Leading article

From retribution to reconciliation after critical events in surgery

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Critical adverse events that occur in surgical patients create a need to reconcile the damage that has been done, while triggering investigation aiming to prevent recurrence. Patients who experience a harmful event or error usually want an explanation, an apology, and assurance that lessons are being learned. Nonetheless, critical incident investigation teams[1,2] and hospital authorities themselves have a tendency to seek accountability, that is, to search for a cause and find someone to blame[3]. Critical event investigations often focus on who instead of what was responsible, and sometimes even start with questioning whether professionals' actions were malicious or intended to cause harm, or whether there was negligence or reckless behaviour involved[4]. This approach may satisfy some demands, but there is much to lose. It generates anxiety for those involved, and may hamper full disclosure of what happened. Involved professionals may be discouraged from acknowledging their responsibility out of fear of self-incrimination.

If learning is the primary objective after a critical adverse event, the focus of the investigation should not be on blame or retribution, but rather on reconciliation and everyone's tasks and responsibilities in the aftermath. This is the main principle of Just Culture: moving away from retribution and blame, instead focusing on reconciliation by meeting hurt with healing, and directing attention to the needs of all involved[5]. The Just Culture theory strives to balance safety and accountability, and offers valuable strategies to improve learning from critical events and dealing with all those involved.

In the traditional approach to critical adverse events, the attention is primarily drawn to questions such as which rule was broken, and by whom, and how serious was that?[5]. The judgement on these issues is distorted by the knowledge of the bad outcome (outcome bias), the fact that investigators are not directly involved (outside bias) and that judging afterwards whether a decision was good or bad is easy (hindsight bias)[6]. The perspective of someone not directly involved who judges a situation with knowledge of the outcomes will be different from the perspective of the surgeon who actually faced the clinical dilemma.

Whereas a retributive approach believes that balancing hurt with punishment will somehow equalize or even eliminate the injustice that has been inflicted, Just Culture believes that hurt requires healing. It strives to restore the damage, trust and relationships that have been disturbed by the event, and to determine those who are responsible to help meet these needs[5]. This is a reminder that it is not only the patient and their family who have been damaged physically, emotionally or otherwise, but also the involved professionals, commonly referred to as second victims[3,7–9]. This approach aligns with second victim or peer support programmes that are increasingly implemented in healthcare[10]. A focus on recovery should be the first priority, and should precede in-depth investigations; victims first, analysis second.

It is believed there is a clear line between acceptable and unacceptable performance. Many think that punishment remains appropriate where there was reckless behaviour. Recklessness and negligence, however, are judicial terms and not clinical behaviours. It will always be difficult, disputable and context-dependent to differentiate between acceptable and unacceptable behaviour. The line between these two may shift based on a host of subjective judgements[5]. As stated by Dekker: 'There really is no line, there are only people who draw it'[5].

The restorative approach should not be interpreted as offering immunity from prosecution of criminal behaviour. Separate processes should remain in place to investigate suspected criminal acts or misconduct in hospitals. The main objective in these investigations, however, is to answer questions from criminal law, whereas the main objective in a modern critical incident investigation should be learning and improvement. Therefore, judicial questions do not have a place in the learning reviews that aim to prevent recurrence of an incident and improve the safety of future patients. External judicial authorities, as recently occurred in the UK in the Bawa-Garba case, may come to a different conclusion from an institution. Although rare, this will of course challenge an individual surgeon's honesty and disclosure, and emphasizes the importance for hospitals and their professionals to have the courage to keep promoting reconciliation internally.

Several strategies may support the shift from retribution to reconciliation, emphasizing that recovery and learning are the primary objectives

following critical events. The shared need for learning from the event should be explicit and used as a starting point for investigations. After all, first and second victims will have different needs, but all share the hope that the event is turned into a learning experience to prevent recurrence[5]. Traditionally patients and families are often told to await the conclusions from formal investigations, with little attention to their specific needs, such as early disclosure and apology. Restoration should start by asking whether they have any specific questions or concerns they would like to be addressed within the investigation.

A set of questions based on the principles of Just Culture can be used to shape accountability and to conduct investigations differently in the aftermath of a critical incident in surgery. Through the process of learning, the professionals and organization remain able to provide accountability. This approach supports a culture of safety that facilitates learning by actively shifting the focus from individual culpability to collective recovery.

Disclosure

The authors declare no conflict of interest.

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