*DEKKER, S., 2013. Second victim: error, guilt, trauma and resilience. Boca Raton, FL.: CRC Press.* 

Dr Helen Vosper School of Pharmacy and Life Sciences, Robert Gordon University h.vosper@rgu.ac.uk

## Patient safety: cultural change, not regulation.

Who is Sidney Dekker? While this is a book review, the answer to this question makes interesting reading in its own right. He describes himself as 'Professor, best-selling author on human factors and safety, and pilot.' An undergraduate degree in psychology led to a Masters in organisation psychology which was followed by a PhD in cognitive systems engineering. He is recognised as an international leader in human factors and system safety, both as a researcher and teacher. He holds several honorary or visiting chairs in major institutions around the world. Clearly concerned that he might be underachieving, he qualified as an airline pilot and managed the phenomenal achievement of running parallel careers as both academic and Sterling Airlines pilot. This qualifies him almost uniquely to explore how human factors approaches in one industry (such as public air transport) can be applied effectively in apparently different scenarios such as healthcare.

This polymathic capability is applied expertly in his book 'The Second Victim,' which explores safety culture from the perspective of the professionals involved in critical incidents and accidents at work. Given the recent events at the Mid-Staffordshire NHS Foundation Trust and the response to this, outlined in 'A promise to learn, a commitment to act' (also known as the Berwick report, Berwick 2013), this book is certainly topical.

Chapter 1 opens with an outline of an American case in which a critically ill infant had died. The cause of death was – at least in part – due to an overdose of calcium chloride. The blame for this incident had been placed firmly at the feet of an experienced critical care nurse, Kimberley Hiatt. She was dismissed from her post (with all the protracted HR processes this involves) and over a period of several months lost not only the child she had been caring for, but her job and ultimately her career and sense of identity. Some weeks later she committed suicide.

It is easy to see the 'first victim' in this scenario – no-one could fail to appreciate the cost in terms of this child's life and the terrible impact that this had on the family. In the sensitive and sympathetic light in which Sidney Dekker develops this and many other stories spanning a range of industries, it is equally easy to appreciate the concept of the 'second victim' – the healthcare professional at the centre of the incident. The early part of the book reinforces this recognition of the second victim, exploring the lived experience of a number of professionals who have found themselves in this position. While the writing style is highly accessible (and genuinely gripping in places) this is a scholarly work, including an in-depth consideration of both the psychological and somaticimpacts of such events, including the increasingly widelyrecognised concept of post-traumatic stress disorder. Particularly interesting is the discussion around the impact of critical events on individual senses of professional identity.

By this point in the book, the reader is likely to be sympathetic to the plight of the second victim and appalled at the personal impact extending beyond the initial incident. The middle chapters of the book look in greater detail at the workplace systems and processes that govern the investigation of such cases. In all cases, there was a complete lack of support for the second victim – in fact, it is quite clear that the processes were based on the assumption that, far from being a victim, these people were the culpable protagonists. Consequently, the procedural approach often involved the isolation of these staff from colleagues which, in effect, actively *removed* support from the second victim. The cultural and political reasons for these behaviours are discussed in depth within the book, particularly the need for institutions to apportion blame: if one person can be held accountable, then there is no apparent need to further investigate safety systems and processes.

These abuses seem incredible, and it is easy to believe that we would never behave in this way. Sidney Dekker points out that this is unlikely to be the case – we are socially conditioned to seek out blame, often as part of a survival mechanism. Furthermore, the toxic systems in which we work support this 'blame-seeking' approach. We also tend to become emotionally engaged with the first victim: it is difficult to read the individual stories of those involved in the Mid-Staffs tragedy without feeling genuinely angry that this was allowed to happen (Francis 2013). This anger needs an outlet, and all too often it turns into blame. Sidney Dekker creates a compelling case for the need to fully recognise (and support) the second victim. This will not only reduce the chances of a critical incident becoming a double tragedy, but will support the building of cultures where mistakes can be openly discussed and learnt from, thus improving safety. In the words of Don Berwick, we must 'abandon blame as a tool and trust the goodwill and good intentions of staff... make sure pride and joy in work, not fear, infuse the NHS.'

This book will be of interest to all healthcare professionals and students of these disciplines. It is highly readable and does not require any significant prior knowledge. The range of material covered (and the references cited within the work) makes it a useful primer in patient safety.

## References

BERWICK, D., 2013. A promise to learn – a commitment to act: improving the safety of patients in England. London: Department of Health. Available from: <u>https://www.gov.uk/government/publications/berwick-review-into-patient-safety</u> [Accessed 20 September 2014].

FRANCIS, R., 2013. *The Mid Staffordshire NHS Foundation Trust Public Enquiry.* Stafford: Mid-Staffordshire NHS Foundation Trust. Available from: <u>http://www.midstaffspublicinquiry.com/report</u> [Accessed 20 September 14].