SUOČAVANJE SA NEIZVESNIM I SLOŽENIM SITUACIJAMA: PODRŠKA ZDRAVSTVENIM RADNICIMA U REŠAVANJU IZAZOVA BEZBEDNOSTI PACIJENATA

RAD PO POZIVU

INVITED PAPER

NAVIGATING UNCERTAINTY AND COMPLEXITY: UNDERSTANDING HEALTHCARE PROFESSIONALS IN ADDRESSING PATIENT SAFETY CHALLENGES

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SAŽETAK

Pružanje optimalnog kvaliteta zdravstvene zaštite je izazov za zdravstvene stručnjake i zdravstvene sisteme širom sveta. Pacijenti se često oslanjaju na zdravstvene radnike da im pomognu u njihovim zdravstvenim problemima i da pruže najbezbedniju i najbolju moguću zdravstvenu uslugu. Međutim, uprkos najvećim naporima zdravstvenih radnika da pruže visokokvalitetne usluge, neočekivani neželjeni događaji mogu uticati na pacijenta. I pacijentima i zdravstvenim radnicima može biti teško da se nose sa ovim događajima, pogotovo kada oni dovode do teške povrede pacijenta. Pored fizičkih i psiholoških posledica koje ovi neželjeni događaji mogu ostaviti na pacijentima, zdravstveni radnici takođe mogu biti emocionalno pogođeni. Pružaoci zdravstvenih usluga koji su uključeni u neželjene događaje često se nazivaju *sekundarnim žrtvama*. Na njih ne utiču samo neželjeni događaji koje pacijent doživljava, već i reakcija koju ti događaji mogu izazvati kod drugih članova zdravstvenog tima, kao i izvan i unutar zdravstvene ustanove.

Neželjeni događaji često imaju sistemski uzrok, što znači da mogu biti rezultat kombinacije organizacionih, kulturnih i faktora sredine.

Iako se obično zdravstveni radnik nadležan za lečenje pacijenata, koji je direktno povezan sa štetom nanetom pacijentu izdvaja kao odgovoran, u većini slučajeva postoji niz događaja i zdravstvenih radnika uključenih u neželjeni događaj. Sledstveno, drugi članovi zdravstvenog tima takođe mogu biti uključeni u događaj, bilo direktno ili indirektno. Ovo može stvoriti osećaj zajedničke odgovornosti među članovima tima i zajednički osećaj gubitka ili krivice kada dođe do neželjenih događaja.

Pružaoci zdravstvenih usluga i ustanove treba da prepoznaju uticaj neželjenih događaja na pacijente i pružaoce usluga. Pružajući podršku i resurse sekundarnim žrtvama, zdravstvene ustanove mogu da pomognu u ublažavanju emocionalnih posledica ovih događaja i da obezbede zdravstvenim radnicima podršku, kako bi oni mogli da nastave da pružaju visokokvalitetnu zdravstvenu uslugu svojim pacijentima.

U ovom radu su navedeni elementi koji su ključni za bolje razumevanje fenomena *sekundarne žrtve* i principa *kulture pravičnosti*, u skladu sa preporukama *ERNST* konzorcijuma.

Ključne reči: neželjeni događaji, zdravstveni radnici, lekarske greške, bezbednost pacijenata, kultura pravičnosti

ABSTRACT

Providing optimal quality care is a challenge for professionals and healthcare systems around the world. Patients often rely on healthcare providers to assist them with their health concerns and to provide the safest and best possible care. However, despite the best efforts of healthcare providers to deliver high-quality care, unexpected adverse events can affect a patient. These events can be difficult for both patients and healthcare providers to deal with, particularly when they result in severe harm to the patient.

In addition to the physical and psychological toll that these adverse events can take on patients, healthcare providers can also be emotionally affected. Healthcare providers who are involved in adverse events are often referred to as *second victims*. These professionals are not only directly affected by the adverse events experienced by the patient but also by the response that these events can provoke in other healthcare team members, directives, and within the health institution.

Adverse events often have a systemic cause, meaning they can result from a combination of organizational, cultural, and environmental factors.

Although usually the professional in charge of patient care who is directly related to the harm is singled out as responsible, there is a chain of events and professionals involved in most events. As a result, other healthcare team members may also be involved in the event, either directly or indirectly. This can create a sense of shared responsibility among the team and a shared sense of loss or guilt when adverse events occur.

Healthcare providers and organizations need to recognize the impact of adverse events on patients and providers. By providing support and resources to second victims, healthcare organizations can help mitigate the emotional toll of these events and support providers in continuing to provide high-quality care to their patients.

This paper outlines key elements for a better understanding of the *second victim* phenomenon and *just culture* principles, in accordance with the ERNST Consortium insights.

Keywords: adverse events, healthcare providers, medical errors, patient safety, just culture

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UVOD

Neizvesne i složene situacije su svojstvene kliničkoj praksi. Iako ovo nisu novi fenomeni, čini se da sve više prepoznajemo i drugačije procenjujemo njihov uticaj na ishode. Razumemo da je pružanje zdravstvene usluge onima kojima je poverena odgovornost za lečenje i negu pacijenata ključno za postizanje pozitivnih rezultata.

Neizvesnost i složenost doprinose nastanku događaja opasnih po život, ubodnim povredama iglom, neočekivanim smrtnim ishodima, incidentima nasilja usmerenim protiv zdravstvenih radnika, stagnaciji u oporavku pacijenata, žalbama, kao i greškama koje štete pacijentima. Ostali faktori koji doprinose greškama uključuju i umor, ometanje, nedostatke u opremi i komunikaciji, kao i zastarele protokole, što sve može uticati na ishode. Osim toga, ako ne razgovaramo o greškama i otvoreno ne srušimo zid ćutanja, naši pacijenti od toga neće imati koristi.

Studije su otkrile da godišnje približno 8% do 12% hospitalizovanih pacijenata [1] i oko 2% pacijenata u primarnoj zdravstvenoj zaštiti [2] doživljava neželjene događaje, od kojih bi se polovina mogla sprečiti [3,4]. Svaki neželjeni događaj se odnosi na jednog ili više zdravstvenih radnika koji se moraju suočiti sa ovim stresnim situacijama oslanjajući se na svoje lične resurse, podršku svojih kolega ili institucionalne resurse. Ovako nastaje fenomen *sekundarne žrtve*, što je termin koji je uveo profesor Albert Vu 2000. godine [5]. Ovaj fenomen je Evropski konzorcijum osnovan u okviru Evropske mreže istraživača koja se bavi sekundarnim žrtvama (engl. *European Consortium established within the European Researchers' Network Working on Second Victims – ERNST*) definisao na sledeći način [6]: „svaki zdravstveni radnik, direktno ili indirektno uključen u nepredviđeni neželjeni događaj i povredu pacijenta ili nenamernu grešku u zdravstvenoj zaštiti, i koji i sam postaje žrtva u smislu da je i na njega/nju događaj imao negativni uticaj".

ERNST konzorcijum, osnovan u septembru 2020. godine, kojeg finansira Program evropske saradnje u nauci i tehnologiji kao *KOST* Akciju Evropske Komisije broj 19113, bavi se ovim pitanjima u okviru četiri radne grupe. Ove grupe su ažurirale definiciju sekundarne žrtve, uspostavile nivoe intervencije koji obuhvataju preventivne i restorativne aspekte, identifikovale ključne elemente intervencija podrške, uporedile prakse sa drugim visoko pouzdanim sektorima i istražile modele za izgradnju otpornosti. Nadalje, osmišljeni su novi pokazatelji za procenu efikasnosti intervencija; razvijeni su mehanizmi za upoznavanje budućih zdravstvenih radnika sa postupkom prijavljivanja incidenata i sa mehanizmima suočavanja sa svojim iskustvima kao sekundarnim žrtvama; dok su sadržaj obuke o bezbednosti pacijenata i propisi na tu temu analizirani na nivou Evrope, kako bi se promovisao zajednički način delovanja.

INTRODUCTION

Uncertainty and complexity are inherent in clinical practice. While these are not new phenomena, it appears that we are increasingly recognizing and assessing their impact on outcomes differently. We acknowledge that providing care for those entrusted with the responsibility of treating and caring for patients is crucial for achieving positive results.

Uncertainty and complexity contribute to life-threatening events, needle stick injuries, unexpected deaths, violent incidents against healthcare professionals, stagnation in patient progress, complaints, and errors that harm patients. Other contributing factors to errors include fatigue, distractions, equipment and communication gaps, and outdated protocols, all of which can affect outcomes. Additionally, if we fail to discuss errors and break the chain of silence openly, our patients do not benefit.

Studies have revealed that annually approximately 8% to 12% of hospitalized patients [1] and around 2% of those in primary care [2] experience adverse events, with half of these being preventable [3,4]. Each adverse event relates to one or several healthcare professionals who must confront these stressful situations relying on their personal resources, the support of their colleagues, or institutional resources. This gives rise to the *second victim* phenomenon, a term coined by Prof. Albert Wu in 2000 [5], which the European Consortium established within the European Researchers' Network Working on Second Victims (ERNST) has defined as [6] 'any healthcare worker, directly or indirectly involved in an unanticipated adverse patient event, unintentional healthcare error, or patient injury, and who becomes victimized in the sense that they are also negatively impacted'.

The ERNST Consortium, established in September 2020 and funded by the European Cooperation in Science & Technology as Action 19113, addresses these issues through four working groups. These groups have updated the definition of a second victim, established intervention levels encompassing preventive and restorative aspects, identified key elements of support interventions, compared practices with other highly reliable sectors, and explored resilience models. Furthermore, a new metric has been devised to assess intervention effectiveness; mechanisms have been developed to introduce future healthcare professionals to incident reporting and to addressing their experiences as second victims; and patient safety training content and regulations have been analyzed in Europe, to promote a common response.

The ERNST Consortium holds four International Forums annually and offers between 20 and 30 scholarships each year for Training School. The Training School addresses the second victim phenomenon, discusses

ERNST konzorcijum organizuje četiri međunarodna foruma godišnje i obezbeđuje između 20 i 30 stipendija svake godine za Školu obuke. U okviru Škole obuke bavi se fenomenom sekundarne žrtve, vodi diskusija o inovacijama u programima podrške i razmenjuju iskustva o implementaciji i održavanju programa. Završni međunarodni forum, koji se poklapa sa završetkom četvorogodišnje *KOST* akcije, održaće se u Beogradu 2. i 3. septembra ove godine.

MATERIJALI I METODE

Ovaj rad opisuje glavna rešenja koje predlaže *ERNST* konzorcijum u pristupu fenomenu sekundarne žrtve. Takođe objašnjava principe koncepta *kulture pravičnosti*.

REZULTATI I DISKUSIJA

Zdravstveni radnici koji preživljavaju iskustvo sekundarne žrtve mogu iziskivati podršku iz svog neposrednog radnog okruženja, kao što je emocionalna prva pomoć [7] koju pružaju obučene kolege, dok u teškim slučajevima može biti potrebna specijalizovana pomoć. U studijama su identifikovane emocionalne posledice kao što su izolacija, stid, strah, flešbekovi, anksioznost i nesanica, sa simptomima koji mogu trajati od nekoliko dana do više nedelja. U nekim slučajevima može doći do posttraumatskog stresnog poremećaja. Nakon ozbiljnog neželjenog događaja koji uključuje pacijenta, zdravstvenim radnicima je potrebna podrška kako bi sprečili dalje negativne posledice po druge pacijente [8], pošto se njihovo rezonovanje i klinički pristup mogu promeniti i zdravstveni radnici mogu pribegavati odbrambenim praksama, potencijalno dovodeći druge pacijente u opasnost. Stoga je u interesu bezbednosti pacijenata da zdravstveni centri osmišljavaju bezbednosne politike koje uključuju programe podrške sekundarnim žrtvama i promovišu principe kulture pravičnosti [9].

Programi podrške sekundarnim žrtvama, koji su prvi put sprovedeni u Sjedinjenim Američkim Državama, služe kao modeli za razvoj novih programa. Inicijative kao što su program „Za tebe" (engl. *forYOU*) u bolnici u Misuriju [10] i program „Otpornost pri stresnim događajima" (engl. *Resilience in Stressful Events - RISE*) u bolnici Džons Hopkins u Baltimoru [11], pokazale su da je podrška kolega najdelotvorniji i najprihvatljiviji način pružanja ovog vida podrške. Zahvaljujući naporima ovih pionira u sprovođenju intervencija, sada razumemo potrebe sekundarnih žrtava. Dok osmišljavamo protokole, puteve ili preporuke za rešavanje posledica neželjenih događaja, od suštinskog je značaja da zapamtimo da sekundarne žrtve iziskuju sledeće: da razumeju uzrok događaja, da znaju sa kim da komuniciraju i šta da kažu, da izbegnu osećaj odbačenosti, da dobiju emocionalnu podršku na dan događaja i u toku

innovations in support programs, and shares experiences on program implementation and maintenance. The final international forum, coinciding with the four-year deadline of the COST Action, will take place in Belgrade (Serbia) on September 2nd and 3rd of this year.

MATERIALS AND METHODS

This paper outlines the main approaches proposed by the ERNST Consortium for addressing the second victim phenomenon. It also covers the principles included in the concept of *just culture*.

RESULTS WITH DISCUSSION

Professionals experiencing a second victim situation may require support from their immediate work environment, such as emotional first aid [7] provided by trained colleagues or peers, and in severe cases, they may need specialized assistance. Studies have identified emotional consequences such as isolation, shame, fear, flashbacks, anxiety, and insomnia, with symptoms lasting from days to weeks. In some cases, post-traumatic stress disorder may occur. Following a severe adverse event involving a patient, healthcare providers need support to prevent further negative consequences for other patients [8], as their reasoning and clinical approach may alter and they may resort to defensive practices, potentially putting other patients at risk. Therefore, patient safety benefits from healthcare centers designing safety policies that include support programs for second victims and promote the principles of just culture [9].

Second victim support programs, pioneered in the USA, serve as models for the development of new programs. Initiatives like *forYOU* at the Missouri Hospital [10] and the *Resilience in Stressful Events* (*RISE*) program at Johns Hopkins Hospital in Baltimore [11] have demonstrated that peer support is the most effective and acceptable means of organizing this support. Thanks to the efforts of these pioneers in implementing interventions, we now understand the needs of second victims. As we design protocols, pathways, or recommendations to address the consequences of adverse events, it is essential to remember that second victims require the following: to understand the cause of the event, to know who to communicate with and what to say, to avoid feelings of rejection, to obtain emotional support for the day of the event and subsequent days, to feel valued, and to have access to legal advice [12].

In the ERNST Consortium, we have analyzed the various intervention approaches and needs of professionals and organizations, and have concluded that the organization of support programs should consider five stages [7]: (1) prevention at both the individual health-

narednih dana, da se osećaju cenjeno, kao i da imaju pristup pravnom savetu [12].

U *ERNST* konzorcijumu smo analizirali različite pristupe intervencijama i različite potrebe zdravstvenih radnika i zdravstvenih ustanova i zaključili da bi pri organizaciji programa podrške trebalo da se planira sledećih pet faza [7]: (1) prevencija i na individualnom nivou zdravstvenog radnika i na organizacionom nivou, (2) samopomoć pojedinaca i zdravstvenih timova nakon incidenta koji je u vezi sa bezbednošću pacijenata, (3) podrška kolega i trijaža, (4) strukturirana stručna pomoć i (5) klinička podrška. U Evropi, neki od ovih programa su: „Ublažavanje posledica kod sekundarnih žrtava" (engl. *Mitigating Impact in Second Victims – MISE* [13], „Drug" (engl. *Buddy Study*) [14], „Program sistematske kolegijalne pomoći" (engl. *Systematic Collegial Help Program – Kohi*) [15], kao i program pod nazivom *„Procedure kod ozbiljnih neželjenih događaja"* (engl. *Procedure for Serious Adverse Events – PSAE*) Univerzitetske bolnice *Clinico San Cecilio* [16]. Zaista, postoje dokazi koji upućuju na to da se briga za dobrobit zdravstvenih radnika direktno odražava na bolje ishode, što, na kraju, donosi korist pacijentima.

Ovi programi ne bi trebalo da budu usredsređeni samo na suočavanje sa veoma stresnim situacijama, odnosno vraćanje u normalno emocionalno stanje nakon incidenata [17]. Intervencije podrške sekundarnim žrtvama su usko povezane sa bezbednošću pacijenata i moraju biti praćene mehanizmima za upravljanje inherentnim rizicima u okviru zdravstvenih aktivnosti koje se sprovode unutar službi, odeljenja i institucija. U suprotnom, zdravstveni radnici postaju ranjivi kada stvari krenu kako ne treba, samo zato što nisu primenjena savremena znanja i odgovarajući alati u organizovanju i sprovođenju kliničkih aktivnosti, odnosno nije uzeta u obzir realnost zdravstvene prakse, koja nije bez svojih rizika.

Shvatili smo da je najveća greška uverenje da samo loši zdravstveni radnici prave greške [18]. Na ovaj način se pažnja usredsređuje isključivo na odgovornost pojedinca, te se ništa ne menja. Time se samo produžava prećutkivanje i okrivljavanje a ne postiže se bila kakva pozitivna promena. Sledstveno, pacijenti pretrpe najviše štete.

Poslednjih godina prikupljamo informacije o tome kako organizacioni faktori, stilovi rukovođenja, inherentna složenost zadatka, individualne razlike u odgovoru na stres i drugi povezani faktori utiču na intenzitet emocionalnog iskustva sekundarne žrtve. Slika 1 ilustruje faktore koji predstavljaju okidače ovog negativnog iskustva.

Koncept kulture pravičnosti odnosi se na organizaciono okruženje u kojem rukovodioci podstiču otvorene diskusije o sistemskim propustima, nenamernim greškama i oblastima gde je potrebno unapre-

care professional and organizational levels, (2) self-care of healthcare individuals and teams after a patient safety incident, (3) peer support and triage, (4) structured professional support, and (5) clinical support. In Europe, some of these programs include the *Mitigating Impact in Second Victims* (*MISE*) [13], the *Buddy Study* [14], the *Systematic Collegial Help Program* (*KoHi*) [15], and the *Procedure for Serious Adverse Events* (*PSAE*) of the Clinico San Cecilio University Hospital [16]. Indeed, there is evidence suggesting that the well-being of providers translates into better outcomes, which ultimately benefit patients.

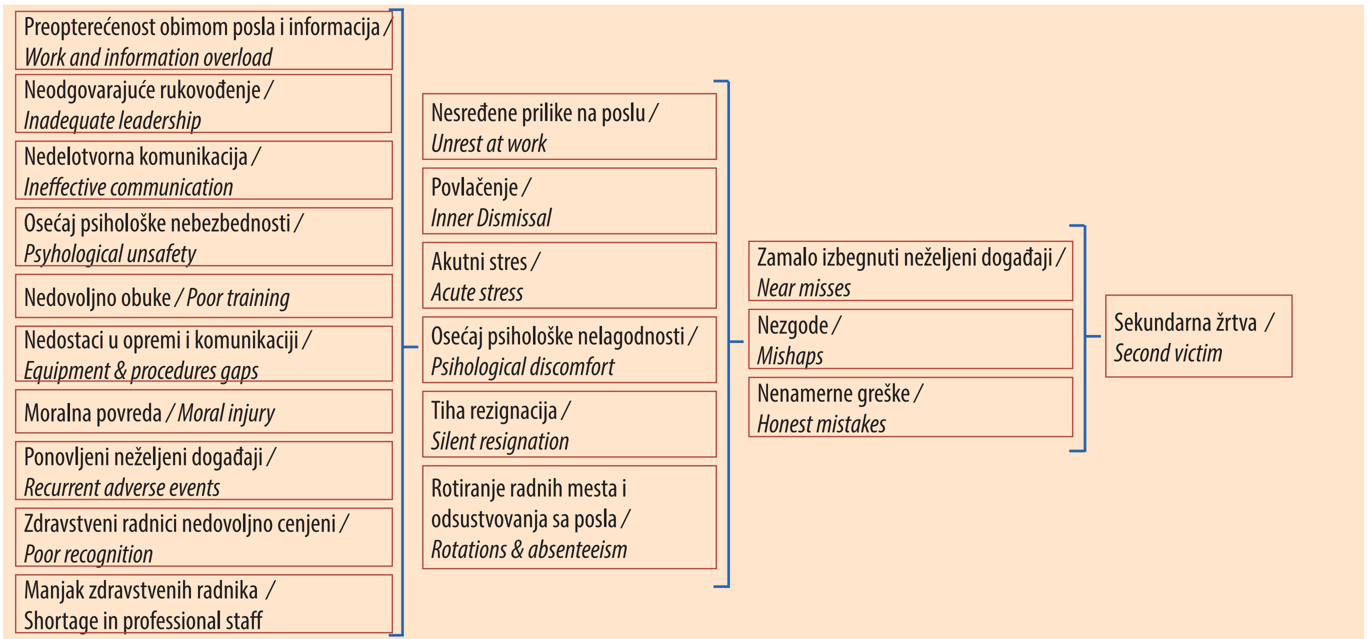
These programs should not only focus on coping with highly stressful situations or regaining emotional normality after incidents [17]. Second victim support interventions are closely linked to patient safety and must be accompanied by mechanisms for managing the inherent risks in healthcare activities within services, departments, and institutions. Otherwise, professionals are left vulnerable when things go wrong simply because current knowledge and appropriate tools were not applied to organize and execute clinical activities, i.e., the reality of healthcare practice, which is not without risks, was not taken into account.

We have learned that the worst mistake when dealing with errors is to believe that only bad healthcare professionals make mistakes [18]. This idea solely focuses on individual responsibility, and consequently, nothing changes. It merely perpetuates silence and blame failing to bring about any positive change. Ultimately, the patients suffer the most.

In recent years, we have been accumulating information about how organizational factors, leadership styles, the inherent complexity of the task, individual differences in stress response, and other associated factors justify the intensity of the emotional experience of the second victim. Figure 1 illustrates the factors triggering this negative experience.

The concept of just culture refers to an organizational environment where managers encourage open discussions about system failures, unintentional errors, and areas for improvement in patient care. It involves avoiding complacency, taking things for granted, fear of speaking up, ignoring fatigue or overload, and acknowledging the uncertainty and complexity of clinical decisions to minimize patient safety incidents. In this context, the priority is to encourage incident reporting, analyze the root causes of incidents, and implement support programs for professionals who have been involved in an honest mistake (Figure 2).

This approach relies on the responsibility of healthcare institution managers to foster an open and honest environment where professionals feel evaluated and treated consistently, constructively, and fairly. Simulta-



Slika 1. Faktori koji predstavljaju okidače za fenomen sekundarne žrtve

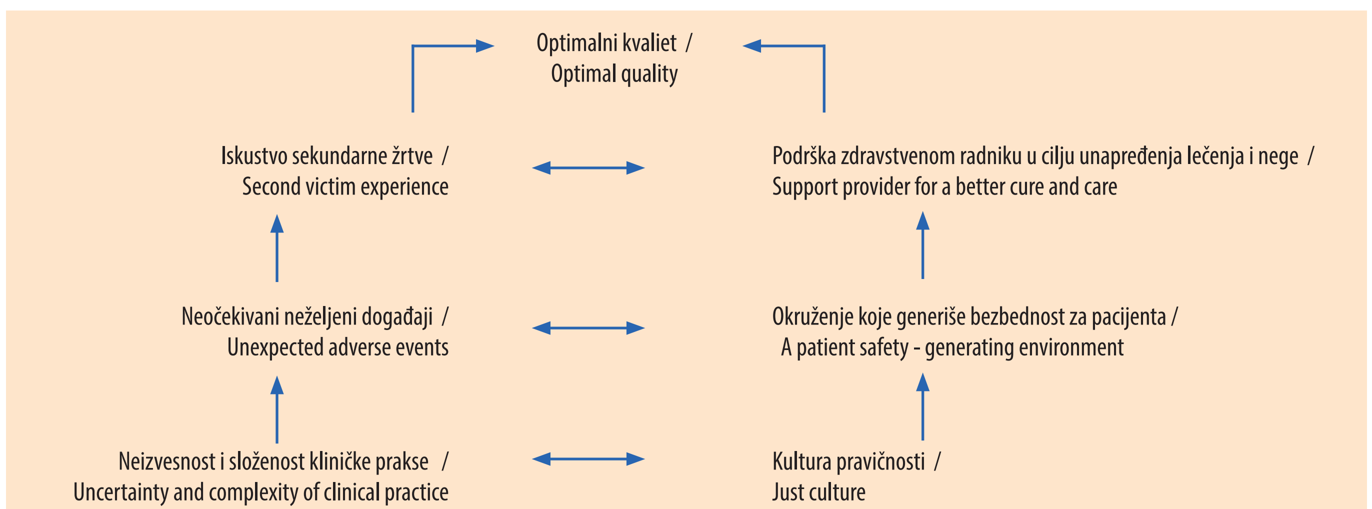
Figure 1. Factors triggering the second victim phenomenon

diti bezbednost pacijenata. U tom smislu je potrebno izbeći samoljublje i uzimanje stvari zdravo za gotovo, prevazići strah od otvorenog iznošenja činjenica, ne ignorisati umor ili preopterećenje poslom i prepoznati neizvesnosti i složenosti kliničkih odluka, kako bi se minimizirali incidenti koji ugrožavaju bezbednost pacijenata. U tom kontekstu, prioritet je podstaći prijavljivanje incidenata, analizirati osnovne uzroke incidenata i sprovesti programe podrške za zdravstvene radnike koji su počinili nenamernu grešku (Slika 2).

Ovaj pristup se oslanja na odgovornost rukovodilaca u zdravstvenim ustanovama da neguju otvoreno i pošteno okruženje u kome zdravstveni radnici osećaju da njihov rad i oni sami bivaju procenjivani i tretirani na dosledan, konstruktivan i pravičan način. Istovremeno, zdravstveni radnici su dužni da na odgovarajući način

neously, professionals have a duty of care to follow procedures, guidelines, and standards appropriately and to seek ways to create increasingly safer environments.

When discussing just culture, we must differentiate between honest mistakes and those that are not [19]. In 2016, the National Patient Safety Foundation and, in 2018, the National Health Service, in the United Kingdom, proposed a logical, simple, and effective scheme to establish this differentiation [20]. Essentially, after each event, we can assess whether other staff members or teams with similar qualifications and training levels would have acted the same (substitution test) and whether the professional(s) involved were aware of violating predetermined standards (intention test). However, just culture also entails providing guarantees to patients (and by extension to society) that honesty,



Slika 2. Kultura pravičnosti i iskustvo sekundarne žrtve

Figure 2. Just culture and the second victim experience

prate procedure, smernice i standarde, te da iznalaze načine za stvaranje sve bezbednijeg okruženja.

Kada je u pitanju kultura pravičnosti, moramo razlikovati nenamerne greške i one koje to nisu [19]. Godine 2016, Nacionalna fondacija za bezbednost pacijenata (engl. *National Patient Safety Foundation*), te 2018. godine, Nacionalna zdravstvena služba (engl. *National Health Service*), u Ujedinjenom Kraljevstvu, predložile su logičnu, jednostavnu i efikasnu šemu za uspostavljanje ove diferencijacije [20]. U suštini, nakon svakog događaja, možemo proceniti da li bi drugi članovi osoblja ili timovi sa sličnim kvalifikacijama i nivoima obučenosti postupili isto (test supstitucije) i da li su uključeni zdravstveni radnici bili svesni kršenja unapred određenih standarda (test namere). Međutim, kultura pravičnosti takođe podrazumeva pružanje garancija pacijentima (samim tim i društvu) da poštenje, odgovornost i transparentnost nastavljaju da postoje i kada se dogode nenamerne greške ali i kada dođe do nepromišljenog i bespotrebnog preduzimanja neadekvatnih postupaka ili preuzimanja određenih rizika.

Pogrešne predstave o ljudskoj nesavršenosti, preovlađujuća kultura okrivljavanja i sledstveno pripisivanje povezane odgovornosti često ometaju identifikaciju neposrednih uzroka nenamernih grešaka. Ovim se stvara iskrivljena predstava o tome zašto dolazi do grešaka i koje radnje treba preduzeti u vezi sa onima koji su u njih uključeni, u cilju sprečavanja ponovljenih grešaka. Sekundarne žrtve su ilustracija ove neravnoteže između razumevanja ljudskog faktora i društvene konceptualizacije kliničke greške [21].

Pravna sigurnost u pogledu profesionalnog angažovanja u bezbednosti pacijenata je još jedno ključno pitanje koje zahteva pažnju. Obično se koriste dva glavna pristupa. Prvi je pristup usredsređen na pojedinca, gde odgovornost za grešku leži na zdravstvenom radniku koji ju je napravio. Ovaj pristup pojednostavljuje razumevanje kauzalnosti greške, pripisujući grešku isključivo pojedincu, a posledica je često kaznena. Kao alternativa ovakvom pristupu jeste pristup u kojem je fokus stavljen na sistem a koji prepoznaje da nastajanju greške doprinosi niz faktora. U okviru ovog pristupa se traži pravična kompenzaciju za oštećenu stranu i on je usmeren ka razumevanju bazičnih uzroka grešaka, kako bi se sprečilo njihovo ponavljanje. Shodno tome, naglasak nije na kazni već na sistemskim promenama. No, važno je napomenuti da su mnogi pravni sistemi širom sveta usvojili prvi pristup, što zahteva dalja proučavanja kako bi se odvagale prednosti i nedostaci svakog od njih.

Trenutno se primenjuju dva moguća zakonska rešenja [22]. Prvi je sistem vanugovorne odgovornosti za štetu koji je rasprostranjen širom sveta. U ovom slučaju se mora sprovesti parnica, pri čemu dve strane su-

responsibility, and transparency are upheld both when honest errors occur, and when inappropriate behaviors or certain risks are recklessly assumed.

Misconceptions about human fallibility, the prevalence of blame culture, and the associated attributions of responsibility often hinder the identification of the immediate causes of honest errors. This distorts understanding regarding why errors occur and what actions should be taken concerning those involved, in order to prevent the recurrence of errors. Second victims exemplify this imbalance between understanding the human factor and the social conceptualization of clinical error [21].

Legal certainty regarding professional engagement in patient safety is another crucial issue that requires attention. Typically, two main approaches are employed. Firstly, the person-centered view, where responsibility for a mistake lies with the professional who made it. This approach simplifies the understanding of error causation, attributing the error solely to the individual. However, the consequence is often punitive. Alternatively, the system-focused view acknowledges that a series of contributing factors are at the core of a mistake. This approach seeks fair compensation for the injured party and aims to understand the root causes, in order to prevent reoccurrence. Consequently, the emphasis is not on punishment but on systemic change. Notably, many legal systems around the world have adopted the former approach, necessitating further study to weigh out the pros and cons of each.

Two legal schemes are already being applied [22]. The first is the tort liability system which is widespread around the world. In this case, litigation is required, and two parts contrast their arguments and evidence in front of a judge or jury. The alternative to this is the so-called *no-fault system*. In this case, medical misadventure can be compensated without the need to prove fault. This is applied in some countries such as New Zealand, Denmark, and Finland.

The blame culture fosters defensive practices and discourages physicians from actively engaging in incident reporting, thus impeding progress in patient safety. Solutions to these challenges are not straightforward, and evidence regarding the best approach to reform is inconclusive, necessitating further research. However, it is evident that addressing the well-being of professionals and promoting speaking up is paramount to enhancing our capacity to avoid adverse events and improve patient outcomes [23]. Additionally, understanding the causes of errors, involving healthcare professionals in safety practices, and fostering a culture where mistakes are acknowledged but are not recurrent are crucial steps on this journey.

protstavljaju svoje argumente i dokaze pred sudijom ili porotom. Alternativa ovome je takozvani sistem odgovornosti za štetu bez krivice (engl. *no-fault system*). U ovom slučaju, medicinski nesrećni slučaj se može kompenzovati bez potrebe za dokazivanjem krivice. Ovo se primenjuje u nekim zemljama kao što su Novi Zeland, Danska i Finska.

Kultura okrivljavanja podstiče defanzivne prakse i obeshrabruje lekare da se aktivno angažuju u izveštavanju o incidentima, čime se ometa napredak u bezbednosti pacijenata. Rešenja za ove izazove nisu jednostavna, i još uvek nema nedvosmislenih dokaza o najboljem pristupu reformi, zbog čega su potrebna dalja istraživanja. Međutim, očigledno je da je izuzetno značajno da se vodi računa o dobrobiti zdravstvenih radnika i promoviše otvoreno iznošenje činjenica u cilju poboljšanja našeg kapaciteta da izbegnemo neželjene događaje i poboljšamo ishode pacijenata [23]. Takođe, razumevanje uzroka grešaka, uključivanje zdravstvenih radnika u bezbednosne prakse i negovanje kulture u kojoj se greške priznaju, ali se ne ponavljaju, ključni su koraci na ovom putu.

ZAKLJUČAK

Prelazak sa reaktivne kulture na kulturu koja generiše bezbednost zahteva implementaciju i proširenje bezbednih praksi i upravljanja rizikom unutar zdravstvenih ustanova. Ovaj proces počinje sa visokoškolskim ustanovama, koje treba da sagledaju postojeće nedostatke u obuci budućih zdravstvenih radnika po pitanju kvaliteta usluga i bezbednosti zdravstvene zaštite pacijenata. Trebalo bi da taj proces sprovode najbolji lideri u zdravstvenim ustanovama, koji treba da promovišu odgovornost i osnaže zdravstvene radnike da vide da njihov rad i oni sami bivaju procenjivani i tretirani na dosledan, konstruktivan i pravičan način, te da ih podstaknu da uče iz svojih grešaka.

Uspostavljanje kulture pravičnosti može da pomogne u ostvarivanju ovih ciljeva. Kultura pravičnosti stavlja naglasak na to da se stručni kadar ne smatra odgovornim za sistemske nedostatke, probleme u komunikaciji ili radne uslove, koji su van njihove kontrole. Istovremeno, nepromišljeno postupanje i nemar se smatraju neprihvatljivim oblicima ponašanja koji se ne smeju tolerisati.

Iskustvo sekundarne žrtve, koje uključuje osećanje odgovornosti za nenamernu grešku, zabrinutost za pacijenta sa komplikovanim tokom bolesti ili osećaj da nije dovoljno učinjeno za pacijenta, treba prepoznati kao problem koji je u vezi sa radnim mestom, a ne samo kao mentalni problem. Ovo iskustvo je mnogo češće među zdravstvenim radnicima nego što se obično misli i ono direktno i negativno utiče na njihovu sposobnost da pruže optimalnu kvalitetnu negu.

CONCLUSION

Transitioning from a reactive culture to a safety-generating culture requires implementing and expanding safe practices and risk management within healthcare institutions. This process starts with higher education institutions, which should review the existing gaps in the training of future healthcare professionals on patient care quality and safety. It should be enforced by the top leaders in healthcare facilities, who must promote accountability and empower professionals to feel evaluated and treated consistently, constructively, and fairly, and learn from their mistakes.

Establishing just culture can help in achieving these objectives. Just culture emphasizes not holding professionals responsible for system failures, communication issues, or working conditions beyond their control. At the same time, reckless behavior and negligence are considered unacceptable forms of conduct that must not be tolerated.

The second victim experience, which includes feelings of responsibility for an unintentional error, worrying about a patient with a complicated course of disease, or the feeling of not having done enough for a patient, should be recognized as a workplace problem and not solely a mental health issue. This experience is much more common among healthcare professionals than is commonly believed and it directly and negatively impacts their ability to provide optimal quality care.

It is of the utmost importance that future research delves into the question of whether healthcare organizations with robust safety cultures take concrete steps to provide much-needed support to professionals grappling with the debilitating effects of the second victim experience. Such an analysis would not only aid in identifying and addressing the underlying causes of this pervasive problem but also help in creating a more empathetic and supportive healthcare system for all.

Conflict of interest: None declared.

Od suštinskog značaja je da se buduća istraživanja bave pitanjem da li zdravstvene ustanove sa snažnom kulturom bezbednosti preduzimaju konkretne korake kako bi pružile preko potrebnu podršku zdravstvenim radnicima koji se bore sa iscrpljujućim posledicama iskustva sekundarne žrtve. Takva analiza ne samo da bi pomogla u identifikovanju i rešavanju osnovnih uzroka ovog sveprisutnog problema, već bi pomogla i u stvaranju sistema zdravstvene zaštite u kojem preovladava veći stepen empatije i podrške za sve.

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