARTICIPACIÓN

ANNEX 4: SURVEY USED IN STUDY 2

Cuestionario para profesionales de hospital:

Edad	○ Hasta los 30 años ○ Entre 31 y 50 años ○ Entre 51 y 70 años
Sexo	○ Hombre ○ Mujer
Profesión	○ Médico ○ Enfermero/a ○ Auxiliar ○ Otro
Unidad o servicio	○ Médico ○ Quirúgico ○ Centrales ○ Otro
Años de experiencia profesional	○ Menos de 3 años ○ Entre 1 y 3 años ○ Más de 3 años

En el caso de que usted se haya visto involucrado en un evento adverso evitable con consecuencias graves, indique si ha observado los siguientes síntomas:	
1.- Revivir el suceso una y otra vez	○ Nunca ○ Alguna vez ○ Casi siempre ○ Siempre
2.- Ira y cambios de humor en el trabajo	○ Nunca ○ Alguna vez ○ Casi siempre ○ Siempre
3.- Ira y cambios de humor en casa	○ Nunca ○ Alguna vez ○ Casi siempre ○ Siempre
4.- Dudas constantes sobre lo que se tiene que hacer en cada caso y si las decisiones clínicas son correctas	○ Nunca ○ Alguna vez ○ Casi siempre ○ Siempre
5.-Pérdida de la reputación profesional entre los compañeros	○ Nunca ○ Alguna vez ○ Casi siempre ○ Siempre
6.- Pérdida de la reputación profesional entre los pacientes	○ Nunca ○ Alguna vez

	○ Casi siempre ○ Siempre
7.-Cuestionarse si continuar en la profesión o abandonarla	○ Nunca ○ Alguna vez ○ Casi siempre ○ Siempre

En el caso de que usted se haya visto involucrado en un evento adverso evitable con consecuencias graves, indique	
8.- Ha necesitado una baja laboral	○ Sí ○ No
9.- Ha solicitado traslado de servicio, unidad o centro de trabajo	○ Sí ○ No
10.- Ha abandonado la profesión	○ Sí ○ No

Preguntas de perdón

En el caso de que usted se haya visto involucrado en un error clínico, en qué medida	
11.- Le gustaría saber si el paciente (o sus familiares)lo han disculpado	○ Sí ○ No
12.- Saber que el paciente (o sus familiares) lo ha disculpado. Lo ayudaría a que se sintiera mejor	○ Sí ○ No
13.- Se arrepiente de no haberle pedido disculpas personalmente (en caso de no haberlo hecho) al paciente (o a sus familiares)	○ Sí ○ No ○ Sí que pedí disculpas
14.- Ha aprendido algo positivo de la experiencia de verme involucrado en un error clínico	○ Sí ○ No
15.- ¿Cuánto hace que cometió el error clínico? (Expresar en meses)	

ANNEX 5: SCREENING DOCUMENT STUDY 3

Para ver si es usted un candidato para realizar las entrevistas necesitaría que contestara a unas preguntas:

Nombre:
Sexo
Edad
Profesión, cargo, departamento en el hospital:
Tiempo de experiencia en su profesión:
¿En qué año se vio usted envuelto en un **evento adverso**?
Describa el **evento adverso**
¿Qué **daño** generó en el paciente el evento adverso? ● No hubo daño (e.g. se administró medicación errónea sin consecuencias) ● Daño menor (resuelto en un mes) (e.g. Se administró medicación que provocó alergia) ● Daño temporal (resuelto en un año) (No se realizó un correcto diagnóstico) ● Daño permanente (Se realizó la amputación de un miembro equivocado) ● Fallecimiento ● Desconocido
¿Usted diría que el evento adverso supuso un importante **impacto a nivel personal** o en su vida profesional? ¿Se considera segunda víctima?
¿Se **disculpó** usted por el evento adverso?
¿Quiere usted participar en una **entrevista** que explora la experiencia del profesional ante eventos adversos?

ANNEX 6: INFORMED CONSENT STUDY 3

Consentimiento informado

Me llamo Carla Martos y soy una investigadora de la Universitat Internacional de Catalunya. Dentro del marco del proyecto de segundas víctimas se propone realizar estas entrevistas en profundidad para conocer mejor la vivencia del perdón en las segundas víctimas.

Participando en esta entrevista usted está colaborando en la exploración del fenómeno de segundas víctimas, en concreto de la vivencia del perdón. Esta evidencia permite elaborar protocolos de actuación y proporcionar formación a los profesionales para la gestión y manejo de estas situaciones.

Se le realizarán preguntas relacionadas con el evento adverso que usted vivió y con la vivencia del perdón y la entrevista será grabada para su posterior transcripción y análisis

Los datos se tratarán con absoluta confidencialidad y de acuerdo Reglamento (UE) 2016/679 del Parlamento Europeo y del Consejo de 27 de abril de 2016 relativo a la protección de las personas físicas en lo que respecto al tratamiento de datos personales y a la libre circulación de estos datos, así como se especifica en nuestro país respecto a la protección de datos según la Ley Orgánica 3/2018, de 5 de diciembre, de Protección de Datos Personales y garantía de los derechos digitales.

Su identidad quedará siempre preservada y todos los datos que puedan identificarle se omitirán.

Muchas gracias

Carla Martos

Consentimiento Informado

Se me ha informado del estudio y su propósito.

He tenido la oportunidad de hacer preguntas sobre el estudio

He hablado con Carla Martos, quien me ha aclarado cualquier posible duda.

Comprendo que tengo libertad para retirarme del estudio en cualquier momento y sin necesidad de justificación y, sin que ello tenga consecuencias profesionales para mí.

Comprendo que la entrevista se enmarca dentro del estudio de investigación de las segundas víctimas del Hospital SJDD.

Comprendo que la información que he proporcionado será tratada con estricta confidencialidad y de acuerdo a la legislación vigente. Los datos obtenidos se utilizarán exclusivamente en el marco de investigación y siempre serán tratados de acorde a la legislación vigente.

Acepto libremente mi conformidad para participar en el estudio. Ante la presente información que la investigadora me ha otorgado, y habiendo entendido esta, ofrezco mi consentimiento a contestar preguntas relacionadas con mi experiencia como segunda víctima de eventos adversos y como profesional del centro SJDD y a que la entrevista sea realizada vía meet, grabada y transcrita para su posterior análisis.

Nombre profesional

Firma profesional

Fecha

Carla Martos

ANNEX 7: INTERVIEW USED IN STUDY 3

Presentación del entrevistado/a

1.- Demográficos

Sexo

Edad:

Profesión

Departamento en el hospital

2.- Hablemos del evento adverso (EA)….

Qué entiende usted por evento adverso

Explique qué paso…

Valorar impacto

¿Cómo fue la experiencia de lo sucedido?

Si lo tuvieras que describir el impacto en una palabra, ¿Cuál sería?

¿Cómo crees que se podría haber evitado?

¿Cómo le influyó al entorno?

¿Cómo estabas justo después del EA? ¿Puedes describir los sentimientos, emociones…?

3.- Manejo posterior de la situación. Aspectos emocionales

¿Qué síntomas tuviste tras el suceso? (Más a largo plazo) ¿Cuándo empezaron y hasta cuándo duraron? Poner ejemplos…

¿Con quién pudiste desahogarte? ¿Cómo de satisfactoria fue esta comunicación?

¿Qué tipo de apoyo recibiste (hospital, compañeros)?

¿Cuáles fueron las consecuencias laborales para ti tras lo sucedido? y ¿personales?

4.- Comunicación y Disculpas y perdón

¿Cómo fue la experiencia de comunicar al paciente/ familia lo sucedido?

Tal y como dijiste en el cribado, No pediste disculpas ¿podrías explicar por qué?*

¿Qué sensaciones te genera no haber pedido disculpas?

*¿Cómo fue la experiencia de querer pedir disculpas y no poderlo hacer?

¿Qué entiendes que es disculparse?

¿Qué entiendes por perdón?

¿Qué hubiera servido de facilitador para pedir disculpas?

¿Hasta qué punto te ayudaría saber si el paciente / familiares le han perdonado?

¿Cree que hay algún beneficio de sentirse perdonado?

Imagínese que el paciente/familiares lo han perdonado. ¿Qué cambios crees que habría en tu vida profesional?

¿Y personal?

-5.- Para finalizar

Tú que has pasado por esto,

- ¿Qué le dirías?
- ¿Qué recomendarías o crees que sería importante que hiciera alguien que vive un incidente?
- ¿Qué apoyo externo necesitaría una persona que vive un incidente?
- ¿Qué sería útil que el hospital ofreciera?

Me gustaría saber si querría compartir algún aprendizaje que haya podido extraer de esta situación

¿Alguna otra cosa que te gustaría añadir o comentar?

ANNEX 8: INTERVIEW TRANSCRIPTIONS

I= Interviewer

P= Participant

PARTICIPANT 1

- Physician specialist in pediatrics.
- 15 years of experience
- Adverse event in 2021
- No consequences
- Personal impact
- No apologies offered

I: ¿Qué entiendes por evento adverso (EA)?

P: ¿Qué entiendo por evento adverso? Pues una acción que puede tener una consecuencia nociva para el paciente, llegue o no al paciente.

I: En concreto, sobre el EA que viviste, ¿me podrías explicar qué ocurrió?

P: Sí. Mira, estábamos en una situación más o menos crítica con una niña a la que se le había diagnosticado una lesión cerebral y tenía una sintomatología compatible con una hipertensión intracraneal. Pauté una medicación, que es el suero hipertónico. La dosis a la que yo quería pautarle era 2ml por kg. La niña pesaba 12kg, creo. Y entonces lo que hice fue multiplicar 12 x 2=240. Como me pareció demasiado 240 y como teníamos preparado 200ml le administré 200ml, cuando le correspondían 24ml.

Y esto le acarreó a la niña una hipernatremia. Una elevación de los niveles de sodio en la sangre que se controlaron en los días siguientes

I: Ok, Si tuvieras que describir una situación de esas características, porque en el *screening* sí que aparecía que te había generado un impacto, ya sea a nivel personal o profesional, ¿Cómo sería ese impacto?

P: Me impactó en el sentido de que yo soy consciente de que todos podemos errar, pero también de la oportunidad de los errores. De hecho, parte de mi trabajo va en relación con el grupo de simulación. Pongo casos de simulación y trabajo con el error y además sé que es una cosa que puede ocurrir.

Pero que me ocurra precisamente a mí, que soy por decirlo de alguna manera el referente y el que más sabe o el que más conoce del trabajo en equipo y de la estabilización de un paciente crítico, que sepa que no tengo que hacer cálculo mental, que lo repito mil veces, que no te fíes del cálculo mental. Que utilices recursos, que busques las dosis, que reconfirmes. Pues esto sí que me impactó. Personalmente bastante y profesionalmente, pues bueno… menos, pero también.

I: ¿Si tuvieras que describir el impacto en una palabra, cuál sería?

P: Frustración sobre todo.

I: Ok, ¿Cómo crees que se podría haber evitado este EA?

P: El problema es que yo me conozco bastante y he trabajado bastante en estas cosas. Yo sé que el cálculo mental no es mi fuerte, que no me gusta calcular dosis de medicación. Coincidió que estaba trabajando con una enfermera que no era la más experimentada del servicio. En este contexto busqué a una enfermera más experimentada, intenté comunicarme de forma eficiente con ellas, pero al final hice lo que no tenía que hacer. Por una cuestión de comodidad dejé de llevar mi libro que contiene las dosis. Creo que si hubiera confirmado las dosis con el libro seguramente me hubiera dado cuenta de que era demasiada dosis y me hubiera sentado ante el ordenador.

No me senté frente al ordenador, porque además de por un problema informático la niña como paciente no estaba introducida en el sistema informático. Una cosa que llevábamos antes los pediatras era una calculadora para cuantificar las medicaciones. Ahora no la llevamos. Posiblemente, si hubiera hecho lo que hago habitualmente cuando pauto una medicación que es mirar la dosis y calcularla, seguramente no me hubiera equivocado.

I: O sea, en el fondo es seguir tu propio protocolo.

P: Sí, hacer lo que hago siempre. Hice una cosa que no hago siempre o que hago menos veces.

I: ¿Sabes explicar por qué ese día fue diferente?

P: Fue diferente en parte porque me dejé llevar, porque se supone que lo sé todo. Otro de los factores es no escuchar Me dejé llevar por las circunstancias. Esta paciente fue trasladada en ambulancia. El médico del SEM me hizo un comentario y aquél día no lo escuché, no lo interpreté.

A posteriori me di cuenta de que me estaba diciendo que le estaba poniendo una dosis demasiado alta a esa niña. Creo que me dejé llevar por la situación. Yo sabía lo que tenía la niña y sabía lo que tenía que hacer, pero puse el piloto automático y…

I: Ok. ¿Cómo crees que influyó esta adversidad en el entorno? ¿Había algún otro profesional involucrado? Me comentabas la existencia de un médico...

P: Sí, a ver. Este otro profesional estoy convencido de que pensó que la dosis era demasiado alta. Es una persona que pasaba por ahí, ¿vale? No he podido contactarla. He hablado con otra compañera mía que, de hecho, es la que luego transcribiendo la historia fue la que detectó el error. Ella en ese momento no se dio cuenta de la situación hasta que calculó y vio que era una dosis demasiado alta. Hablé con la enfermera, había dos.

La más experimentada señaló que le pareció que era una dosis demasiado alta, pero reconoció que no me lo dijo. Por su parte, a la enfermera menos experimentada se le pasó por alto la situación.

I: Y, ¿Cómo estabas justo después del EA?, si me puedes describir sentimientos, emociones…

P: Estaba frustrado, porque yo creo que… bueno, era un caso en el que estaba bastante claro lo que había que hacer. Me sentí como un estúpido, porque era una paciente que yo sabía que debía recibir una cirugía y que al final quien solucionaría su situación era la cirugía. Tenía miedo por si no se podía llevar a cabo esa operación y estaba avergonzado porque era una paciente que no iba a controlar yo. Yo no sería el responsable de bajarle el sodio, porque ingresaría en la unidad de cuidados intensivos. Y también me sentí triste.

I: Ok. ¿A largo plazo o a medio, largo plazo tuviste algún tipo de sintomatología?

P: No

I: Y ¿Con quién pudiste desahogarte o con quien compartiste esta experiencia?

P: Con varias personas. Fundamentalmente con tres: mi pareja, Vanesa y otra compañera.

I: ¿Cómo de satisfactoria fue esta comunicación con ellos?

P: Variable. Mi pareja, que es médico, seguramente le pondría un 6 o un 7 en una escala sobre 10. De hecho ella fue la que me aconsejó hablar con alguien de mi entorno laboral. Con Vanesa, "pues no sé, bien, normal". Quien más me ayudó fue la otra compañera de trabajo que tiene una visión más parecida a la mía. "Pero con todas bien".

I: Además de las personas que citas, ¿Hubo algún otro tipo de apoyo o soporte?

P: No. Bueno, intenté hablar con mi jefe. Con mi jefe, pero "no pasa res, tots ens equivoquem".

I: Con lo cual, entiendo con esto que no hubo consecuencias laborales.

P: No.

I: Respecto a la familia de la paciente, ¿Hubo comunicación?

P: No. Es otra de las cosas… Yo era consciente de la situación y no hablé con ellos. De hecho, ni los profesionales que la atendieron después tampoco comentaron el error a la familia.

I: Con lo cual, como ya comentabas en el cribado, tampoco hubo una disculpa y el motivo sería que como ya no hubo comunicación, ya no hubo disculpa.

P: Correcto. Creo que yo debería haber buscado el momento de comunicarlo.

I: Tienes la sensación de…

P: Creo que sí.

I: Entonces, ¿Hubieras querido pedir disculpas?

P: Sí.

I: La sensación que te queda al no haber podido pedir esas disculpas, ¿cuál fue?

P: Bueno, al final la cosa fue bien. La cirugía urgente fue bien. El sodio se controló sin mayores complicaciones. La niña no tuvo la enfermedad tan grave que pensábamos, pero la sensación fue que hicimos lo que hacemos siempre. La gente de fuera de la sanidad nos dice siempre que nos tapamos entre nosotros. Esa fue la sensación.

Afortunadamente todo fue bien, porque podía no haber ido bien. Seguramente en el momento en que pasó y como pasó no lo hubiera comunicado. Pero si hubiera sido yo el responsable de la paciente, pasado un tiempo, unas horas al menos, y viendo a la familia impactada sí lo hubiera hecho. Me llama la atención que no lo hicieran los compañeros de la UCI. Sí que me llama la atención.

I: ¿Cómo definirías la disculpa. Qué entiendes por disculparte o por pedir perdón?

P: Pedir perdón es por un lado asumir que te has equivocado, que has cometido un error y que esto no es gratuito ya que te genera un estrés, una preocupación, una sensación negativa y al final ese estadio solo lo vas a superar con el perdón.

En su esencia el perdón es un acto egoísta. Pides perdón porque te sientes mal y quieres sentirte mejor. La persona que tienes enfrente puede pensar: "entiendo que te has equivocado, que no estoy de acuerdo contigo, que has hecho una cosa que no está al nivel. Pero bueno, entiendo que no lo has hecho de mala fe, que es un error y que te sientes mal. Te perdono".

I: Ok. ¿Hasta qué punto te hubiera ayudado el saber que los familiares te hubieran perdonado?

P: Bueno, supongo que el que puedan comprenderte me hubiera evitado bastantes sensaciones negativas. Seguramente hubiera pasado vergüenza por pedir perdón para sacarme de encima otras sensaciones negativas como el sentimiento de culpa.

I: ¿Qué elementos hubieran facilitado el pedir disculpas? Entiendo que debería haber una comunicación.

P: La comunicación es fundamental para exponer lo que ha pasado. Seguramente a mí me hubiera ayudado que lo hubiera comunicado otra persona. Si la situación de la niña no hubiera sido tan preocupante y el entorno hubiera sido otro, posiblemente también hubiera facilitado el perdón.

Pero bueno, de hecho la evolución médica fue favorable, la niña acabó con un diagnóstico bueno, yo creo que si lo hubiéramos comunicado de forma natural hubiera surgido el perdón. También me hubiera sido más fácil pedir perdón si hubiera seguido en contacto con la familia. Pero al perder el contacto y tratarse de una intervención puntual…

De todas formas conseguí estabilizar a la niña, en pocos minutos estaba en la UCI, en pocas horas estaba en quirófano. La información que tiene la familia para bien o para mal es esta.

I: Si nos imaginamos que estos familiares te hubieran perdonado, te han perdonado por esto. ¿Qué cambios crees que habría en tu vida personal y profesional?.

P: Ahora mismo, yo creo que poco. En los siguientes días, sí. Especialmente en las siguientes semanas, porque me hubiera ayudado a bajar la situación de estrés. Pero entiendo que a largo plazo no hubiera habido cambios.

I: Para finalizar. Tú que conoces este hecho, ¿Qué le dirías a alguien que pase por una situación de evento adverso?

P: Primero tranquilidad. Hay que ver si se puede solucionar y de qué medios disponemos para hacerlo. Y luego recomendaría que lo comunique porque se sentirá mejor, que lo comunique a los profesionales, que lo comunique a la familia, que lo comunique a quien lo tenga que comunicar, que lo comunique a los implicados y luego que pida perdón, sí.

I: ¿Qué apoyo externo necesitaría una persona que vive un incidente de estas características? Porque cuando me hablabas de con quién te habías desahogado aparecía la pareja y dos profesionales, ¿pero consideras que necesitarías algún otro tipo de apoyo externo o con eso sería suficiente?

P: Depende, creo que hay que tener en cuenta si se alarga la situación y depende de la persona. Si es una situación que te va agobiando necesitas otras estrategias, yo creo. Quizás con un compañero o con un amigo, aunque te quedes corto, pero sí lo recomiendo incluso sin sufrir una situación estresante.

I: ¿Quizás sugerirías algún tipo de desahogo para rebajar los niveles de tensión en vuestra vida profesional en situaciones críticas?

P: Sí sí.

I: ¿Qué sería útil que ofreciera el hospital, ante un evento adverso o incidente?.

P: Lo primero que le pediría a mi institución cuando me enfrento a un evento adverso es que exista alguien que sepa cómo actuar, Cómo cuidarme en el primer momento. Yo soy pediatra de urgencias, ¿no?, esto es una urgencia. Porque si no tienes asistencia te pasas días y días hecho un desastre.

O sea, al menos alguien que haga una primera intervención. Y luego que no se juzgue, pero que tampoco te digan, "bueno nos equivocamos todos". Ya sé que nos equivocamos todos. Quizás cometemos errores y luego hemos aprendido, también ha aprendido el equipo y en dos días estamos bien; pero bueno, a veces necesitas un poquito más. Alguien que se interese por cómo vas después de lo sucedido. Pero, ¿es suficiente con que lo haga un compañero?, pues no lo sé.

Sí que podría haber un psicólogo que estuviera al tanto de estas situaciones, que parte de su cometido fuera esto. Que se comunicaran todos los incidentes, todos los eventos adversos. Existe un registro. Pues quizás en la institución tiene que haber alguien que te responda inmediatamente y luego alguien que sepa un poco, porque hacemos todos lo que podemos, pero que sepa un poco más y que se interese por cómo vamos. Si vamos bien, se cierra el caso, y si no es así se estudian los siguientes pasos.

I:¿Crees que este hecho te afectó laboralmente en los momentos posteriores o en los días siguientes?

P: En la primera semana o primeras semanas fui más cauta. Intento ser cauta. He recuperado mi librito. Sí que evité atender a algún tipo de paciente parecido a éste en las primeras dos semanas.

I: ¿Quieres compartir algún aprendizaje que hayas podido extraer de esta situación?.

P: Mira, he aprendido que tengo que hacer lo que hago siempre, como lo hago, y que cuando pongo el piloto automático al menos tengo que ser consciente de que estoy asumiendo unos riesgos. He aprendido que a pesar de que yo me buscara estrategias para que todo fuera bien, a veces no no es así y que mis estrategias igual no son las correctas y que quizás yo también tenga que pedir las cosas más explícitamente.

A raíz de todo esto se hizo un cambio en el manejo de estos pacientes. Los cambios no solo se dan en las personas…

I: ¿Alguna otra cosa que te gustaría añadir?

P: No.

I: Agradecer tu tiempo.

I= Interviewer
P= Participant

PARTICIPANT 2

- Physician specialist in pediatric anesthesia
- 17 years of experience
- Adverse event in 2017
- No consequences
- Personal impact
- No apologies offered

I: Lo primero que tendría que preguntarte es: ¿qué entendemos como evento adverso?

P: Pues un evento adverso es algo que le producimos al paciente, alguna situación que le provocamos al paciente, secundario al tratamiento que hemos pautado, o alguna técnica que hayamos hecho sobre él.

I: Y en concreto, en este evento adverso del que nos vamos a referir, ¿de qué año estamos hablando?

P: Pues mira, estaríamos hablando... si estamos en el 2021, pues hace más o menos 4 años, o sea que sería 2017 más o menos.

I: Cuenta por favor qué es lo que pasó.

P: Mira, para que lo entiendas un poco más, yo soy anestesióloga, y el evento ocurrió dentro del quirófano, era una cirugía abdominal, ¿vale? En estos pacientes para hacer analgesia, en el intraoperatorio y en el postoperatorio, lo que hacemos es pincharles una epidural, ¿de acuerdo?. Entonces, esta epidural se pincha cuando el paciente está despierto y luego la usamos para poner anestésico local y medicación en el intraoperatorio y en el postoperatorio. Pues durante el intraoperatorio, hubo un error de administración de medicación y en vez de ponerle anestésico local por la epidural, le pusimos otro fármaco que es un vasoconstrictor que se llama Efedrina, ¿vale? Evidentemente al paciente no le dijimos nada, este vaso puede hacer vasoconstricción, y claro, el catéter epidural, está en el espacio epidural y a veces está cerca de alguna raíz nerviosa, entonces si ponemos un vasoconstrictor, podíamos hacer daño a alguna raíz nerviosa, pero bueno, afortunadamente no pasó nada, y el paciente nunca supo nada porque no le pedimos disculpas.

I: Ok.

P: Estaba dormido.

I: ¿Y cómo te impactó este suceso?

P: Bueno, realmente yo soy la responsable y tengo residentes que están haciendo la residencia en el hospital y quien al final administró la medicación, porque yo le dije que pusiera más en este sitio local para que no tuviera dolor fue el residente, pero de hecho está a mi cargo y se equivocó de jeringa.

Como responsable sí que me siento mal, porque evidentemente no nos gusta que nos pasen eventos que puedan perjudicar o hacer daño al paciente, pero bueno, es lo que hay y hay que tener la cabeza fría. El residente estaba muy preocupado por si el paciente cuando se despertara tuviera algún tipo

de consecuencia a nivel neurológico, pero afortunadamente cuando se despertó el paciente no tenía nada. Realmente yo me siento responsable de todo, y sí que es verdad que desde ese día estoy muy obsesionada con que los residentes cojan la medicación que toca y siempre que tengan la jeringa en la mano, ¿qué es lo que tienes y qué es lo que has cogido? ¿Sabes?

I: Ok, porque ¿cómo crees que se podría haber evitado esta situación?

P: Bueno, realmente es porque las jeringas no estaban rotuladas. Normalmente, en el quirófano tenemos… supongo que a lo mejor en ese momento no tanto, pero tenemos mucha restricción con todas las jeringas y todas están rotuladas y llevan unas pegatinas con diferentes colores para que no nos equivoquemos ¿vale?. El tema de la seguridad está muy implantado sobre todo a nivel de los fármacos en el quirófano. Entonces, lo que administramos por la epidural siempre lo cargamos aparte y no hay etiquetas específicas, entonces, lo escribimos con un rotulador y ese día no estaba identificada y cogimos una por otra.

I: Ok, ¿Y cómo os disteis cuenta de que había un error?

P: Porque cuando ya estaba con la jeringa conectada con el sistema del catéter de la epidural, había administrado unos cuantos ml y lo giró, y vimos que ponía efedrina, en vez de poner la jeringa del anestésico local, pero ya estaba administrado el fármaco. Realmente es de los mismos ml y era bastante fácil equivocarse.

I: Ok, entonces a nivel de prevención, sería hacer lo que ya hacéis, solo que ese día por lo que sea no se hizo, que es lo de rotular todo…

P: Sí, en ese momento no estaba todo tan instaurado y hoy en día con el tema de la seguridad del paciente, el *checklist*, y sobretodo el error de administración de fármacos, han puesto mucho hincapié en eso, y sí que es verdad que está todo rotulado, las jeringas que llevan fármacos que son más peligrosos son de otro color. Lo tenemos un poquito más controlado, o lo intentamos.

I: Vale, ¿cómo describirías tus emociones, sensaciones, cuando te das cuenta de que ha sucedido esto?

P: Hombre, da rabia equivocarte sabes, pero realmente, es rabia e impotencia, porque da rabia equivocarse e impotencia porque en aquel momento el fármaco está administrado, está dentro de un espacio en el que no puedes acceder, y solo te queda esperar y pensar que ojala no pase nada.

I: Claro, hay una parte allí de tensión hasta que en este caso se despertara el paciente, imagino…

P: Sí. Sobretodo yo como responsable, porque al fin y al cabo soy la responsable, y la residente estaba muy muy preocupada, pero bueno…

I: Hay algún tipo de sensaciones, secuelas... bueno ahora, me decías que a día de hoy, sigues comprobando todo.

P: Siempre antes de administrar un fármaco hago como un doble check y miro. Yo tengo que decirte que soy una persona bastante tranquila e intento no obsesionarme con estas cosas. Tengo otros compañeros a quienes les pasan cosas parecidas y pierden a veces un poco el norte de la obsesión al final. Es un error, los errores existen y ya está, es así.

I: Cuando ocurrió, ¿pudiste compartirlo con alguien, desahogarte con alguien…?

P: Bueno, sí. Realmente tenemos esa tendencia entre nosotros y cuando nos pasan cosas adversas lo intentamos verbalizar y compartirlo entre todos. Es un poco un mecanismo de defensa que tenemos, porque luego siempre encuentras a alguien que te dice: "bueno pues a mi también me pasó lo mismo, o me ha pasado algo parecido…", y eso nos ayuda. Nosotras estuvimos toda la mañana juntas en el quirófano reflexionando: qué podíamos haber hecho, por qué ha pasado esto, qué tenemos que mejorar de cara al futuro… Y entonces pues bueno, supongo que esto también nos ayudó.

I: ¿Solo fue entre iguales como si dijéramos, o alguien más de otro tipo de cargo u otra persona…?

P: No, al final quedó entre nosotras y ya está. Y como luego el paciente se despertó y no tenía ningún tipo de secuela, no dijimos nada más. Evidentemente, si luego hay secuelas sí que hay que avisar a los superiores, pero en principio como no hubo un evento… o sea, sí que fue una administración adversa por un lugar que no tocaba, pero como luego no hubo un evento adverso físico a la paciente, pues no lo comunicamos a nadie más.

I: Vale, entonces en este caso, no se le comunicó al paciente ni se le pidió disculpas, ninguna de las dos. ¿Qué crees que hubiera tenido que ocurrir para haberlo comunicado al paciente?

P: Pues, el catéter epidural está en el espacio epidural que está alrededor de la médula, si este fármaco hubiera provocado algún tipo de problema neurológico como que la paciente no hubiera podido mover una pierna, o se quedara parapléjica o hubiera algún tipo de secuela neurológica, evidentemente se lo hubiéramos tenido que comunicar, que ha habido este evento, este error de administración y que ha pasado esto.

I: Estamos enfocados a entender el cuándo se disculpa. Cuándo no se disculpa en un caso así con esas secuelas, ¿habría algún tipo de disculpa hacia el paciente?

P: Depende un poco de la individualidad de cada caso y de cada persona. Si tu crees que el evento adverso es culpa tuya, o sea, por un error de administración, creo que el paciente se merece que se lo expliques. Luego, él tiene la opción personal de decidir qué hacer con eso. Pero creo que siempre una buena explicación ayuda a entenderlo todo siempre. Luego hay pacientes que reaccionan de una forma positiva y otros de forma negativa. Pero creo que si hubiera habido una secuela, bueno creo que yo se lo hubiera dicho.

I: Comunicar, no disculpar, ¿o también?

P: Se le hubiera comunicado, bueno, le hubiéramos explicado que ha habido un error de administración de fármaco, le hubiera explicado la realidad y que los errores existen y que sintiéndolo mucho nos ha pasado.

I: Vale, ¿pero no entra la parte como más de perdón, como más de disculpa y perdón?

P: Bueno sí, supongo que va todo un poco junto, comunicar el evento adverso y disculparse un poco por el error. Pero siempre partiendo de la base de que somos humanos y nos equivocamos, ya te digo que hay veces que hay pacientes que lo entienden y otros que no tanto, pero bueno.

I: Sí sí, luego ya el cómo cae eso es otra cosa. Y tú que has pasado por esto, ¿qué le dirías a un compañero que vive una situación como la que viviste?

P: Mira precisamente esta mañana en el cambio de guardia y ayer también pasó algo bastante grave aquí en la UCI y lo hemos estado hablando, porque esto es algo que nos pasa habitualmente. El caso

de ayer fue más grave porque acabó en fallecimiento del paciente, y yo creo que hay que reflexionar sobre la situación, analizar qué cosas hiciste bien, qué cosas hiciste mal y qué cosas se pueden mejorar. Y al final, el error no es solo de una persona y de una situación, siempre es una concatenación de cosas que pasan, que te llevan al error.

Creo que hay que ser consciente de que estas cosas pasan, intentar que no se vuelvan a repetir, mejorar las técnicas o lo que tu puedas controlar. Yo le he dicho esta mañana a otro residente, tienes que coger esa idea, cerrarla y guardarla como en una habitación y cerrar la puerta y no darle más vueltas, porque si no al final te vuelves un poco obsesivo ¿no?. Y no tenerle miedo a eso que ha pasado y te ha salido mal e intentar volverlo a repetir lo más rápido posible, si es una técnica como si dijéramos sabes…

I: ¿Para no cogerle miedo?

P: Para no cogerle miedo sí.

I: ¿Y crees que en casos en que igual hay una secuela, recibir el perdón de ese paciente o de los familiares, cambia algo la sensación que le queda al profesional o no?

P: ¿Recibir el perdón por parte de la familia, o sea, que la familia esté como agradecida?

I: Bueno, más que agradecida, es como, bueno ha pasado esto, yo que sé, no puedo mover una pierna, suponemos que es recuperable pero va a requerir de X cosas. "Mira nos hemos equivocado sin querer hemos puesto la medicación errónea, te ha generado esta secuela, lo siento, vamos ahora hacer todo lo posible por ayudarte a recuperar". Y que la opción por parte del paciente sea, ostras, primero shock, y luego decir, bueno todos nos podemos equivocar imagino que estáis bajo mucha presión, ¿qué puedo hacer ahora? Y vamos a seguir.

P: Hombre, siempre alivia un poco este sentimiento de culpa y de rabia que te da interno, claro. Si luego encima de eso te enfrentas a una familia que se enfada y que al final te acaba denunciando es bastante fatal eh…

I: Claro claro, estáis muy expuestos en vuestro día a día a eso, a todo un conjunto de factores de presión asistencial etc., que pone en riesgo de alguna forma…

P: Sí, mucho riesgo si. De hecho, he estado en mucho riesgo porque el año pasado fui a un juicio y delante del juez tuve que justificar una acción mía, otra historia claro.

I: ¿Y allí hubo algún tipo de disculpa, perdón por parte de la familia?

P: Uy no no no, la familia está muy enfadada, muchísimo. De hecho estoy acusada de homicidio imprudente. O sea, que… yo y unos cuantos más, no solo yo, pero muy muy enfadada, piensa que somos malos profesionales y que no debemos seguir trabajando, por algo que en el fondo no pasó, pero bueno…

I: Bueno aquí está la parte de diferenciar cuánto es tuyo, cuánto no… Y ¿qué apoyo externo necesitaría un profesional que vive un incidente quizás más tenso o más grave?

P: Hombre yo creo que hacer un poco de "coaching" y no sentirte solo es importante, y me pongo en la piel del residente que ha salido esta mañana que estaba bastante triste. Creo que recibir el consejo de los que somos más mayores y a los que nos han pasado muchas cosas también ayuda, y que tu te sientes mal porque quizás has hecho algo mal, y que sobretodo lo suyo ha tenido una consecuencia bastante grave, y que los mayores o los que tienen más experiencia te ayuden y te

digan, oye pues mira por aquí, mira por allá, creo que te ayuda. Luego también juega un papel tu carácter personal, ya que hay gente que es más obsesiva y que le da más vueltas a las cosas y entonces esto lo malinterpreta. Y otros que bueno, ha pasado esto, te vuelves un poco más cuidadoso con todo, a lo mejor durante una época eres como muy cuidadoso y luego te vas relajando otra vez, es así…

I: ¿Y el hospital tendría que ofrecer algo en particular?

P: No estaría mal que tuviéramos un poco de ayuda psicológica a veces. No estaría mal.

I: ¿Un poco de apoyo psicológico?

P: Sí, cuando pasan estos eventos adversos, por ejemplo. Yo me he visto involucrada en un evento adverso, bueno otra historia diferente, realmente. Esa familia me ha hecho casi "*mobbing"* a mí, me ha gritado fuera… Y al final, llegas al punto de pensar jolín pues a lo mejor tienen razón y sí que soy mala profesional, cuando no es verdad.

Esto si que estaría bien, en todo este proceso que hemos estado en comunicación con los abogados del hospital, que hemos llegado a una declaración delante del juez y tal, el apoyo, esa parte emocional que te tiene que ayudar a ti, o te la buscas tú personalmente, o realmente, es que incluso mi jefa suprema en ese momento tampoco me ayudó en absoluto, esto lo he tenido que gestionar yo toda sola...

I: ¿Mucha soledad entonces, no?

P: Sí, bueno yo porque lo comparto con todo el mundo, pero sí que es verdad que el proceso lo llevas tú sola. Al final, la que va a hablar con el juez eres tú, no viene nadie más contigo.

I: Ok. O sea, que quizás algún tipo de apoyo psicológico sería…

P: Sí, y creo que sí. Un poco como para… Porque da igual la experiencia o la edad que tengas, porque si realmente te pasa un evento adverso grave, muy grave, con consecuencia negativa para el paciente, esto te toca, te toca igual si llevas un año ejerciendo como si llevas 40.

I: Claro, bueno por eso somos humanos, porque erramos y porque también esto nos afecta.

P: Sí.

I: Bueno, ¿algún tipo de aprendizaje que puedas extraer de esta situación?

P: Bueno, lo que te decía, que antes de poner cualquier fármaco de la vena o de cualquier otro, porque claro nosotros pinchamos muchos catéteres por todas partes, entonces, no es lo mismo administrar un fármaco endovenoso, también canalizamos arterias que por allí no se pueden poner fármacos y también tenemos muchos catéteres periféricos que tampoco se pueden poner ciertas cosas, o a veces es al revés, las cosas que van por los catéteres que son anestésicos locales, hay gente que las pone endovenosa, y esto es tóxico y el paciente puede morir. Es verdad que hay que ser muy cuidadoso. Antes de poner cualquier fármaco lo vuelvo a mirar dos veces, es algo como un doble "*check"*, hago un doble "*check"* antes de ponérselo.

I: ¿Alguna otra cosa que te gustaría añadir o comentar?

P: Bueno no sé, la gente tiene que entender que el error es humano, lo que pasa es que la sociedad está acostumbrada un poco al resultado, está muy informada y no admiten las malas consecuencias,

todo el mundo está como acostumbrado al éxito 100%, y esto no existe, como a la inmediatez y a que todo salga perfecto. Entonces, creo que eso ahí falla. Yo por lo menos con los pacientes que visitamos, y que nosotros nos encargamos de hacer el preoperatorio ante una cirugía a veces muy compleja, soy a veces un poco "mala", y les explico todas las cosas que pueden pasar. Pero es que por ejemplo, los cirujanos a veces son bastante benévolos, y explican: "no, usted se operará, estará dos días en la UCI, y se irá a su casa", y es mentira muchas veces, porque las cosas se complican y acaban mal. Entonces cuando ellos no tienen esa información previa, luego si pasa un evento adverso, no lo gestionan. En cambio, si tú le has explicado al paciente que pueden ocurrir complicaciones la familia y el mismo paciente están mucho más preparados para afrontar todo eso.

I: La información al final ¿no?

P: La información es básica. Creo que ese vínculo que establecemos con ellos de explicarles lo que va a pasar y las posibles cosas que pueden pasar es súper importante.

I: Muchísimas gracias por tu tiempo y por compartir. Te dejo con tu guardia, que espero que esté siendo leve.

P: Sí, más o menos. De hecho yo hice la tesis doctoral sobre los eventos adversos, bueno sobre las denuncias que habían recibido los anestesistas durante más o menos 15 años y estoy muy sensibilizada con todo esto.

I: Ok, pues ya buscaré.

P: Bueno no sé si te interesará, pero está bien la verdad. Si necesitas cualquier cosa me dices. Espero que te haya servido.

I: Muchas gracias, que tengas buena tarde.

I= Interviewer
P= Participant

PARTICIPANT 3
- Pediatric nurse
- 15 years of experience
- Adverse event in 2021
- No consequences
- Personal impact
- No apologies offered

I: Y eres… la profesión, cuál sería la categoría…

P: Enfermera pediátrica, bueno sí, tengo la especialidad, así que sería enfermera especialista en pediatría.

I: Fenomenal, y a nivel de responsabilidad, ¿formas parte de un equipo?

P: Sí sí. Bueno el equipo digamos de enfermera de urgencias, estoy en turno noche. Somos un equipo de enfermeras auxiliares y digamos que urgencias está repartido entre los niveles doses y treses, evolución… y luego lo que son niveles tipo CAP, que se vería un nivel cuatro o cinco, por triaje digamos. También existe la figura de coordinadora de la noche, que se va turnando entre todo el equipo… es un poco la que coordina todo, toda la noche, los ingresos… bueno que hay una persona que coordina todo el trabajo. En las urgencias de San Juan de Dios nos organizamos así. Hay un equipo en el que hay una persona de cada turno y quedamos cada X tiempo para organizar las urgencias de la mejor manera. Cada noche hay dos enfermeras que se encargan de lo que es el pasillo de las cosas más urgentes. De los niveles 1, 2,3 que son las que se encargan más del paciente crítico digamos. Y luego, pues las otras enfermeras, dependiendo de cómo está la situación dan un soporte a estos pacientes que están más graves. Depende un poco de la noche que tengas, porque a veces se montan unos follones brutales…

Pero bueno, la verdad es que tenemos un equipo que llevamos ya muchos años, aunque también hay gente muy nueva, pero nos organizamos bastante bien. Esto es súper importante también, porque depende de con quien trabajas tienes más soporte o no. Entonces pues eso, nos organizamos un poco así, evolución, equipo 1, 2 tal… entonces hay la figura de la coordinadora y la que está en triaje digamos. Bueno no sé, a modo de resumen eh. Y aparte pues está la supervisora que en cualquier momento puedes llamarla. Pero de categoría somos todas enfermeras y luego la figura de la coordinadora de urgencias, que va rotando a diario, para que no recaiga toda la responsabilidad sobre la misma persona.

I: Claro, bueno también así, ¿tiene esta parte un poco dinámica no? Que no te toca siempre lo mismo.

P: Exacto, bueno sí, nos lo vamos combinando un poco para que no sea siempre la misma figura de paciente crítico, porque al final, acabas pffff!!

I: Claro, ¿es un desgaste, no?

P: Sí sí, porque aparte de todo esto, pues claro, nos vienen las ambulancias, el paciente que convulsiona y entra dentro, desde triaje que te están llamando que tiene un debut diabético, el niño oncológico que también pasa, quieras o no, todo esto es…

I: Sí sí, intensito.

P: Es intenso sí, por eso te digo, que según qué noche… Por eso el tema que te puse lo vi importante porque hay mucho problema de comunicación a veces en momentos así muy estresantes, sobretodo la comunicación de órdenes verbales, que se comenta, se deja como en el aire, tú te piensas que tu compañera lo ha oído, o… el otro confía que lo has oído tú… Claro esto puede causar mucho error, y me pareció interesante ponerlo, porque puede crear un problema y que el paciente al final no acabe con la medicación adecuada o con aquello que se tiene que hacer en ese momento.

I: Claro, porque ¿Cómo definirías un evento adverso?

P: Evento adverso te refieres a… ¿que hubiera un problema no?

I: Claro, tú cómo lo entiendes, qué sería para ti una definición de evento adverso, un problema…

P: Yo lo definiría como… A ver cómo te lo explicaría… Pues que a veces puede haber muchos eventos adversos, por problemas de comunicación. En urgencias trabajamos en equipo y cualquier problema o duda que tengas sobre una medicación puedes preguntar, pero a veces si tus compañeros también están ocupados por no molestar igual te arriesgas a… y resulta que hay un problema, es que puede haber tantas cosas… En momentos de mucho estrés o trabajo tienes que estar muy concentrado en lo que estás haciendo. Además se amontonan las peticiones, que si el médico del paciente del 7 necesita *això*, y cuando vas allí, el otro necesita una vía urgente...y hay tantos problemas… en un momento determinado puedes tener tres millones de cosas en la cabeza y decimos: "bueno vamos a priorizar…puedes tener cuatro o cinco órdenes a la vez y claro, tienes que priorizar, tienes que desarrollar y a veces son muchos… es el problema de ya. No, no es que ¡eso es urgente ya!

I: Inmediatez.

P: Sí, es complicado eh… A veces, básicamente es priorizar y luego estar segura de lo que estás haciendo y si no pues preguntar o decir, *un moment*. El problema muchas veces es decir *un moment* vamos a pensar y a hacer las cosas bien, priorizar y sobretodo pues eso, no equivocarte y ser consciente de lo que estás haciendo. En un servicio de urgencias, puede haber, pf....

I: ¿Muchas oportunidades de error…?

P: Eso, vas aprendiendo. Al final aprendes a priorizar a decir *un moment*, esta medicación no la he preparado nunca, vamos a leerlo o si necesitas ayuda poder decir ven un momento y lo hacemos entre las dos a ver si tú lo ves igual que yo o a lo mejor… Muchas veces también los residentes más nuevos igual te ponen una medicación que dices, ostras pues igual esto no me cuadra. Pero claro, todo esto lo hace la experiencia, igual si tu estas a tope y acabas de empezar no dudas tanto. El otro día lo hablábamos con unas compañeras y es verdad que al principio tú no eres tan prudente. O sea al final, al cabo de los años, te vas dando cuenta de que tienes como más miedo a las cosas, eres más prudente, más "*bueno, un moment no?*", esto no lo veo claro o voy a preguntarlo…

I: Incluso, ¿al final de tu jornada laboral, no? Que al final no es lo mismo cuando entras que cuando sales.

P: Exacto, para nada, para nada! Que estás más fresco, que tal, que vas haciendo y sobretodo por la noche lo ves, que a las 7 de la mañana no tienes la cabeza tampoco tan clara, entonces por eso, yo veo mil.

I: Mil oportunidades no? Entre comillas, mil huecos ahí…

P: Sí sí, eso sí que es verdad, conforme va pasando el tiempo, y la experiencia que tu tienes y tal, tienes como más miedo a las cosas, eres como más prudente, porque has visto muchas cosas que pueden pasar, ya sea que te han pasado a ti o a compañeros o que te han explicado, entonces es como que eres más prudente porque ves un montón de cosas que dices, ostras, puede pasar.

I: Eres más consciente del peligro.

P: Exacto, eres más consciente del peligro. Y fíjate que en pediatría yo creo que igual, porque lo miraba mi carrera profesional digamos y dices ostras realmente vamos con mucho cuidado, sobre todo con las medicaciones, las enfermeras somos como muy conscientes del riesgo y realmente tú lo revisas. A ver que también depende de cómo seas, pero es una cosa que yo creo que hay equivocaciones, pero bueno que te lo miras tanto que eres como más consciente de las cosas del niño. Bueno, menos mal, de alguna manera eres como más consciente de todo lo que puede pasar y se pregunta mucho por lo que creo que eso es un punto a favor.

I: ¿De la experiencia, no?

P: Sí, sí, sí…

I: Incluso las y los enfermeros que empiezan, están en mayor riesgo de errar.

P: Sí, totalmente, por eso siempre les decimos, mucho cuidado, cualquier cosa que no sepáis preguntarlo, no pongáis cosas que no sabéis. En esto sí que somos muy (gesto de que lo llevan a rajatabla).

I: Para que se conciencien ellos también.

P: Sí, porque no es lo mismo un niño que te pesa 3 kg a uno que te pesa 15. Claro, entonces el volumen de líquido o las medicaciones… Claro, no es lo mismo. Entonces hay muchísimas cosas que vas aprendiendo y al final es lo que les quieres transmitir, el hecho de decir "*bueno oju*" porque es difícil. O bueno, sobretodo en críticos, cuando viene un paro, claro, hay mucha gente, muchas órdenes, y entonces es complicado. Y a parte, claro, ves con cuidado para que no te equivoques.

Creo que la gente es muy consciente de dónde está y que te puedes equivocar muy fácilmente. Bueno no sé si te he contestado un poco la pregunta.

I: Sí, es esta parte de alerta, es esto un poco lo que se respira en vuestra unidad ¿no?

P: Sí, exacto, es urgencias, entonces tienes muchos frentes abiertos, en un momento te pueden surgir un montón de cosas y que todo sea urgente y tienes que hacerlo. O sea, que no es fácil.

I: Claro, y en concreto, no sé si puedes explicar este evento al que tú hacías referencia, si lo puedes explicar, por favor.

P: Sí, fue una noche en la que también teníamos mucho follón y yo llevaba a un niño que era oncológico que nos vino fatal, con fiebre, muy decaído, bueno, estaba muy "chocado" digamos. Y luego vino otra niña que nos vino derivada de otro hospital que era un PIMS, que son niños que

tienen proceso multisistémico por el covid, ¿vale?. Es decir, son niños que tuvieron el covid, y pasados 3-4 meses, desarrollan un proceso multisistémico de todos los órganos que provocan como una inflamación. Era una niña que también venía con tensiones muy bajas… Al principio se pensaba que era una posible sepsis y tuvimos que correr un poco. La historia fue que también teníamos que pasarle los antibióticos… Y fue complicado porque también tuvimos problemas con el *portacat*. Bueno, fue como un poco...al final bien eh, pero claro, yo llevaba dos pacientes críticos, en niveles 2 y 3. Y justamente estos dos eran míos. Mi compañera me comentó: bueno no te preocupes, quédate tú con el oncológico… También por todo el tema covid, si llevo el oncológico, intentas llevar más cuidado por tema de prevención. Entonces me dijo eso, quédate tú con el oncológico, que yo me quedo el PIMS y vamos siguiendo la medicación. Yo estaba preparando cosas y de repente el médico dijo, "ostia, hay que ponerle la heparina subcutánea". Fue una orden verbal que yo sí que oí, pero mi compañera no, entonces le dije, vale no te preocupes. Digamos que mi compañera me dijo no te preocupes que yo iré siguiendo todo lo que pone en el programa (bueno tenemos como varios programas, está uno donde nos van poniendo las administraciones de las medicaciones y luego está el *Sabac*, que se utiliza cuando un paciente ya sigue las medicaciones que hay que ir poniéndole durante un tiempo.

Entonces mi compañera me dijo, "no te preocupes que ya iré mirando lo de las medicaciones" y se me olvidó decirle sobre todo lo de la heparina, porque estaba liada con el paciente oncológico. El médico dio por supuesto que estaba puesto y resulta que el médico tampoco lo puso para urgente, sino que lo puso para las 9:00 de la mañana. Fueron varias circunstancias en un momento determinado que por X… Bueno, al final no tuvo consecuencias pero las podía haber tenido. Porque fue una orden verbal que yo sí que escuché y mi compañera no, al final nos dividimos el trabajo y ella llevaba a aquél y yo llevaba al otro, y que mi compañera para hacerme un favor… yo tampoco caí y no le pregunté: ostras, ¿has oído lo de la heparina? Y el médico dio por supuesto que nosotras lo habíamos puesto. En principio todo bien, no tuvo consecuencias, pero fue a las 08:00 de la mañana cuando pasamos el parte nos dimos cuenta de que la heparina no estaba puesta. Porque él dijo, la heparina… y su compañera le dijo, no, la heparina "*jo no la he posat*". A pues yo sí que lo oí. Y vimos que en el *Sabac*, estaba pautado a las 09:00 de la mañana. Fue un cúmulo de cosas y piensas ostras qué mala suerte también… y el médico dijo: ostras pues es verdad, la verdad es que lo tendría que haber puesto bien, ponerlo como urgente, y no habría salido a las 09:00 de la mañana… O sea, que al final estuvimos hablando entre todos y coincidimos en que esa orden no debería haber sido en modo verbal, sino que debería haber sido pautada y preguntarle a la enfermera "*qui s'encarregarà d'aquest pacient*" bueno, pues tal persona, y entonces dar la orden verbal y aparte pautar la medicación como urgente, porque él además tampoco se dio cuenta de que no lo había pautado bien. Fue un cúmulo de cosas, que por A o por B, esa medicación no se puso. Y sí que lo estuvimos hablando entre todos y sí que dijimos, ostras, pues porque claro él decía yo te veía a ti que también ibas de culo, porque tú ya llevabas el paciente oncológico que requería también el ya. Mi compañera por hacerme el favor, llevó a la niña con el PIM, y al final por X circunstancias, se dio una orden de voz, que yo escuché y mi compañera no, yo di por supuesto que sí que se había puesto, el médico también, y resulta que mi compañera, pobre, que era la que llevaba tal pues claro, estaba apuntado como a las 09:00 de la mañana y esa medicación no se puso. Al final la niña estaba bien y no pasó nada y tampoco se comentó a los padres, porque no pasó nada. Pero sí que es verdad que te replanteas el hecho de decir, ostras, podría haber pasado algo con repercusiones para nosotros, y todo por X circunstancias de… uno te dice, el otro escucha, el otro no...

I: Y a nivel de impacto, si tuvieras que describir qué te supuso el haber vivido esto, que afortunadamente no llevó a ningún perjuicio para la niña.

P: Pues nada, realmente, cuando nos dimos cuenta fue un impacto bastante ostras! Y de hecho lo vivimos los tres a la vez. Él nos preguntó si lo habíamos puesto, yo dije "*jo crec que sí que s'ha posat*", y la otra chica dijo *"no s'ha posat*" y entonces fue como (gesto de mucha sorpresa). Fue un poco, ostras, lo hemos hecho fatal. O sea, que estábamos más o menos tranquilos porque la niña estaba controlada, y realmente la estuvimos controlando toda la noche. De hecho la tuvimos monitorizada porque hacía unas bajadas de tensión brutal, pero al fin y al cabo sabíamos que estaba bien. Fue el impacto de decir, ostras, lo hemos hecho fatal. Cómo podemos rectificar esta manera de actuar, porque nos encontramos muchas veces en esta situación. No tuvimos ni un minuto para realmente sentarnos y decir, "*escolta, aquesta medicació la vull ja*", que su enfermera lo supiera… Fue impacto de decir qué ha pasado, por qué hemos fallado en esto, qué podemos solucionar, y por qué muchas veces nos encontramos con este estrés laboral. Nos sirvió mucho para mejorar todo el nivel de la comunicación entre nosotros. Ostras, nos tenemos que oír, porque muchas veces, estamos en muchas cosas y a veces lo más importante damos por supuesto que lo has escuchado y lo has puesto y realmente no ha sido así. O sea, dirigirse más a la enfermera responsable de ese paciente, ya que a veces se dicen muchas cosas sin pensar que esa persona tiene que hacer tres millones de cosas. Nos sirvió un poco para decir ostras, tenemos que escucharnos y realmente si es una medicación urgente pues el decir "*ei, això és urgent!*". Ya te digo fue un cúmulo de cosas que realmente quedó como todo en el aire y no le dimos la importancia a esto.

I: Ok… Y a nivel de emoción y sensación, cuando os dais cuenta los tres, que decíais ostras.

P: Pues un poco de pánico porque dices, ostia, a ver qué le puede repercutir al paciente, es el momento este de decir, ostras, a ver qué pasa. Bueno, estas cosas siempre… el pensar ostras, ahora qué, qué le podrá pasar… Bueno es que estas cosas siempre acabas con el momento de pánico, de a ver qué puede pasar.

I: Claro, y en este caso, ¿esta sensación como de alerta, cuánto tiempo te duró? Porque es verdad que ya enseguida parece que buscasteis soluciones… pero ¿te duró esta sensación de pánico?

P: Pues mira, sabes que pasa, que yo en estas cosas soy muy… que le doy muchas vueltas. Que cuando pasan cosas de estas le doy bastante a la cabeza y no me lo saco. Y cuando sales de trabajar de noche, que estás como más saturada, pues la verdad es como que te vas a dormir un poco pensando en todo el tema este. Y la verdad es que me duró bastante, de hecho al día siguiente llamé para saber que la cría estuviera bien y que no hubo ningún problema. Y ya te digo que estaba más o menos tranquila porque ella ya estaba bien y ya está, se le puso la medicación y fue a planta y todo bien. Pero sí que es verdad que te replanteas mucho pues eso, la repercusión que podría haber, lo que podría haber pasado. O realmente, el tema de la comunicación entre los compañeros, entre el médico y la enfermera, entre nosotras, el poder decir, ostras que no tiene que pasar esto. Entonces, pues sí que lo tuvimos bastante presente, bastantes días.

I: Ya, más o menos, ¿me sabrías decir cuántos días?

P: Pues mira, te podría decir que es un tema que se ha hablado bastante, sobre todo entre nosotros para que no vuelva a ocurrir. Entonces, entre tres, bueno más o menos porque, como que vamos haciendo nuestra jornada laboral es más o menos lunes, miércoles, sábado, domingo, martes, jueves, viernes, sabes, que por la noche es complicado, porque si trabajas de lunes a viernes, pues al día siguiente lo puedes comentar… no sé, a ver, en principio es un tema que ahí está, sabes, que siempre lo vamos comentando "*que no ens torni a passar*", pero así de comentarlo bien, pues igual, eso unos 3-4 días, igual si que los estuvimos hablando. O sea, que fuera comentado, luego cada uno…

I : Claro, claro, bueno ese *run run*, esta sensación ¿esto cuánto te duró?

P: Sí, sí cuando te pasan estas cosas que te equivocas y tal la verdad es que depende mucho de la persona, pero ostras, yo soy muy de darle muchas vueltas a las cosas, entonces quieras o no, al final acabas diciendo ostras, pues tengamos una solución. De hecho con el tema, el médico nos dijo, de este caso he aprendido que si quiero tener una medicación urgente, tengo que pautarlo mejor en el programa, más que en el *Sabac* y así lo veréis mejor… Bueno estas cosas siempre dan que pensar un poco en cómo mejorar esta comunicación, o por ejemplo, cuando lo hablé con él, "*si m'has de dir algo urgent, millor dir: escolta Sandra, aquesta medicació…"* y yo le habría dicho, pues mira, lo lleva tal paciente ¿sabes?

Bueno fue un cúmulo de cosas que dices, bueno, no es culpa de nadie y culpa de todos. ¿Sabes lo que te quiero decir?

I: Si si, tal cual… Y entonces, a nivel de desahogo, fue, esta otra enfermera, el médico, y ¿hubo alguien más a quien transmitiste esto?

P: Sí, había otra doctora y mis compañeras, fue un poco en general. De hecho, por la mañana lo estuve hablando con mi compañera también y bueno, así que fue un poco a nivel general de todo el equipo.

I: Vale, y ¿cómo te sentiste después de haber podido compartir las sensaciones con personas que quizás no estaban tan en el frente?

P: Pues eso, la verdad es que cuando explicas estas cosas, te sientes mejor, porque tus compañeros también siempre te apoyan y cada uno ve una versión que a ti, bueno pues siempre te intentan ayudar y decir: "claro es que íbamos a tope, era muy difícil, porque tal, no te preocupes..." Entonces cada uno te da su visión y sí que es verdad que estas cosas, hablarlas, sobretodo en equipo y que cada uno te diga su opinión y cómo lo han visto ellos, tanto sea negativo como positivo, pues va muy bien, es que hay que hacerlo, yo creo que hablar estas cosas, sobretodo en equipo.

I: Ya está, perdona.

P: Sobre todo cuando hacemos simulacros. Lo que va muy bien son los de "briefing", que es cuando empiezas tu luego a hablar, esto es una cosa que va muy bien, y yo en estas cosas, siempre intento eso, hacer partícipe a todo el mundo, "*a mi m'ha passat això*", entonces tienes la visión de todos los compañeros que tanto sean positivas como negativas, también te da un poco el pensar que podría haberlo hecho así, asá. Pues mira, en ese momento no lo pensé, mira pues yo creo que estas cosas hay que hablarlas.

I: ¿Entre los compañeros…?

P: Sí, porque es eso, a todo el mundo le puede pasar, todos somos humanos y al final es una cosa que nos puede pasar a todos, entonces yo sí que creo que estas cosas hay que hablarlas.

I: ¿Hubo algún tipo de consecuencia laboral para tí?

P: No

I: A nivel personal pues lo que me comentabas, de quedarte con este run run…

P: Claro, sí sí, te quedas con si puede haber alguna consecuencia o no, pero en este caso no hubo ninguna porque la cría se recuperó y estaba bien en ese momento, pero es verdad que esa medición se tendría que haber puesto a las 03:00 de la mañana, y no a las 09:00, claro, son horas.

I: Y me comentabas que no se había comunicado al paciente ni a los familiares.

P: No, no se comunicó. La cría estaba bien y no hizo falta. Otra cosa es que hubiera traído consecuencias, entonces sí que se hubiera comentado yo creo "mira, ens ha passat això", pero en este caso, como que la niña estaba bien y no hubo consecuencias pues no se comentó.

I: Vale, con lo cual, tampoco hubo necesidad de pedir disculpas ni os encontrasteis en esa tesitura.

P: No.

I: ¿Por qué crees que si hubiera habido consecuencias, hubierais pedido disculpas?

P: Yo creo que sí, si realmente hubiera habido alguna consecuencia, yo creo que sí, porque es una cosa que tienes ahí, y al final… yo creo que sí, tampoco nos hemos encontrado en ningún caso que digas, ostras, ha sido muy consecuente y hemos tenido que… Pero creo que a nivel moral de cada uno, yo creo que sí.

I: Y crees que... Bueno, uno pide disculpas y el otro "perdona" como si dijéramos, ¿Crees que los familiares hubieran perdonado si hubiera habido alguna consecuencia?

P: Claro, esto no lo sé, no sé cómo se lo hubieran tomado. Sabes que pasa, que los padres, no es lo mismo pacientes adultos que niños, a veces, los padres… Te das cuenta de que realmente, bueno normal, cada padre es muy protector de su hijo. Depende también de las consecuencias que hubiera tenido, si realmente hubiera estado mal, pero poniéndole la medicación luego está bien… Pero claro, si el crío sigue mal, no sé yo eh…¿Sabes lo que te quiero decir?

I: Y con este, claro porque sale mucho esta emoción, como lo expresas este "pesar", pongamos que bueno, nos imaginamos, porque podría ser que ocurriese algún día que realmente haya algún tipo de consecuencia, con esta sensación que te queda, ¿desearías volver?

P: No, yo creo que dejaría mi profesión. Es que llevar eso es fuerte, el llevar una consecuencia muy negativa, o muy consecuente… No sé eh, esto lo hemos hablado muchas veces con las compañeras y casi todas estamos de acuerdo, el que pudiera ocurrir, en niños, pf no sé eh, por eso también vamos con mucho cuidado y revisando, porque es eso, una consecuencia mortal, bueno a mi me da un patatús.

I: ¿Y crees que si la familia te perdona te cambiaría?

P: No, bueno me da la sensación de que esto.. es pff. Depende mucho de las familias, hay mucho que tu lo ves, que hay familias que pese a lo que le está pasando a su hijo, notas la empatía, pero hay otras que uf, es muy complicado. La verdad es que no sé, no podría decir… es que no sé, es que un hijo, ojo eh…

I: Sí sí…

P: Bueno nosotros en urgencias nos hemos encontrado a padres haciendo comentarios muy desagradables. O sea, que dices, ojo eh.

I: Hacia…

P: Hacia el personal sanitario. Por ejemplo, bueno esto ya hace años que pasó. Había mucha espera, estábamos en la sala de críticos, con un paciente que se nos iba, un niño, y al final acabó la cosa fatal, que tu ya sales fatal de aquella sala, y encontrarte a un padre y que te diga que llevan 5 horas esperando y tal y decirle, bueno es que hemos estado en la sala de críticos con un niño… y él decirte, a mi me da igual el otro niño. ¿Sabes?, eso quieras o no, es muy duro. Por eso a veces los padres no sé si ciertas cosas las entienden. Los padres oncológicos a veces son muy duros, que también lo entiendo, porque es una situación muy difícil y realmente tienen a su niño, su hijo que está muy grave y tampoco están para hostias. Pero a veces supongo que te tienes que ver en la situación, pero a veces si tu fueras pues depende de cómo te lo tomaras. Igual si que te dirían "pues tranquila, no pasa res, estas cosas pasan" o pueden decir… pff.

I: No solo la propia vivencia, sino un poco la mirada del padre hasta cierto punto.

P: Sí, y más nosotros, que los padres cada vez están más integrados en nuestro trabajo y realmente ya tiene que ser así, pero… pf no sé. Yo creo que moralmente y para quedarte tranquila sí que iría a pedir perdón o lo que fuera por haberme equivocado pero yo no sé la reacción del padre. Por mi experiencia no sé exactamente cómo podrían reaccionar. A lo mejor te dicen, "pues mira no pasa res", o a lo mejor pf… no sé.

I: Para ir acabando, tú que has pasado por una situación tensa como ésta, ¿qué le dirías a otra persona que acaba de vivir un hecho como el que viviste?

P: Pues le diría eso, que estas cosas pueden pasar, que estando donde trabajamos cada día vivimos una cosa diferente y que esto es una cosa a la orden del día y con la que aprendemos. Al final, lo importante es que vayamos con cuidado, que realmente lo hablemos con el equipo, miremos lo que ha pasado, las cosas negativas, el poder analizar toda esta situación, y que bueno que somos humanos y puede pasar de todo. Que estamos en una profesión que es muy complicada y en la que tienes mucha responsabilidad y que puede pasar porque vives en un momento de estrés y de muchísimo trabajo. Hablarlo con el equipo e intentar solucionar las cosas y mirar cómo poder resolver esta situación y que no vuelva a pasar otra vez. Esto es lo que le diría. Estas cosas nos sirven para ver qué es lo que podemos hacer mejor.

I: Y a nivel de apoyo que una persona que vive lo que tu viviste necesite algún tipo de apoyo externo, que todo lo que me comentas es dentro de la estructura, los compañeros y demás...

P: Sí necesitaria… Creo que en este caso la ayuda de tus compañeros ya está. Si hubiera habido una consecuencia mayor entonces a lo mejor sí que puedes pedir, de hecho el hospital, en muchas cosas y en otras circunstancias, nos ha dicho que si necesitamos algún tipo de ayuda, como un psicólogo, la podríamos tener. Pero yo creo en este caso que con la ayuda de tus compañeros, de los que tienes más confianza, de tu equipo, es el que te puede ayudar en este caso, como que no hubo más consecuencias pues bueno, quedó allí y ya está no? Y eso es lo que te decía, yo creo que el poderlo hablar. Es que hay personas que igual se les queda dentro y el no poder exteriorizar y que tus compañeros te digan "escolta, no pasa res, això serveix para poder…

I: Aprender, mejorar…

P: Sí, un poco hablarlo con las personas implicadas y decir, ostras, qué ha pasado y qué podemos hacer para que no vuelva a pasar.

I: Claro, claro. Y si hubiera habido alguna consecuencia un poco mayor, a nivel de hospital ¿qué tipo de apoyo crees que sería importante que el profesional pudiera tener?

P: El de tu supervisor. Yo creo que el apoyo más importante es el de tu supervisor, explicarle la historia y en principio él es el que te tiene que apoyar, y a partir de aquí, es el jefe de urgencias y luego pues eso. Yo creo que básicamente sería el de tu supervisor, que te diga "bueno Sandra, no passa res, tienes mi apoyo".

I: ¿Y a seguir y aprender, no? Sobretodo que sirva para aprender y cómo incluso todos habéis cambiado la manera de proceder...

P: Sí, por eso que a medida que pasan estas cosas, nos sirve un poco para ver en qué hemos fallado y qué tenemos que hacer para mejorar esta situación.

I: Claro, súper. No sé si quieres añadir alguna cosa, comentar algo más…

P: Pues en principio yo creo que te he pegado un rollo…

I: Para nada, es muy interesante sobre todo ver desde dónde lo vives, desde que fue un susto importante, pero que no fue en vano, sino que habéis hecho cosas.

P: Sí sí, hemos hecho cosas… Me has preguntado algo muy interesante que no me había planteado, el hecho de los padres, cómo aceptarían que tu les dijeras… porque esto no sé, ya te digo, no sé cómo lo aceptarían.

I: Crees que si hubiera habido alguna consecuencia podrían haber dicho "esto hay que comunicarlo, hay que pedir disculpas". ¿Sería útil que el hospital tuviera algún sistema para acompañaros?

P: A ver, en principio el hospital tiene un servicio de incidencias. Que nosotras las incidencias que tenemos sobre todo de este tipo, con la familia… todo se registra, entonces hay un comité, en el que está metida Vane. Analizan todas las incidencias y nos dicen las cosas que hay que mejorar. Esto está muy bien, porque claro, ya es que las registres, y entonces se analiza sobretodo el poder mejorar, ya sea a nivel de medicaciones, a nivel de problemas que hayas tenido con padres o a nivel un poquito de todo. Y este sistema está muy bien, y pienso que a partir de aquí se tendría que analizar el problema. Pero claro, creo que este grupo estaría allí, pero también depende mucho del problema que tengas y del apoyo que tu tengas. Esto es muy importante… Básicamente creo que se analizaría un poco el tema y a partir de ahí ver un poco qué ha pasado, y se supone que el hospital en ese aspecto te tiene que apoyar.

I: Y si el hospital una vez que se analiza, te dice que tienes que comunicarlo a la familia y pedir disculpas, crees que tendrías que ser tú o que tendría que ser otro?

P: Yo creo que sí, porque piensa que tu has llevado al paciente y esas personas han confiado en tí y de alguna manera durante un período de tiempo eres tú la cuidadora, y con la familia tienes un "feedback", claro. Ellos han confiado en ti y eres la enfermera que los lleva. A mi si que me gustaría, y de hecho, pediría ir yo.

Creo que depende un poco de cada uno, pero es importante el poder decir "pues mira, m'he equivocat", más que otra persona. No sé exactamente cómo lo deben hacer, pero creo que sí que es importante el poder disculparse, y para ti, después a ver cómo reacciona la familia, que eso también puede ser un palo grande, pero que también dar la cara es importante emocionalmente para tí… Claro que no sé, es que pfff. Si te pasa una cosa de estas, te tiene que pesar mucho, entonces el poder disculparse y que la familia... pues al final...

I: Reaccione como pueda. También habría que ver la gravedad de las consecuencias o a lo mejor se ha complicado mucho pero se ha podido subsanar. Nos hemos olvidado de una cosa pero le hemos puesto otra y...

P: Claro, claro… depende mucho de la gravedad del asunto. Es que ya te digo, de niños a adultos yo creo que la cosa cambia mucho, porque el niño…

I: Todos ponemos los ojos en eso ¿no?

P: Sí, es complicado.

I: Bueno, pues agradecer que te hayas abierto de esta manera.

P: ¡Cualquier cosa ya sabéis!

I: Te mando ahora el consentimiento para que me lo puedas enviar firmado.

P: Si, te lo firmo.

I: Muchas gracias.

P: De nada, cualquier cosa ya sabéis. Que ningún problema de verdad, me parece muy interesante el tema. Antes en el periódico veías: "enfermera que se ha equivocado y ha puesto…" decías madre mía, que no te pase a ti.

I: Claro es que también el foco está muy allí, con toda la otra parte que hacéis y que funciona súper bien. Pero bueno, alarma, asusta…

P: No es un trabajo fácil eh, no lo es. Y es eso, en un servicio de urgencias, te viene un millón de cosas y quizás todas a la vez, y claro a veces tienes que decir, "bueno ahora estoy trabajando, olvídate de todo y céntrate en esto", y a veces también cuesta, no es un trabajo fácil. Por eso cuando viene gente nueva, avisarles de preguntarlo todo, no pongáis nada si tenéis dudas. Una cosa que he aprendido es seguir tu instinto. Si no lo ves claro, no lo pongas, avisa a quien tengas que avisar, pero tienes que seguir un poco tu instinto de que eso no lo veo claro… Pues no. Esto yo lo he aprendido y realmente me va bien. Si no lo ves claro, pregunta o haz lo que sea, pero no lo hagas, porque no va a salir bien.

I: Bueno, el escucharte y guiarte de tí.

P: Pues nada, cualquier cosa ya sabéis y si queréis que pregunte lo que sea puedo hablar con el supervisor, en casos de estos pues a ver qué pasaría, que esto también me gustaría saberlo a mí.

I: Bueno, igual a nivel personal ¿no? De cuál sería el protocolo de funcionamiento.

P: Sí sí, pero ya te digo que existe el servicio de incidencias que aquí tendrías el apoyo de bueno, qué ha pasado y qué vamos a hacer al respecto. Que haya este comité ya te da cierta tranquilidad.

I: Pues nada, mucho ánimo.

P: Bueno Carla muchas gracias.

I: Que vaya muy bien, encantada.

I= Interviewer
P= Participant

PARTICIPANT 4
- Pediatric physician
- 6 years of experience
- Adverse event in 2019
- Permanent consequences
- Personal impact
- No apologies offered

I: Como ya he visto en el *screening*, te viste envuelta en el error. ¿Nos podrías contar qué pasó exactamente?

P: Era un niño que entró por cirugía y había sido operado recientemente de una fimosis y tenía fiebre. Mi compañera de la mañana le pidió una analítica y estaba pendiente el resultado. Por la tarde me lo quedo yo. Sale la analítica y estaba alterada. Estaba pendiente de recoger la orina para ponerle el antibiótico. Total que no orinó en toda la tarde y tampoco se tomaron constantes ni nada. Cuando vamos a hacer el cambio de turno por la noche, el niño estaba bien. Voy a verlo después de la analítica y veo que no hay un foco claro de la fiebre. Veo que está bien, vale pues esperamos a la orina. Pasan las horas. Llega el turno de la noche y al hacer el cambio el niño estaba ya aséptico, estaba chocado. Tenía mal color, constantes alteradas que no se habían mirado en toda la tarde y nada, se tuvo que ir a la UCI para ponerle neurotrópicos. Fue como que había pasado mucho tiempo esperando la orina. Que como el niño estaba bien queríamos cogerla por bolsa, pero bueno, no lo hizo. Igual se le podía haber sondado, se podía haber empezado antes el antibiótico y eso.

Y luego fue a posteriori que me afectó más de lo que en principio era. Porque la mayoría de veces no pasa nada, no viene de… si vas a verlo y el niño está bien y no pasa nada, pero en este caso, sí. Luego fue más complejo de lo que era. En la UCI estuvo mucho tiempo. Se descubrió que el foco era un absceso meníngeo, se quedó parapléjico. O sea, que no podía… que ahora va en silla de ruedas. Fue todo muy dramático. Me sentí como… que tenía… muy culpable, muy mal y bueno… sabes.

Fue muy realmente muy extremo y….m…

I: Y Eh. Sí que te impactó ésto, quizás no tanto en el momento, sino posiblemente a posteriori. Si tuvieras que describir este impacto o ¿cómo te afectó?.

P: Perdí mucha seguridad, todo lo tenía que mirar mil veces. Hacer medicina defensiva y bueno… como retroceder. Toda la confianza ganada durante la residencia y la experiencia y tal pues y dudar de todo y ya… era como volver a empezar.

I: Como crees que se podía haber evitado lo que sucedió.

P: Bueno pues… con la experiencia seguro que también. Igual si yo también hubiera pedido ayuda o una segunda opinión, pero claro, nadie sabía de este niño. A posteriori luego, el mismo día a la noche la de la UCI. Me escribe una de la UCI que es de un año más que yo y me dice claro como has hecho. Tenías que haber puesto el antibiótico. A posteriori es muy fácil, no? Pero en ese

momento, pues, el niño no orinaba porque ya tenía el tema meníngeo este. Todavía me hizo sentir como peor, sí. Peor.

I: Cuánto tiempo pasó entre que te das cuenta de lo que está pasando y empiezas a sentir todas estas sensaciones.

P: El mismo día, bueno, me escribieron tal y yo ostras sí. Fueron los días siguientes en los que le fui dando más vueltas… Luego, además el niño… yo iba mirando. Estuvo mucho tiempo ingresado… si fuera una sepsis le pones el antibiótico y en dos o tres días empieza a mejorar, pero fue un caso muy extraño y se fue haciendo más grande.

I: Cuánto tiempo te duraron estos síntomas.

P: Meses…

I: Vale. Y con quién pudiste desahogarte. ¿Cómo hiciste para encontrar apoyo?

P: Se lo conté a mi pareja, lo que pasa es que no es médico, me entendió pero tampoco…a mi madre se lo dije y bueno, ya está y luego pues con la compañera que entró por la noche que fue la que lo subió a la UCI y lo comentamos un día después y un tiempo después y todavía nos acordamos.

I: ¿Cómo fue de satisfactoria esta conversación con esta compañera?.

Bueno, bien. Igual fue… lloré y fue la primera vez que pude hablar con esta compañera.

I: ¿Desde el hospital recibiste algún tipo de apoyo?

P: No

I: ¿Hubo consecuencias laborales?

P: No

I: ¿Cómo fue la experiencia de comunicar al paciente o a la familia lo que sucedió?

Lo cambiamos de box, les dijimos que había que poner antibiótico. Bueno, eso tampoco fue tal… no entendían que estuviera bien y que de pronto no estuviera bien y tuviera que ir a la UCI. También es una situación que vemos, que en urgencias, bueno, ya pasa. Esto no me resultó tan traumático. Lo que ocurre es que a posteriori seguramente esta familia no se acuerda de mi, pero ya cuando viene este niño a urgencias yo no voy a verlo. Prefiero que vaya otro.

I: Bueno, te proteges ahí.

I: No hubo ninguna disculpa por lo que aparecía en las preguntas.

P: Ya… yo no sé hasta qué punto hubo sensación de error por parte de la familia, así que no sé pero bueno, de verdad que no sé.

I: Te quedaste con ganas de pedir disculpas o no es algo que necesitaras.

P: No, no en ese momento.

I: ¿Qué entiendes por disculparte?

P: Eeeeh, no, no sé pedir disculpas, y poder no sé, poder hablar, y ver, no sé… bueno, saber el otro punto de visto, supongo que para uno mismo es bueno

I: Para ti como profesional.

P: Sí, seguramente.

I: Pedimos disculpas generalmente buscando que haya un perdón. ¿Qué entiendes por perdón?

P: No, más que nada, para poder yo perdonarme a mi, ya no buscando que el otro lo entienda quizás. Pero para decir mira, ya está. He hecho lo que he podido, he pedido disculpas aunque el otro pues igual no me perdone.

I: ¿Qué crees que te hubiera ayudado para pedir disculpas?

P: No… es que yo no podía verlos. Me sentía muy mal.

I: Claro, claro.

I: ¿Crees que habría algún beneficio en sentirte perdonada, crees que algo hubiera cambiado si tu llegas a saber aunque no haya esa interacción que la familia te ofrece este perdón.

P: Sí. Seguro que sí.

I: En esto que decías antes de ayudarte a perdonarte a ti.

P: Sí.

I: Imagínate por ejemplo que esta familia te traslada este perdón, qué cambios crees que habría en tu vida personal o profesional.

P: Igual antes habría entendido pues que forma parte de nuestra profesión. Habría sido más rápida la recuperación digamos y ya está.

P: Con el tiempo todo mejora.

I: Te hubiera ayudado esto en el momento más cercano a lo que pasó.

P: Sí. Yo me sentí mal por ello, pero también fue todo lo que me cuestioné. Me hice mucho daño.

I: Esta carga tuya.

I: ¿Qué hubieras necesitado?

P: No lo sé. Hablar con la compañera fue bien y entender que bueno, que lo entendían y ya está. Y luego, pues tiempo. Igual por la experiencia habría entendido que esto puede pasar. Aprendí también que se puede pedir a algún compañero ayuda. Acababa de finalizar la residencia y no tenía que saberlo todo ni poder manejar cualquier cosa yo sola. Justamente somos bastantes y nos podemos ayudar.

I: ¿Tú que has pasado por esto, qué le dirías a alguien que se encuentra en tu misma situación?

P: Que… no sé… que no le culparía. Simplemente intentar ver el aprendizaje y… bueno, que son cosas que pasan. Igual sí que le diría que intente pedir perdón quizás.

I: ¿Qué le dirías a esa persona?

P. Que son cosas que pasan, que intente ver el aprendizaje, tanto de actuación como de pedir ayuda. Y luego pues igual que pida perdón si lo siente así y ya está.

I: ¿Y qué apoyo externo necesitaría una persona que vive un incidente?

P: Em… bueno, igual tener herramientas para salir de… o que no se hagan más grandes los pensamientos, la preocupación o el daño que te haces que va creciendo y es peor que el hecho en sí al final.

I: Igual alguien que pueda acompañar en esa parte quizás más psicológica.

I: ¿Qué sería útil que el hospital ofreciera?

P: Igual sí, un apoyo psicológico para poder hablarlo y eso, que te daría herramientas para poder relativizar, y para… no hacerte tanto daño, no sé cómo decirlo.

I: ¿Qué aprendizaje te llevas de esta situación?

P: Que bueno, que eso, mmm no sé, creo que ya lo he estado comentando, que bueno, que es bueno hablar las cosas, que hay que tener también una buena autoestima como de no, repetirte lo malo, e intentar ver las cosas buenas y ver pues en perspectiva y esto.

I: Digamos, cuando ocurre un evento como este. La parte de comunicarle a la familia lo que ha pasado. ¿No acabaron de entender bien lo que había ocurrido?.

P: Es que no me acuerdo de esto. Lo que te preguntan siempre, no sé. No, con la familia, no…

I: No sé si quieres comentar alguna cosa más.

P: Eh no.

I= Interviewer
P= Participant

PARTICIPANT 5
- Pediatric physician
- 8 years of experience
- Adverse event in 2018
- Consequences include death
- Personal impact
- No apologies offered

I: Vale, perfecte, doncs. ¿Eres así como datos demográficos, eres mujer, de qué edad?

P: 34 años.

I: Vale. ¿Y tú profesión es?

P: Soy pediatra

I: ¿Tienes algún cargo de responsabilidad?

P: Bueno sí, ejercer la pediatría considero que es algo...Es una cosa amb bastanta responsabilitat. No de gestió, però penso que la nostre feina té molta responsabilitat darrere.

I: En las preguntas que te pasé de "screening", comentabas que habías vivido un error, un evento adverso

P: Sí

I: Me podrías decir, ¿qué entiendes por evento adverso?

P: Doncs considero que es qualsevol situació no desitjada en la que hi ha un error, ja sigui que arriba un pacient o no. De vegades aquest error es pot identificar a temps i aturar-lo i unes vegades li arriba el pacient i no li implica cap conseqüència i d'altres vegades si que li pot generar, i de diferent grau. Aleshores, qualsevol error penso que es un event advers en diferent grau de conseqüència però després que tots s'haurien d'analitzar per intentar evitar que realment tinguin conseqüències greus.

I: Y tú viviste un evento adverso, podrías explicar por favor, ¿qué ocurrió?

P: Bueno, he viscut més d'un però el que et vaig comentar que pot ser es el més significatiu i amb un desenllaç més dur, va ser el cas en que era unitat neonatal en la que hi ha prematurs extrems i estem en situacions greus. Era un festiu, hi havia molta feina, estàvem dos pediatres només, com tots els festius en aquell lloc. Hi havia una situació a parts que estava amenaçant que havia de néixer un nen que pot ser estava malament, i Bueno el típic. Doncs vas una mica a totes bandes i el que va passar va ser que jo vaig iniciar una cadena d'errors en el que l'estrès va acabar amb aquest nen petit que va morir. La qüestió va ser que era un nadut prematur extrem de 25 – 26 setmanes, recordo que va néixer molt petit, com 600 grams feia, molt petit també per la seva edat gestacional, i no duia vies no duia altres dispositius i duia tota la medicació oral y la alimentació. I en duia el biberons, que se li posen per sonda perquè era un prematuret molt petitó encara, duia diluït, perquè tenia el ronyó suposo immadur i en part per la orina i necessitava reposicions. I en lloc de posar-li una quantitat que era 0,1 ml en cada presa, doncs en el moment de jo fer la transcripció de un paper en el altre, en comptes de posar 0,1, vaig posar 1 i això es va anar repetint durant 2 o 3 dies

posteriors. Jo vaig iniciar la cadena d'errors, es evident. En comptes de posar aquest 0,1 vaig escriure 1, se'm va colar el 0 y la coma, infermeria va administrar 1, perquè era el que estava prescrit a vegades els hi sobta "osti quanta quantitat" però i confien, per bueno se li va administrar. Al dia següent doncs es va tornar a passar visita, ja era un dia laborable i se li va continuar administrant aquesta quantitat, al dia següent igual. Finalment el nen va fer una interocolitis, es va complicar i amb aquesta interocolitis, el nen va morir. Duríssim.

I: Sí, sí… Ara escoltant-te sí, totalment

P: N'he viscut d'altres, no sé si vols que t'ho expliqui ara o pot ser en un altre...

I: Bueno anem amb aquest si et sembla

P: Vale

I: Si tuvieras que describir el impacto, en una palabra, ¿cuál sería?

P: ¿El impacto para mí?

I: Sí.

P: Pues no ho sé, es que en una paraula em costa però...

I: O en una frase.

P: Et diria com...Realment tenim molta responsabilitat. O sigui tenim molta responsabilitat i això em va fer pensar moltes coses. Bueno la frase que em va fer pensar tot això va ser "Tothom s'equivoca, els cambrers poden trencar plats, nosaltres podem trencar nens" Vull dir...

I: Clar… El que bueno es una mica, el que fa coses te probabilitat d'equivocar-se.

P: Sí, el que passa que el nostre error pot desencadenar en una cosa molt greu.

I: Y ¿cómo cres que se podría haber evitado?

P: Jo crec que en aquest cas pues varies coses. Una descarregant la pressió assistencial d'aquell dia, probablement si jo hagués anat amb el cap una mica més amb el cap amb el que feia ho hauria vist.

L'altre, es evitar fer les transcripcions a mà. Les transcripcions a mà no haurien de ser, hauria de ser un tema, no sé, informàtic, que quan li posessis aquesta dosi que es deu vegades més, pam, saltés un "estàs segur?" L'altre es pot ser tenir una infermeria experimentada que digui " de veritat? Això es molta quantitat. T'ho has pensat bé?". L'altre es l'endemà revisar tot el que estigui escrit a mà, no et fiïs de l'anterior. ES com tot. I jo per la meva part, el dia que vaig cometre l'error penso " Per què?". Doncs perquè jo estava pensant en una altre cosa, aquest nen relativament estava estable, dintre de tot i media que no estaven bé i median que havia de néixer un que pintava fatal i no estava en lo que estava fent en aquell moment, estava pensant pot ser en una altra cosa.

I: Amb aquesta reflexió has estàs pensant molt en aquesta part, no?

P: Sí

I: ¿Como estabas justo después de lo que sucedió? ¿Como te diste cuenta?

P: Bueno aquell mateix dia no em vaig enterar, em vaig enterar com un mes després perque una pediatra de plantilla d'allà del lloc aquest, em va trucar i m'ho va explicar. I es com que en aquell moment em vaig quedar "Uala en serio?". De fet els hi vaig dir "No sé… Li hem explicat a la mare? Voleu que en parlem davant d'ella?" I em van dir que no, que hi havia u equip de persones que es dedicaven a això i que pensaven que era millor que no, però que evidentment a la mare se li havia

explicat i vaig pensar que Bueno... En el fons la gent ha de saber la veritat. També va fer el seu dol, perquè pobre dona... A mi em sabia super greu el nen també, però infinitament més greu la seva mare

I: Clar, totalment. ¿Y tú podrías describir qué sensaciones, sentimientos, emociones tenías o tuviste cuando se te informó de que esto había ocurrido?

P: Si bueno, recuerdo…Recordo com que vaig fer, ostras... Tenia una cosa a sobre de dir. De cop i volta et cau una pedra a sobre que a saber si vaig ser plenament conscient que aquella pedra que tenia a sobra, no me la trauria mai. Va ser, hauré d'exercir una feina o dedicar-me a una altre cosa. Però amb això, sempre. I vaig recordar, que durant la carrera em van dir que això passaria. I vaig pensar, "ostia quanta raó tenien" I va ser com el primer en realitat així tan greu. I vaig pensar "hauràs d'aprendre a conviure amb això o no sé.. Plantejar-t'ho seriosament.. però" S'aprèn a conviure però...tela.

I: ¿Y tuviste algún síntoma de tipo ansioso, o que te costara dormir o en esta línea?

P: No

I: Vale

P: Es que coincidió cuando estaba embarazada y tenía un sueño que me moría. Coincidió en esta época.

I: Sí que es verdad que...

P: O sea ya estaba embarazada cuando pasó esto y no lo sabía.

I: Pero sí que es verdad como que por lo que cuentas, tienes una piedra que te acompaña. No es algo que hayas podido dejar en ese momento, ¿no?

P: No, pero yo esto m'ho prenc d'alguna manera de dir "eh que has fet una cosa molt important, molt delicada, que tots ens equivoquem, per tant. O sigui ho vaig agafar una mica com "anem a intentar a fer-ho millor, tots. Des de la comunicació, des de vigilància de possibles errors pel que penses i vegis que es una altre cosa. Les altres coses que van passar, son un parell d'errors de comunicació d'infermeria i de dosi. Penso que es un tema de comunicació i estar al dia, i també em plantejo molt el tema de la formació continuada. En el meu hospital soc el que sempre diu que això ho hem de fer, hem d'anar a un hospital més aviat petit, hem d'anar de tant en tant a fer un reciclatge a un hospital que tinguin més moviment d'aquestes coses..., M'ho prenc una mica com una oportunitat per tots intentar millorar perquè si no es com "així no mates el temps a confiar-se i apalancar-se" per que un vegin els altres companys.

I: ¿Con quién pudiste desahogarte o con quién compartiste cómo estabas con lo que sucedió?

P: Amb la meva parella, el meu marit i amb unes companyes pediatres que tinc confiança

I: ¿Y cómo fue de satisfactoria esta comunicación con ellos?

P: Sí fue satisfactoria, pues me sentí escuchada, me sentí que em comprenien, no em vaig sentir jutjada. O sigui, una de les frases que jo dic de vegades es "mira jo vaig matar a aquell nen" o sigui, de vegades em surt així, i el meu marit sempre em diu, "no ,no vas ser tu, va ser una cadena d'errors, una cadena de persones, una cadena de circumstàncies" I efectivament, o sigui no vaig anar jo a la incubadora i vaig acabar amb aquell nen a consciencia o sigui va ser una cadena de desgràcies que jo vaig iniciar, que es va continuar i que el nen va morir. També es un nen de molt risc, pot ser això li passa a un nen que pesa el doble, que es el pes adequat per la seva edat i pot ser

té interocolitis però no es mor... Era també un nen molt fràgil i era com bueno, pues pobre va anar tot al revés

I: ¿Desde el hospital recibiste algún tipo de apoyo? O compañeros...

P: No, la verdad es que no. La trucada d'aquesta dona i ja

I: ¿Hubo algún tipo de consecuencia laboral o personal para ti?

P: No, no lo que pasa es que como coincidió, va coincidir amb que jo estava embarassada a principi i era el lloc on jo feia guàrdies puntuals. Al cap de 3 o 4 mesos ja vaig deixar d'anar a aquell lloc perquè bueno el tema de l'embaràs i les guàrdies, estava a quatre hospitals i havia de baixar una mica el ritme

I: Bueno, no tuviste oportunidad de hablar con la familia, por tanto, tampoco pediste disculpas, pero tenías ganas de pedir disculpas o tenías...

P: Claro. Sí sí. Claro yo también un poco pensaba en su madre, ¿no? Que si necesitaba poner una cara o algo, pero... Jo suposo que l'hospital no va voler posar una sola cara perquè de fet tampoc es una sola cara, no? Però sí clar, demanar-li disculpes, evidentment.

I: ¿Y qué sensaciones te generó no haberlo podido hacer?

P: "Esto está a medias" Como de haberlo dejado a medias.

I: Porque cuando pedimos disculpas, muchas veces buscamos perdón. ¿Consideras que eso podría ser así?

P: Bueno y también... No sé...De que me gustaría supongo ver cómo está ella, como ella lo ha encajado, comprensión por ambas partes y simplemente decirle que lo siento, que estas cosas... Es que, ¿qué le puedes decir?

I: Sí, tal cual. Porque para ti, este pedir disculpas, ¿qué entiendes exactamente por pedir disculpas?

P: Supongo que sería más, mirar a la persona a los ojos, explicarle com va anar la situació, simplificando. Y no sé, pedirle disculpas por el error. Es decir, hubo esta situación, yo fui la que lo inicié y decirle que lo siento mucho realmente, que pienso en este niño muy a menudo, que no se piense que me he olvidado.

I: O sea, un poco la parte, entre comillas, ha servido como para revisar cosas para que no vuelva a ocurrir, o sea que no ha sido como en vano quizás.

P: Sí, pero sabiendo que las cosas pasan. Que yo puedo hacer esto, pero es que es esto, un camarero rompe platos y nosotros podemos romper niños. Intentando que no pase, pero a veces hay situaciones así. Es terrible.

I: ¿Hasta qué punto te ayudaría saber si esta madre, de la que hablabas antes, te ha perdonado?

P: ¿No sé, porque no sé si ella me identifica como una persona, sabes? Se le explicó que hubo este error, pero no sé si ella personifica como una única persona. No sé, yo espero que esta madre haya podido vivir bien su duelo, haya... no sé, ya sé que es lo peor que te puede pasar que se te muera un hijo, pero que esté feliz y ojalá pueda tener un hijo. La madre tenía cuarenta y tantos y era un primer hijo

I: ¿Pero crees que podría tener algún beneficio el sentirse perdonado en este contexto?

P: No lo sé, a estas alturas 3 años después, es como que ya lo he cocinado bastante. Seguramente, hace un par de años, sí. Pero ahora es como que pienso, bueno eso está allí, espero que esa madre

esté bien, yo por mi parte sigo intentando formarme, formar a gente que esté a mi alrededor y siempre que haya un error declararlo para mirar que estas cosas no pasen.

I: ¿Declararlo a la institución?

P: Hay un sistema informático en el hospital donde yo trabajo, en el hospital hay un sistema informático, un apartado en el que tú puedes informar de los eventos adversos. Entonces, siempre que haya algo, yo siempre digo "ostras esto lo tenemos que informar" y es anónimo y pienso que ostras, es muy importante porque si al final se detectan 5 errores en una misma cosa pues...Habrá que cambiar eso.

I: Claro. Y decías que tres años después, has hecho como tu propio trabajo personal y quizás no tendría tanto impacto o no tanto peso ahora mismo. Pero hace tres años, ¿el saber que esa madre te ha perdonado, qué crees que hubiera cambiado en tu vida profesional o personal?

P: Pues no sé, quizás en ese momento me hubiera resultado más fácil a mí, pero no sé si hubiera llegado a cocinarlo tanto, de alguna manera asi que mai se sap, això que dic jo. Pot ser el fet de que els primers mesos i els primers dies a mi em fos més dificil, pues va fer que d'alguna manera m'actives més a buscar solucions per a que això pasi menys, perquè no podem dir que no passa, perquè això no es veritat.

I: Y un poco en la línea de... ¿Por qué algún beneficio de esta parte de sentirse perdonado, crees que hay?

P: Hombre supongo que sí. També pensant en com se sent la mare. Si una mare es capaç de perdonar, vol dir que ella també s'ho ha treballat molt el seu dol i està en camí constructiu. No? O sigui me'n alegraria per ella. Perquè pensaria "has fet capaç de reconstruir tot aquest dolor de forma pot ser positiva per ella" perquè si es capaç de perdonar, pot ser ho està fent bé. M'alegraria per ella.

I: Y ahora en la línea de ir finalizando. Tú que has pasado por esta situación, por un evento adverso. ¿Qué le dirías a una persona que pasa por un evento adverso?

P: Pues que... li faria una abraçada, si vol. Perquè en aquell moment es el que jo necessitava, li diria que ho sento molt, que em sap molt greu, que l'entenc, que a mi també m'ha passat. Li demanaria que m'expliques com ha estat per a que es desfogués i li diria que es una merda però que aquestes coses passen. Que hem d'aprendre de tot això, per intentar que passi menys, però que va dins de la nostre feina. I el que hem de fer es buscar solucions, maneres per a que cada vegada això passi menys. Que si li ve de gust o compartís amb els seus companys, jo ho vaig fer, jo li vaig explicar al meus companys més propers "Em va passar això. Fixeu-vos, no es el mateix uno, que cero como uno.."No es el mateix tres que treinta y tres, o sigui...Que moltes vegades jo ho explico perquè m'ha passat i que no us passi. I això no ho evitarà però es veritat que quan algú m'explica "mira m'ha passat això" penso, quan m'hi trobo penso "Ostres..." D'alguna manera s'encenen alarmes. I després li diria que això, que es una cosa que segurament ho passarà malament durant una temporada però de tot pots treure una cosa constructiva i el que ha de fer es intentar que passi menys.

I: ¿Qué apoyo externo necesitaría una persona que vive un evento adverso?

P: Al menys com a mínim, a casa jo crec que es important poder-ho explicar perquè clar... Algú de la família, algú de l'entorn proper. I després algun company que et pugui entendre a nivell mèdic. Perquè jo li explicava al meu marit que es informàtic i vale sí, m'entenia la meva part emocional. Però el que era la part mèdica pot ser no ho entenia tant. I en el meu cas era relativament fàcil però en un cas pot ser una mica més complex, necesitas a algú que pugui entendre la situació mèdicament també. I haurà casos que suposo que es necessitarà un ajut una mica més especialitzat d'algun psicòleg o algú que pugui acompanyar. Potser sí.

I: ¿Y qué sería útil que el hospital ofreciera?

P: A vall d'Hebron per exemple, tenen un servei a la unitat neonatal que es molt interesant, que son sessions que comenten casos de dol perinatal. Pues nadons que han mort pel que sigui. Es un hospital que té molta complexitat i hi van tots els casos pot ser més desgraciats, però ja sigui que han mort perquè ja tenia una patologia prèvia que ja es sabia o perquè han tingut alguna intercurrència. I alguna vegada suposo que hi haurà hagut un cas així d'algun error.

Però es comenten els casos de naduts que han mort, llavors penso que això està bé perquè hi van pediatres els que volen i també hi ha una psicòloga diria. Jo he anat a alguna online per saber de què anava però. Està bé, es un equip del propi hospital el que va a comentar aquestes coses. Això estaria bé, tenir un equip a l'hospital.

I: Para comentar casos para detectar cosas que pueden ocurrir y que no vuelvan a pasar.

P: Bueno a ver, no. Sobre todo, desahogarse. Es un grupo de más de "Pues me he sentido así." "Y ¿cómo estás ahora?" "Pues me siento así". De compartir cómo te sientes, no tant la part técnica. La part tècnica aniria per una altra banda, per la part de vigilància, de seguretat del nadó, de seguretat assistencial una altre cosa. Però aquest es un grup de més com et sents i aquest que et dic de Banyoles hi ha una psicòloga que per exemple em sembla super interesant

I: Entonces, como resumen. ¿Cuál es el aprendizaje que has podido extraer de este evento desafortunado que viviste?

P: Pues diría que tots som humans, tots ens podem equivocar, el que s'ha d'intentar es que passin les menys vegades possibles. Detectar-ho a temps, compartir el coneixement també dels errors. ES molt fàcil compartir els casos clínics "Mira m'ha passat això i era tal." Però "Mira em va passar això i em vaig equivocar amb això" Saps? Compartir –ho també. Per a mi el coneixement es "Aquestes coses passen i em de buscar totes les maneres per a que passin el menys possible i ser conscients..." Si no vols tenir un error amb un nen, pues dedicat a una altre cosa. I a mi això em costa.

I: Sí Bueno.. Es tota una experiència molt dura i crec que els professionals que us enfronteu a això, heu de generar molta resiliència, no? Bueno, aprendre, continuar i saber que aquesta es la cara i la creu. Perquè per l'altre banda també teniu una part super maca i porteu endavant un munt de situacions. Però ens enrecordem o criden més l'atenció quan no va bé, probablement. No sé si quioeres añadir alguna cosa o comentar...

P: Bueno sí, quizás. Jo penso que en el meu hospital, jo soc de les que plantejo amb més insistència el tema de la formació continuada. I jo estic en un hospital relativament petit que habitualment els nens neixen sans, habitualment no son prematurs extrems, son prematurs tardans que generalment no fan molta complicació. Els nens més gran generalment es curen sols, alguna vegada hi ha alguna cosa més important. I de tant en tant passa que neix un nen malament, que ve un nen gran que está malament. Aleshores, també en els hospitals petits es difícil fer guàrdies i estar allà, perquè estas sol. Que no es el cas del lloc on em va passar això, que això si que era un lloc una mica més gran. Però penso que en els hospitals petits, que de vegades es té la sensació de "Bueno aqui esto es más tranquilo" Hasta que pasa algo, i el dia que passa estàs menys entrenat, també el teu equip està menys desentrenat, no tens tanta costum a tractar amb aquestes situacions. Per tant per mi es crucial que hagi una formació continuada de presencia física en una unitat de crítics, neonatal y pediàtrica. I es com jo m'estic plantejant la meva feina en els propers mesos, i fer de tant en tant una rotació però presencial a les unitats que he dit, i no sé si servirà o no. Al menys, ho he intentat.

I: I tant. Doncs de nou, moltíssimes gràcies per participar, per trobar el moment i per compartir una situació com aquesta perquè no es fàcil a vegades donar visibilitat en aquestes situacions. I t'ho agraeixo moltíssim

P: De res.

I: O sigui, que vagi molt bé i moltíssimes moltíssimes gràcies.

P: De res, que vagi molt bé a tu, Carla,

ANNEX 9: PUBLISHED EDITORIAL

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Carta al Editor

Percepción del médico como segunda víctima tras un error durante la práctica clínica

Physician's perception as second victim after an error during clinical practice

Sr. Editor:

Durante la práctica asistencial se originan incidentes no previstos que pueden afectar a la seguridad del paciente. Casi uno de cada 10 pacientes se ve afectado por un evento adverso (EA) durante su periodo de hospitalización[1]. Las consecuencias de este hecho hacen que estos pacientes se conviertan en primeras víctimas, pero no son los únicos afectados. Albert Wu en el año 2000 introdujo el término de segunda víctima[2] para referirse a todo profesional sanitario que se ha visto envuelto en un EA, error y/o daño al paciente y se puede convertir también en víctima traumatizada por el incidente[3].

Atender a estos profesionales se ha convertido en prioridad de las autoridades sanitarias, y así se recoge en el Plan Nacional Estratégico para 2015-2020 a través de la importancia de proporcionar soporte a los profesionales asistenciales[4]. En este sentido, hay estudios que enumeran diferentes fases de atención a la segunda víctima en los que se describe una atención inicial realizada por los propios compañeros para finalmente desarrollar una fase en el que puedan ser atendidos por profesionales especializados[5].

Se pretende analizar la percepción de los médicos/as como posibles segundas víctimas de un error durante la práctica asistencial, así como explorar la gestión realizada en torno al incidente. Todo ello, a través de un estudio descriptivo realizado mediante una encuesta auto-administrada *online* enviada a los médicos/as del Consorci Parc de Salut Mar (n = 555) durante los meses de febrero a junio de 2018, de los cuáles contestaron 102 profesionales.

El perfil medio del participante es una mujer médica con edad comprendida entre 31 y 50 años perteneciente a una especialidad médica con más de 3 años de experiencia profesional. El 79,4% (81) de los médicos/as encuestados experimentan o han percibido haberse visto envueltos en un incidente que ha afectado a la seguridad del paciente.

Los profesionales de la medicina tienen una mala percepción de la atención que reciben por parte de la organización tras un EA, ya que consideran que no se les proporciona el apoyo suficiente. En concreto, hemos detectado que un 41,1% de los participantes (42) considera que el hospital no ofrece apoyo psicológico tras el incidente. Los modelos de atención a la segunda víctima, hacen hincapié en la necesidad de poder recibir, como primera actuación, el apoyo de los propios compañeros[3,5]. En nuestro estudio encontramos que un 52% (53) de los médicos percibe que su equipo le apoya tras un suceso de estas características.

Con relación al EA, un 64,7% ha tenido que informar a los pacientes del error y un 55,9% (57) han presentado dudas sobre los procesos asistenciales y si las decisiones clínicas eran las correctas tras verse envuelto en el incidente. Estos profesionales afirman no haber recibido suficiente formación sobre cómo ha de realizarse esta comunicación con el paciente o sus familiares. Además, el 70% de los médicos/as tienen miedo a afrontar consecuencias legales derivadas del incidente (tabla 1), a pesar de que un 52% (53) de los médicos no han observado un incremento de las reclamaciones en su servicio tras comunicar el error.

Finalmente, los sentimientos de culpa, la percepción de inseguridad, y/o sintomatología compatible con el shock emocional quedan patentes en nuestro estudio. Por todo ello, habría que incrementar el soporte a la segunda víctima desde la propia institución, haciéndole partícipe de las soluciones, y dotándole de herramientas para poder afrontar una comunicación eficaz y constructiva con el paciente y su familia.

Consideramos que sería de gran interés la creación de una guía de actuación de atención a las segundas víctimas desde el propio hospital, que debería basarse, entre otras cosas, en el apoyo entre iguales, así como hacer hincapié en el bienestar emocional y psicológico, ya que los niveles de culpa y malestar emocional en estos casos son elevados. Además, sería recomendable potenciar la formación en cómo comunicar para afrontar mejor estas situaciones.

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Tabla 1
Probabilidad de incidente con consecuencias graves en el hospital

N = 102	Probabilidad		
	Alta Porcentaje (N.º)	Media Porcentaje (N.º)	Baja Porcentaje (N.º)
Error con consecuencias graves en el hospital	38,2 (39)	39,2 (40)	22,5 (23)
Error con consecuencias graves en el servicio	21,6 (22)	36,3 (37)	41,2 (42)
Disculpas tras un error	41,2 (42)	40,2 (41)	18,6 (19)
Miedo a afrontar consecuencias legales	69,6 (71)	25,5 (26)	4,9 (5)
Miedo a perder el prestigio profesional	58,8 (60)	30,4 (31)	10,8 (11)

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Carla Martos[a,*], Juan Gutierrez[b] y Priscila Giraldo[c]

[a] *Universitat Internacional de Catalunya (UIC Barcelona), Sant Cugat del Vallés, Barcelona, España*
[b] *Jefatura de Sección del Servicio de Medicina Interna, Hospital del Mar, Docencia Medicina, Universidad Autónoma de Barcelona, Barcelona, España*
[c] *Jefatura del Servicio de Atención al Ciudadano, Hospital del Mar. Docencia, Universidad Pompeu Fabra, Barcelona, España*

* Autor para correspondencia.
Correo electrónico: cmartos@uic.es (C. Martos).