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Guilt without fault: A qualitative study into the ethics of forgiveness after traumatic childbirth



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ABSTRACT

When a life is lost or severely impaired during childbirth, the midwife and obstetrician involved may experience feelings of guilt in the aftermath. Through three empirical cases, the paper examines the sense of guilt in the context of the current patient safety culture in healthcare where a blame-free approach is promoted in the aftermath of adverse events. The purpose is to illustrate how healthcare professionals may experience guilt without being at fault after adverse events, and Gamlund's theory on forgiveness without blame is used as the theoretical framework for this analysis. Philosophical insight has proven to be a useful resource in dealing with psychological issues of guilt and Gamlund's view on error and forgiveness elucidates an interesting dilemma in the field of traumatic events and medical harm in healthcare, where healthcare professionals experience that well-intended actions may cause injury, harm or even death to their patients. Failing to recognise and acknowledge guilt or guilty feelings may preclude self-forgiveness, which could have a negative impact on the recovery of midwives and obstetricians after adverse events. Developing and improving support systems for healthcare professionals is a multi-factorial task, and the authors suggest that the narrow focus on medico-legal and patient safety perspectives is complemented with moral philosophical perspectives to promote non-judgemental recognition and acknowledgement of guilt and of the fallible nature of medicine.

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1. Introduction

Midwifery and obstetrics are associated with the happy event of following a woman through the process of childbirth. However, in rare cases, the infant or mother suffers permanent, severe and sometimes fatal injuries related to labour and delivery, and it may turn into a traumatic event for both the family and the healthcare professionals. Healthcare professionals (HCPs) who experience an unanticipated adverse event are referred to as 'second victims', as opposed to 'first victims', who are the patients and their relatives (Wu, 2000). Second victims often feel responsible for the outcome and may experience burnout, emotional distress, depressive symptoms, sleep disorders and posttraumatic stress disorder

(PTSD) (Beck, 2011; Beck and Gable, 2012; Croskerry et al., 2010; Denham, 2007; McCay and Wu, 2012; Scott et al., 2009; Seys et al., 2013a, Seys et al., 2013b; Sheen et al., 2015; Sirriyeh et al., 2010). In particular, the issues of guilt and feeling responsible appear to be central following the event for the second victims, challenging not only their confidence and self-esteem, but also their ability to move on and put the event behind them (Beck et al., 2015; Wu and Steckelberg, 2012; Scott et al., 2008). In a mixed methods study comprising a national survey of Danish obstetricians and midwives and a qualitative interview study with selected survey participants, we found that obstetricians and midwives struggle with issues of blame, guilt and existential considerations in the aftermath of a traumatic childbirth (Schrøder et al., 2016a; Schrøder, 2016). These findings contrast with current patient safety culture, which encourages blame-free attitudes and approaches errors as systemic (Kohn et al., 2000; Weiner et al., 2008; Zinck Pedersen, 2013). The system perspective on error promoted

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in the blame-free culture has been criticised by Collins et al. (2009) who argue that physicians do not consider errors in a systemic context but direct the blame inwards. This may indicate that, although the current patient safety programs have promoted a more just and learning culture with less blame and shame, the personal feeling of guilt remains a burden for each HCP (Schröder et al., 2016a). The moral implications of guilt and blame are rarely discussed in this context. Griswold (2007) has argued that philosophical insight is valuable in dealing with psychological issues of guilt, and following this argument, we adopted a moral philosophical perspective on guilt and forgiveness to understand the issues at stake for HCPs involved in adverse events.

In this paper we use three paradigmatic cases from our empirical study to address the theoretical concerns of guilt and forgiveness from the perspective of the second victim. We contextualise our findings to the current patient safety culture in which a blame-free approach is promoted following adverse events. Drawing upon the work of Gamlund (2011, 2014), we examine how midwives and obstetricians may experience guilt without being at fault after a traumatic childbirth, and we argue that the acknowledgement of this guilt may be a decisive factor in achieving self-forgiveness.

2. Theoretical background

2.1. Human error in a culture of patient safety

Previous studies have investigated the prevalence and severity of secondary trauma experienced by HCPs after a traumatic event and have acknowledged the need for institutional awareness of the second victim to establish an effective support system (Seys et al., 2013b; Beck and Gable, 2012; Beck et al., 2015; Scott et al., 2009; Wu, 2000). The literature with respect to the 'second victim' refers to the Institute of Medicine's report on the medical error in the United States "To Err is Human: Building a Safer Health System" (Kohn et al., 2000). This report marks the beginning of a paradigm change in healthcare to replace the 'blame culture' with a 'just culture', encouraging disclosure and education after an adverse event (Woodward et al., 2009; Wu and Steckelberg, 2012; Scott et al., 2009; Denham, 2007; Berlinger, 2005; Marx, 2003; Pettker and Funai, 2010). When adverse events occur, the blame culture focuses on the role of the individual and uses punishment or sanctions, whereas the just culture promotes disclosure and a learning organisational approach. Though the two cultures have different approaches, the aim remains the same: to reduce the number of errors in healthcare. In 2001, a change of culture was also promoted in the Danish healthcare system with the establishment of the Danish Society for Patient Safety in 2001. The society ensures that patient safety is an aspect of all decisions made in Danish healthcare to develop and build an improvement in quality and a patient focused safety culture (The Danish Society for Patient Safety, 2015). Following a traumatic event, the management of employee reaction largely addresses what lessons can be learned from the incidents. This may produce procedural changes in work practices to prevent similar incidents, but the HCP's and their reactions and management of an adverse event are not equally considered (Schröder, 2016).

The title of the report indicates that human error is inevitable whenever humans deliver healthcare and alludes to the complete aphorism "to err is human, to forgive, divine", although the nature of forgiveness after medical error is not addressed in the report (Berlinger, 2005, p. ix). Self-forgiveness may play an essential part in the aftermath of an adverse event, yet it remains largely unaddressed in the literature concerning the second victim. The therapeutic effect of self-forgiveness should be considered in this context, because

(...) a failure or inability to forgive oneself is problematic morally and psychologically. (...) A failure to forgive oneself, when self-forgiveness is due, may lead to destruction of one's capacity for agency, and even to self-annihilation. (...) The issue is humanly important; it is also complex philosophically (Griswold, 2007, p. 122).

2.2. Forgiveness and medical error

It is widely agreed that forgiveness is governed not only by social norms, but also by moral norms (Griswold, 2007), and philosophical exploration of forgiveness as a moral phenomenon has brought about many different views without reaching consensus (Fricke, 2011). According to Gamlund, self-forgiveness and interpersonal forgiveness follow the same structure (Gamlund, 2014), and we will not distinguish between the two. It is a common assumption in moral philosophy that there is nothing to forgive unless the person has deliberately done wrong to another person (Gamlund, 2011; Griswold, 2007; Murphy, 2003). Gamlund (2011) refers to this as 'the standard view', where blameworthiness or culpability is considered a necessary condition for forgiveness. In cases where the individual has done wrong, but has either an excuse or a justification for his action, forgiveness is not the appropriate response. A conduct may be excused if the person who engaged in it lacked substantial capacity to conform his conduct to the relevant norms (as in the insanity defence), and a conduct may be justified in cases, where the conduct would normally be wrong, but in the given circumstances and all things considered, it was the right thing to do (as in lawful self-defence) (Murphy, 2003; Gamlund, 2011). In other words, we can do wrong without deserving blame for it, and when there is no blame, there is nothing to forgive. From this perspective, self-forgiveness may not be an issue for HCPs, because it is presumed that they never intentionally make mistakes to do harm to their patients. However, blame, guilt and self-forgiveness were distinct themes in our empirical study (Schröder et al., 2016a), indicating a shortcoming of the standard view.

An alternative view is offered by Gamlund who argues that there is conceptual space for forgiveness in certain cases where a person has an excuse or a justification for her action, contradicting the preservation of a core notion of forgiveness for unexcused or unjustified wrongdoings as presented in the standard view. Gamlund argues that in some cases the individual has an excuse or a justification for her wrongdoing, but may still seek forgiveness. This view will be unfolded as the cases are presented, but the background in this context involves the work of Gorovitz and Macintyre (1975) who argued that clinical medicine is inherently fallible, and that inevitably, mistakes will be made. Sometimes because of the state of development of the particular medical sciences at issue, and sometimes " (...) because of the inherent limitations in the predictive powers of an enterprise that is concerned essentially with the flourishing of particulars, of individuals" (p. 19). Clinical work as a process of acquiring, interpreting, managing, and reporting the disorders of human illness has been characterised as an error-ridden activity (Paget, 1988, p. 34). These positions contrast the understanding of the current patient safety culture, which Zinck Pedersen (2013) argues is characterised by a domination of an organizational myth of failsafe systems. Under the headline of systems thinking, organisational learning, and 'non-blame', errors are now described as 'adverse events' or 'critical incidents' and these efforts have been closely linked to the technical ambitions of the programme. These ambitions involved the introduction of non-sanctioning incident reporting systems, incident analysis tools, and a wide range of safety systems and procedures that are all

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