The Role of Compassion after an Adverse Event in a Hospital

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What is the influence of compassion in the primary reaction after an adverse event, and could its presence or absence be a factor for the success or failure of reconciliation in a hospital setting?

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Abstract
When a physician is involved in an adverse event, two things happen at once. A patient or family is harmed. And so, in a different way, is the physician. This thesis asks what enables or prevents compassion in the physician's primary reaction, and whether that compassion shapes the trajectory towards reconciliation. Eight semi-structured interviews were conducted with medical specialists in Dutch hospitals each with direct experience of a serious adverse event. The data were analysed using Max van Manen's hermeneutic phenomenological approach, attending to lived experience rather than causal explanation. Four themes structure the findings. The first is lived impact: an existential rupture marked by shame, counterfactual thinking, and eroded professional confidence. The second is the first reaction: a composite of action and numbing, dominated by the reflex to explain rather than acknowledge. The third — the central theme — examines compassion's presence and absence. Three distinct mechanisms of failure emerge: compassion fatigue, arising from structural exhaustion; compassion distress, the acute state in which the physician's own suffering leaves no space for the other's pain; and the defensive reflex, a trained product of a professional culture that treats failure as inadmissible. These are distinct problems requiring distinct responses. The fourth theme maps outcomes. Reconciliation occurred where someone stayed with the patient's suffering rather than simply accounted for the event. Such procedural responses consistently closed the relational space in which repair might have grown. The central finding is that compassion is not a character trait. It is a condition-dependent state. The physician involved in an adverse event is herself a second victim, and her capacity for compassionate communication is directly impaired by her own unresolved distress. The second victim experience is co-produced by the surrounding system: where colleagues and institutions respond with recognition, recovery becomes possible; where they respond with silence or judgment, it stalls. Five recommendations follow: an independent contact person for affected families; never entering a disclosure conversation alone; timely peer support for second victims; replacing counterfactual critique with local rationality inquiry; and measuring/addressing adverse event response by relational repair, not only legal outcome.

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SMALL KINDNESSES

I've been thinking about the way, when you walk
down a crowded aisle, people pull in their legs
to let you by. Or how strangers still say "bless you"
when someone sneezes, a leftover
from the Bubonic plague. "Don't die," we are saying.
And sometimes, when you spill lemons
from your grocery bag, someone else will help you
pick them up. Mostly, we don't want to harm each other.
We want to be handed our cup of coffee hot,
and to say thank you to the person handing it. To smile
at them and for them to smile back. For the waitress
to call us honey when she sets down the bowl of clam chowder,
and for the driver in the red pick-up truck to let us pass.
We have so little of each other, now. So far
from tribe and fire. Only these brief moments of exchange.
What if they are the true dwelling of the holy, these
fleeting temples we make together when we say, "Here,
have my seat," "Go ahead—you first," "I like your hat."

By Danusha Laméris (Laméris, 2020)

Abbreviations

ACSQHC – Australian Commission on Safety and Quality in Health Care

CDA – Critical Discourse Analysis

CFM – Cerebral Function Monitor

ECG – Electrocardiogram

EMDR – Eye Movement Desensitization and Reprocessing

ICU – Intensive Care Unit

KLM – Koninklijke Luchtvaart Maatschappij (Royal Dutch Airlines)

PTSD – Post-Traumatic Stress Disorder

WHO – World Health Organization

Contents

Introduction

In my career as a doctor, I have experienced several adverse events, sometimes resulting in death. These events have not only impacted my patients and their families but also my own life. Each event shaped my professional and personal views on how to care for the ones who are hurt. The way I responded had impact on the feelings my patients and their family had. In the beginning of my career, I received a complaint and the first thing I did was to explain myself. I thought being accountable meant that I had to be open about my medical decisions. A reluctant apology was appropriate — but to be honest, it wasn't entirely sincere.

Later in my career I worked as an anaesthetist and paediatric intensivist in a children's hospital. Working with children and parents requires a different approach than adult medicine. I was not only treating the child but the entire family system around the child — which demands more than just explaining and clarifying what is happening to their child. Empathy and compassion are possibly even more important because the treatment of a child is as collaboratively as possible with the parents. This means that a positive social relationship must be built where mutual trust plays a crucial role.

The difference in how I perceived the relation between patient, family and healthcare professional made me reflect on how we react in general after an adverse event in the Dutch hospital setting. This idea was reinforced by my work for a medical liability insurer, where 50-60% of claims are rejected. In many of these claims, there is often evidence however that there is insufficient acknowledgment of the suffering experienced by individuals, leading these patients to seek financial compensation. Open disclosure alone was not sufficient to alleviate their distress — acknowledgment of suffering was missing.

The Australian Commission on Safety and Quality in Healthcare outlines the following elements of open disclosure (ACSQHC, 2024), similar to the Dutch situation:

- An apology or expression of regret, including the words 'I am sorry' or 'we are sorry.'
- A factual explanation of what happened.
- An opportunity for the patient, their family, and carers to share their experience.
- A discussion of the potential consequences of the adverse event.
- An explanation of the steps taken to manage the adverse event and prevent recurrence.

While these elements are meaningful, experience shows they are a simplified description of reality. Acknowledging the suffering is also crucial (Iedema et al., 2011) — but how do you do that when you are personally affected by the incident?

A restorative approach focuses on repairing harm and rebuilding trust between patients, healthcare professionals, and the wider organisation (Kidder, 2007; Nickson & Neikirk, 2024). A restorative response is required to repair substantive losses, employ a fair and transparent process of resolution and address the psychological needs of acknowledgement, respect and dignity of all the people involved (Wailling et al., 2022). Rebuilding trust and relationships require ability, integrity and perhaps most of all benevolence (Mayer et al., 1995). Compassion is a benevolent emotional response towards another who is suffering, coupled with the motivation to alleviate their suffering and promote their well-being (Gilbert, 2019). Compassion is not yet a research object in a restorative approach after an adverse event — hence my research question will be more focussed on compassion.

What is the influence of compassion in the primary reaction after an adverse event, and could its presence or absence be a factor for the success or failure of reconciliation in a hospital setting?

Background and literature review

My research question is based on the theoretical perspective of compassion and the philosophical position of restorative just culture or practice. Compassion has become a major focus for international research in prosocial behaviour (*The Oxford handbook of compassion science*, 2017). Mascaro et al present an integrated theoretical review of methodologies used in the empirical study of compassion (Mascaro et al., 2020).

From literature there is a general definition of compassion as "a benevolent emotional response towards another who is suffering, coupled with the motivation to alleviate their suffering and promote their well-being"(Gilbert, 2019); The Dalai Lama (2002); (Strauss et al., 2016) From the definition of compassion Mascaro et al. include research conducted on compassion and related constructs that share or resemble some or all of the basic criteria that characterise compassion. These are (1) an awareness of another's suffering, (2) a benevolent emotional or affective response, and (3) the motivation to help or act (Strauss et al., 2016).

The ways to identify or quantify compassion, Mascaro et al. describe four clusters of features. (1) empirical perspective, (2) state versus trait, (3) ecological validity, and (4) quantitative versus qualitative.

Empirical perspective

A compassionate experience may be examined from a first-, second-, or third-person perspective. First-person data typically focus on the subjective experience and self-reported assessment of one's own compassion, collected in scale questionnaires, interviews, and focus groups. Second-person data often represent the perspective of the receiver or in vivo witness of compassion. A third-person perspective, or observational perspective, applies when the experimenter or observer determines the presence, absence, and measurement of compassion, and interprets evidence such as physiological and behavioural observations. For the research question I limit myself to the first-person perspective of the physician.

State versus trait

Another cluster of features pertains to the psychological distinction between dispositional or trait-level versus momentary or state-level measurement. State-level measurements examine the relationship between

internal processes and/or external circumstances and varying intensities of compassionate affect, motivation, and observable behaviour. Conversely, other research methods aim to understand compassion as an enduring individual or psychological trait. Traits — unlike states — are relatively stable aspects of a person's way of thinking, feeling, and acting over time and across a broad range of circumstances. The hypothesis is that an adverse event can significantly impact the intensities of compassionate affect, motivation, and observable behaviour. Therefore, for this research, I consider compassion as a state.

Ecological validity

Lastly, methods for understanding compassion generate data with varying degrees of ecological validity, meaning that findings cannot always be uniformly transferred or generalised from controlled settings to real-life contexts. Theoretically, the closer a study's methods mirror everyday life, the more ecologically valid its evidence will be. Typically, studies that impose stricter control of variables do so at the expense of ecological validity, favouring precision, replicability, or other strengths instead. This consideration is particularly significant given the social and environmental context of emotions and the crucial role of emotion, in the form of affect and motivation, in our understanding of compassion and its manifestations (Griffiths & Scarantino, 2005). A phenomenology-inspired method has therefore less ecological validity than a field study because it depends on the memory of an emotion — a field study, however, is ethically and practically seldom possible.

Quantitative versus qualitative

Quantitative data are numeric values that correspond directly or indirectly to measurements and/or observations of compassionate phenomena. Strauss et al. conducted a systematic search of measures of compassion, but all identified measures were found to have notable psychometric weaknesses (Strauss et al., 2016). Furthermore, since my research question focuses on the specific context of the moment after an adverse event, a general questionnaire would generate insufficient data.

Qualitative data, by contrast, describe compassionate phenomena through language or images, interpreted using non-mathematical methods. Qualitative, first-person approaches based on narratives, interviews, interactions, or focus groups examine the richer contours of compassion. These methods allow

participants to contextualise their responses, assess significance, and inform researchers about unexpected factors that arise in situ (Mascaro et al., 2020).

The epistemology of compassion science acknowledges the multidimensional nature of compassion and embraces an interdisciplinary approach to inquiry. Drawing from fields such as psychology, neuroscience, sociology, anthropology, and philosophy, researchers integrate insights from diverse disciplines to gain a comprehensive understanding of compassion and its underlying mechanisms. Constructivism as epistemology emphasises that knowledge is actively constructed by individuals based on their experiences, interactions, and mental processes. Constructivists argue that knowledge is subjective and context-dependent, shaped by social and cultural factors — though there is also an observational or naturalistic approach to compassion.

And in this research, a constructivist epistemology is adopted. Compassion after an adverse event is not treated as a fixed quantity waiting to be measured, but as a lived, situated experience that is co-constructed in the relationship between physician and patient, and made accessible only through the physician's own account of it. This aligns directly with the choices outlined above: compassion is approached as a state rather than a trait, from a first-person perspective, using qualitative rather than quantitative data. A hermeneutic phenomenological approach — as developed by Van Manen (Van Manen, 1990) — follows naturally from this epistemological position, since it treats the researcher's interpretive engagement with the participant's narrative as constitutive of understanding, rather than as a source of bias to be eliminated. The following section outlines this methodology in more detail.

Literature Review

There is little known about the role of compassion after an adverse event. Searching the keywords COMPASSION AND ADVERSE AND EVENT, results in 120 documents. 78 Were related to medicine and ultimately 20 documents related to my research question. There is no prior research done on compassion after an adverse event involving physicians — there is, however, more literature on compassion fatigue in healthcare and secondary traumatic distress or compassion distress. No earlier research seems to exist on the effect of the absence of compassion in the first reaction after an adverse event.

Iedema et al showed in a qualitative study that besides open disclosure, there is need for support and eventually closure. Patients and family members want closure at the end of the open disclosure process, and they believe that closure should occur through shared agreement between the patient and staff. And surprisingly patients and family members express concern about staff not being well supported by their colleagues within their own organisation. They believe that staff should be emotionally and professionally supported throughout the incident disclosure process (Iedema et al., 2011).

More recently Wailling et al argue that incident responses should be conceived within a relational as well as a regulatory framework. It involves bringing together all those affected by an adverse event in a safe and supportive environment, with the help of skilled facilitators, to speak openly about what happened, understand the human impacts, and clarify responsibility for the actions required for healing and learning (Wailling et al., 2022).

The restorative approach emphasises the importance of addressing the justice needs of all parties involved, including patients, families, health professionals, and organisations. It promotes active participation, respectful dialogue, truthfulness, accountability, empowerment, and equal concern for all individuals. The goal is to restore well-being and relationships alongside understanding what happened. The approach involves restorative conversations, facilitated meetings, circles, storytelling, and actions captured in a shared document. It also acknowledges the importance of empathy, dialogue, and trust-building in the healing process. McQueen et al calls it person-centred compassionate communication that attempts to redress the power imbalance (McQueen et al., 2022).

The empirical nature of compassion is not well understood; it involves the presence of suffering and a desire to relieve it within a dynamic relationship that may change over time. Compassion is at once considered essential to good medical care and, in some jurisdictions, proposed or enacted as a legal patient right, yet its intangible, emotion-linked nature makes it difficult to specify, measure, or enforce — creating an inherent tension for legislators and regulators, who must decide whether an emotional response can be turned into an enforceable standard, and for physicians, who may be held to a duty they cannot simply choose to fulfil (Paterson, 2011).

On the other hand, the absence of compassion is a well-known research topic in healthcare. Compassion fatigue and compassion stress have first been described in 1995 by Charles Figley as a

phenomenon of secondary traumatic stress (Figley, 1995). Since then, multiple papers have been published on this topic (Berg et al., 2016; Cocker & Joss, 2016; Jain et al., 2019; Van Mol et al., 2015; Wentzel & Brysiewicz, 2018)

In the field of safety science, there are not many papers on compassion although Todd Conklin in his book "When the worst accident happens" clearly states that "Leadership's response to failure matters" (Conklin, 2019, 2020). In short, compassion in safety science plays a crucial role in recognising and addressing the suffering of individuals and communities affected by accidents. It involves promoting empathy, understanding, and support, and emphasises the importance of alleviating suffering and promoting well-being. Compassion also involves social responsibility, safety improvement and prevention, and treating victims as human beings. Additionally, primary and secondary victims can play a significant role in promoting safety by sharing their experiences and speaking from the heart if shown compassion. However, the role of compassion in safety science still has received limited attention (Zwetsloot & Bruin, 2023).

Methodology

For the research question a qualitative approach was chosen to describe compassion, compassion fatigue and compassion distress as a phenomenon in language. Phenomenology-inspired empirical studies of compassion address questions ranging from how participants identify subjective experiences of feeling, receiving, and training in compassion (Pauley & McPherson, 2010), to what compassion "is like for them" to experience, receive, and cultivate (Lawrence & Lee, 2014). Other phenomenology-inspired studies have similarly examined the subjective, first-person dimensions of compassion inhibition and compassion fatigue (Jack, 2017; Mascaro et al., 2020; Waite et al., 2015).

Data collection

The interview is an important data gathering technique involving verbal communication between the researcher and the subject. Interviews are commonly used in survey designs and in exploratory and descriptive studies. There is a range of approaches to interviewing — from completely unstructured, in which the subject is allowed to talk freely about whatever they wish, to highly structured, in which the subject responses are limited to answering direct questions (Mathers et al., 2000, p. 113).

The semi-structured interview, valued for its accommodation to a range of research goals, typically reflects variation in its use of questions, prompts, and accompanying tools and resources to draw the participant more fully into the topic under study. Semi-structured interviews incorporate both open-ended and more theoretically driven questions, eliciting data grounded in the experience of the participant as well as data guided by existing constructs in the particular discipline within which one is conducting research (Galletta & Cross, 2013, p. 45).

Semi-structured interviews have been used as a method in compassion research (Baránková et al., 2019; Fagan et al., 2022; Joy et al., 2022). To define the presence or absence of compassion (compassion fatigue) it is methodological valid to compare the research findings with earlier research on the subject.

The interviews were semi-structured with the following topics:

1. Can you remember a case where you had to tell your patient that something went wrong?

2. Inquiry about the presence of compassion. Compassion can be defined as a cognitive, affective, and behavioural process consisting of the following five elements that refer to both self and other-compassion (Strauss et al., 2016):
    a. *Recognising suffering.*
    b. *Understanding the universality of suffering in human experience.*
    c. *Feeling empathy for the person suffering and connecting with the distress (emotional resonance).*
    d. *Tolerating uncomfortable feelings aroused in response to the suffering person (e.g. distress, anger, fear) so remaining open to and accepting of the person suffering.*
    e. *Motivation to act/acting to alleviate suffering.*
3. Inquiry about the presence of compassion fatigue. How hard is it to show compassion when you see suffering on a daily basis. Signs of compassion fatigue (Cocker & Joss, 2016):
    a. Exhaustion, anger, and irritability.
    b. Negative coping behaviours such as alcohol and drug abuse.
    c. Reduced ability to feel sympathy and empathy.
    d. Diminished sense of enjoyment or satisfaction with work.
    e. Increased absenteeism.
    f. Impaired ability to make decisions and care for patients or clients.
4. Inquiry about the presence of compassion distress. Compassion distress is when there is a disability to tolerate difficult emotions in oneself when confronted with someone else's suffering (Gilbert, 2015). Compassion distress has similarities with compassion fatigue however it is possible that the physician did not see that much suffering but failed to show compassion because of inner competing motives. Signs of lacking distress tolerance are (Simons & Gaher, 2005):

a. Emotional Overwhelm: Frequently feeling overwhelmed by the suffering or needs of others can indicate a lack of distress tolerance. This may involve intense emotional responses like anxiety, sadness, or anger that are difficult to manage.
b. Avoidance Behaviours: Avoiding situations where compassion is needed, such as not engaging with distressed individuals or avoiding specific tasks that involve dealing with others' suffering, can be a sign. This avoidance can be physical or emotional, such as detaching emotionally from patients or clients.
c. Burnout: Experiencing burnout, characterized by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment, can indicate low distress tolerance. Burnout is common in professions requiring high levels of compassion, such as healthcare and social work.
d. Compassion Fatigue: Similar to burnout, compassion fatigue specifically arises from the constant demand for empathy and compassion. Symptoms include feeling numb or disconnected from the suffering of others, reduced empathy, and a sense of helplessness.
e. Impatience or Irritability: Reacting with impatience, irritability, or frustration towards those in distress or towards colleagues and loved ones can signal difficulty in managing distressing emotions.
f. Substance Abuse or Maladaptive Coping Mechanisms: Using alcohol, drugs, or other maladaptive coping strategies to deal with stress and emotional discomfort is a clear sign of poor distress tolerance.
g. Physical Symptoms: Chronic stress and an inability to tolerate distress can lead to physical symptoms such as headaches, gastrointestinal issues, fatigue, and sleep disturbances.
h. Withdrawal and Isolation: Social withdrawal or isolation from colleagues, friends, or family as a way to cope with stress can indicate low distress tolerance. This can manifest as reduced participation in social activities or decreased communication with others.

i. Negative Self-Talk and Self-Blame: Engaging in negative self-talk or self-blame when unable to alleviate others' suffering or when faced with challenging emotional situations can reflect a low ability to tolerate distress.

j. Inconsistent Performance: Fluctuating work or caregiving performance, where periods of high efficiency and engagement are followed by periods of significant decline, can be a sign. This inconsistency often reflects underlying emotional struggles.

5. The final part of the interview will focus on the subsequent course of the adverse event. Whether some form of reconciliation has taken place or if a complaint or claim has been filed.

Informants and ethical considerations

Medical specialists or medical trainees who were involved in an adverse event took responsibility to give the first reaction to a patient or its family. Because the research question is focused on the presence or absence of compassion and not on the adverse event, an interview with a complaint officer about the follow-up of the adverse event was not part of the study design for ethical reasons — it was sufficient to ask whether the adverse event had consequences for the physician, patient, or family.

Seventeen (17) medical specialists were invited for an interview. The selection of informants was based on a variety of specialisations. Ultimately, eight (8) informants agreed to participate in an interview. The following medical specialists are represented:

Pulmonologist

Paediatrician

Vascular surgeon

Paediatric intensivist

Urologist

Neonatologist

Gynaecologist

Anaesthetist

Six of the eight participants were women and two were men. An informed consent has been signed prior to the interview. The interviews were held in Dutch and aimed for a duration of 60 minutes — the average duration was 68 minutes. Four (4) contacts were face-to-face, and the same number was via Microsoft Teams.

All eight participants were assigned pseudonyms prior to analysis. The names used throughout this thesis — Anna, Thomas, Sophie, David, Noor, Helena, Susan, and Claire — are fictitious. No participant is referred to by their real name at any point in the data or the analysis.

This choice reflects a methodological commitment as much as an ethical one. Van Manen (1990/2016) identifies the protection of the participant's lived experience as a primary ethical obligation: the text must preserve the essence of the experience without exposing the person who shared it. Anonymisation serves that purpose. The question is how.

In phenomenological research, three approaches are common. The first — and most widely used — is the pseudonym. The researcher assigns each participant a fictitious first name, which the participant carries consistently throughout the analysis and writing. The second approach uses labels such as 'Participant A' or codes such as 'P3'. The third uses initials.

For this study, pseudonyms were the only methodologically defensible choice. Van Manen's approach centres the lifeworld of a person, not the output of a data source. When a reader encounters 'Participant A said...', the human being behind the account recedes. When they encounter 'Anna described how she trembled at the telephone', the person — and therefore the lived experience — remains present. Pseudonyms preserve that presence while severing the link to the real individual.

Pseudonyms were also chosen to correspond to the actual gender of each participant. This was a deliberate decision rather than an incidental one. In a phenomenological study, gender is not a neutral demographic variable that can be reassigned without consequence: it belongs to the lived body, and it shapes how a physician is positioned within a professional culture, how emotional expression is read by colleagues, and what is expected of her in the aftermath of an adverse event. A reader who encounters an account under a pseudonym of the opposite gender is interpreting the experience through a lifeworld that is not the participant's own.

This is not a costless choice. Bosk (Bosk, 2003) disguised the gender of the one female resident in his surgical ethnography precisely because the rarity of her position would otherwise have made her identifiable, and gender-consistent pseudonymisation forgoes that layer of protection. In this study the trade-off was resolved in favour of fidelity, on the grounds that the necessary protection could be achieved by other means — generalising institutional context and case-specific detail, and, where residual risk remained, seeking renewed and specific consent. Reassigning gender would have purchased protection at the price of the phenomenon itself.

Given that all eight participants are medical specialists working in a relatively small professional field in the Netherlands, pseudonymisation alone is not sufficient to guarantee non-identifiability. Specialism, institution, and the specific nature of the adverse event described can, in combination, render a participant recognisable to colleagues even without a real name. Where this risk was present, identifying details — including institutional context and certain case-specific features — were generalised or omitted. In two instances, quotations were lightly paraphrased at the level of phrasing rather than meaning, to reduce the possibility of recognition. In all cases, the phenomenological substance of the account was preserved. Participants were informed of these measures and provided written consent for the use of their anonymised accounts.

This thesis does not claim that these measures eliminate the risk of recognition. That residual risk is inherent to phenomenological work, which depends on the concrete particularity of an account for its evidential force: the detail that makes an experience recognisable as lived is often the same detail that makes it traceable. Generalising it away would protect the participant at the cost of the phenomenon.

Where this risk could not be reduced further without damaging the account, renewed and specific consent was sought after the analysis was written, rather than relying on the general consent given before the interview. In one instance the participant was shown the quotations attributed to her pseudonym in their final form and asked two questions: whether she agreed to their use, and whether her consent extended to the residual risk that colleagues familiar with the case might recognise her. She confirmed both in writing. That confirmation is held with the study documentation.

Expected Results and Analysis

Max van Manen's hermeneutic phenomenological approach is centred on exploring and interpreting the lived experiences of individuals to understand the deeper meanings and essences of those experiences. This approach combines elements of phenomenology and hermeneutics, emphasising both the description of lived experiences and the interpretation of their meanings within specific contexts. Here are the key aspects of van Manen's approach:

- Lived Experience (Lifeworld): Van Manen focuses on the concept of the lifeworld, which refers to the world as experienced in the immediacy of everyday life. The goal is to capture and describe the essence of these experiences as they are lived by individuals.
- Intentionality: This concept refers to the directedness of consciousness towards objects or experiences. Van Manen explores how people are intentionally directed towards their experiences and how these experiences are meaningfully constituted in their consciousness.
- Reflective Analysis: The approach involves a deep, reflective analysis of lived experiences to uncover their essential meanings. This reflection is both descriptive and interpretive, aiming to reveal the essence of the experience and its significance.
- Hermeneutic Circle: Understanding is seen as a circular process involving a continuous movement between the parts and the whole. Researchers engage in a dialogue with the text (e.g., interview transcripts, reflective writings) to interpret and understand the meanings embedded within it.
- Epoché and Reduction: While van Manen acknowledges the phenomenological practice of epoché (bracketing), he emphasises that complete bracketing is impossible. Instead, researchers should at least instead be aware of their preconceptions and strive to engage with the experience as openly as possible.
- Thematic Analysis: Identifying and interpreting themes is a central aspect of van Manen’s method. Themes are the structures of experience that make it what it is.

Thematic analysis involves isolating and articulating these themes to understand the essence of the experience.

- Writing and Rewriting: Van Manen places a strong emphasis on the process of writing as a method of phenomenological research. Writing and rewriting help to clarify and deepen the understanding of lived experiences, making the meanings more explicit.
- Contextuality: Van Manen's approach recognises that experiences are always situated within specific contexts. Understanding the context is crucial for interpreting the meanings of experiences.
- Researcher's Role: The researcher is not a detached observer but an active participant in the research process. Their subjectivity and interpretive insights are integral to the phenomenological inquiry.

In the phase of hermeneutic phenomenological reflection, van Manen's approach helps to grasp the essential meaning of the experience being studied. Thematic analysis is conducted according to the themes of compassion, compassion fatigue and compassion distress or distress intolerance. These phenomenological themes "are more like knots in the webs of our experiences, around which certain lived experiences are spun and thus lived through as meaningful wholes" (Van Manen, 1990, p. 90).

For van Manen (Van Manen, 1990), writing is not the last step of his research process. He argued that writing is a reflective part of his interpretive phenomenological method. Phenomenological writing does not just involve writing up the results. To write phenomenologically is to reflect. For van Manen, to write is to do research (Beck, 2021, p. 77).

Results and Thematic Analysis

This analysis draws on eight semi-structured interviews with medical specialists working in Dutch hospitals. Following Van Manen's hermeneutic phenomenological approach (Van Manen, 1990), quotations are chosen for their meaning, not their frequency. They function as phenomenological exemplars — moments in which the essence of an experience becomes visible in language. A summary cannot do that work. The quotations must speak.

Reflexive Stance

Before entering the material, I bracketed a number of assumptions that could easily distort the analysis. The assumption that an adverse event implies negligence. The assumption that a physician who seems cold is actually cold. The assumption that open disclosure repairs relationships. The assumption that a complaint or claim signals communication failure. Whether any of these are true in a given case is precisely what the interviews should show — not what I bring to them. Throughout the analysis, the primary frame is the physician's lifeworld, not causal or legal logic (Van Manen, 1990). Quotations are selected for meaningfulness, not representativeness.

What Runs Through All Eight Accounts

Eight specialists — a paediatrician, a paediatric intensivist, a pulmonologist, a vascular surgeon, a gynaecologist, a neonatologist, a urologist, and an anaesthetist — each describe a moment when something went wrong and the ground shifted. The specific events differ widely. What does not differ is the structure of what followed: a disruption at the intersection of responsibility and role. These physicians had to simultaneously be the person who acted and the person who must carry what that action produced.

The emotional registers vary. But beneath them runs a shared undercurrent: shame, doubt that does not let up, and the loop of counterfactual thinking. Helena nearly quit medicine. Susan developed PTSD. Anna suppressed what happened for years. Sophie retreated into technical mastery. Thomas watched compassion erode under the weight of a family's escalating distrust. David described shame as the urge to disappear into the corner of a room. Noor could not make contact with a patient in the very space meant for repair. Claire stood without any support in a culture that looked away.

What is also clear, though: compassion was not gone. It was blocked — by shame, by emotional overload, by the reflexive need to defend, or by coping strategies physicians learned in training without ever being told that is what they were learning. Where compassion did break through — in David's department, in Helena's telephone call, in the complaint officer's single sentence to Anna — it almost always involved some combination of distance, support, and the willingness to simply be present rather than explain.

Key Quotations

The quotations below were selected to carry essential meaning across the four themes. All were originally spoken in Dutch; translations are the researcher's own.

Participant	Quotation	What it shows
Helena (Gynaecologist)	The first baby that truly died in my hands.	Not metaphor — her hands were where it happened. The adverse event lodged itself in the body before it became a thought.
Helena	I lost my mojo. I didn't do this right. That is how I went into summer holiday.	The holiday was meant to restore. It didn't. Doubt travelled with her.
Helena	She screamed at me for ten minutes. I was literally trembling at the telephone.	Fear and duty occupied the same moment. She stayed on the line anyway.
Helena	I think the greatest compliment was that she wanted to come back to me.	Trust rebuilt — not through explanation but through sustained presence.
Susan (Anaesthetist)	You flew for the wrong reason, and you have turned this patient into a vegetable. The ground truly fell away.	The judgment of colleagues landed harder than the event itself. A second wound.
Susan	He said the stress I must have experienced was truly indescribable.	The first response that named her suffering before evaluating her decisions. The turning point.
Susan	I didn't really make contact. That part feels unfinished to me, even now.	She knew it wasn't indifference. She had no space left. That is different.

Sophie (Paediatric intensivist)	The mother kept screaming: You killed my child. That swept away everything the external expert had said.	Logic and acknowledgement do not live in the same register. You cannot argue someone out of grief.
Sophie	My most important advice: bring someone with you who has distance.	She had learned this the hard way. Distance in another person creates space for the patient.
David (Vascular Surgeon)	It's not shame in the classical sense — but you feel utterly incompetent.	Existential, not situational. The event implicates the self, not just the action.
David	We work against a baseline of zero. That baseline is perfection.	The cultural substrate that makes every shortfall feel catastrophic.
David	David, you are too deep into this. Go and walk around the block. I'll continue for now.	One colleague, one sentence. That is what a compassionate architecture looks like in practice.
Noor (Urologist)	I felt profoundly unheard. There was no movement towards each other.	The complaints procedure closed the very door it was supposed to open.
Noor	If you are the only one being open and she uses it to fire another arrow — at some point you reach your limit.	Not fatigue from repetition. Depletion through asymmetry. Those are different problems.
Anna (Pulmonologist)	I was a master at suppressing feeling. Simply making it unfelt.	A learned skill, not a character flaw. The training produced it.
Anna	Ten minutes at the outpatient clinic is not enough time to make a connection.	Not a personal failing. A system constraint. The two should not be confused.
Claire (Neonatologist)	When people look away, you have no support. Then you are defending rather than being compassionate.	Absence of support does not just leave you alone — it actively pushes you into the wrong posture.
Thomas (Paediatrician)	The moment anger becomes incomprehensible — that is when the professional limit steps in.	There is a threshold. Compassion does not require the physician to absorb everything.

Theme 1: The Lived Impact

An adverse event does not arrive as a problem to be solved. It arrives as a rupture. Something in the physician's understanding of herself — as competent, careful, someone who does not cause harm — breaks open. That is what this theme is about.

Meaning Units

Quotation	What is lived?	Van Manen reading
The first baby that truly died in my hands. (Helena)	The event as bodily fact, not abstraction	The hands that delivered life now mark the moment life ended. The impact is not symbolic — it is somatic and immediate.
I lost my mojo. That is how I went into summer holiday. (Helena)	Confidence gone; grief as constant companion	Holidays should reset. This one deepened the wound. Doubt does not respect institutional time-off.
You feel as though you have destroyed someone's life. (David)	Guilt fused to identity, not just to the act	This is not 'I made a mistake.' This is 'I am the cause of profound suffering.' Those are not the same experience.
The ground truly fell away. They said I turned this patient into a vegetable. (Susan)	Second trauma inflicted by the system's judgment	The adverse event was survivable. The response of colleagues and the institution was the thing that broke her.
I felt deeply guilty. That child ultimately died. (Sophie)	Guilt as enduring weight, independent of verified causality	Responsibility does not wait for a formal determination. The physician assigns it to herself long before any investigation concludes.
I was a master at suppressing feeling. Simply making it unfelt. (Anna)	Impact buried, never processed	Not a natural response — a trained one. The training taught suppression as function.
We work against a baseline of zero. That baseline is perfection. (David)	Perfectionism as the cultural amplifier of every failure	In a system where anything less than perfect is by definition insufficient, each adverse event carries existential weight.

Sub-Themes

Being struck by moral shock

The event enters experience as a moral rupture, not just a clinical problem. Helena was already questioning her own actions while still completing the caesarean section. Susan could not begin to process the flight until a colleague acknowledged what she had been through. Sophie drowned herself in CFM literature — a retreat into expertise that kept the unbearable at arm's length.

Responsibility carried in the body

Impact is somatic before it is cognitive. Trembling at the phone. Blisters on the hands. The sensation of the floor dropping. These are not metaphors. The body absorbs what the mind has not yet processed, and it does so immediately and involuntarily.

The erosion of professional confidence

After an adverse event, the doubt is not only about the action. It is about the person. Helena thought about leaving the profession. Susan could not manage a complex case. Anna wondered, years later, whether she could have handled things if the harm had been permanent. The usual anchor of professional identity becomes unstable ground.

The counterfactual loop

Every participant described it: the questions that have no answer but that keep returning. Should I have acted sooner? Read the monitor more carefully? Referred earlier? The loop does not produce learning. It produces exhaustion. Helena called it a film that plays again and again. There is no pause button.

The second blow: being judged after the event

For several participants, the most damaging moment was not the adverse event itself. It was what colleagues, the institution, or the patient's family did next. Susan's department head wished her 'every success with processing the incomprehensible decisions' she had made. That sentence arrived when she was already on the floor. It did not help her up.

Phenomenological Narrative

There is a moment in which the physician stops being the doctor who helps and becomes the person in whose hands something went wrong. Sometimes it happens fast — a baby that doesn't respond, an alarm, a radiological report. Sometimes it creeps in slowly, a growing realisation that what was done was not enough. Either way, what distinguishes this from ordinary grief or regret is the tight coupling to one's own action. This is not just terrible. This was done by me.

The impact lives in the body. Hands tremble. The ground falls away. Doubt rides along to the summer holiday uninvited. The body refuses to file away what the mind would prefer to close. And here lies a paradox that several participants named, each in their own way: the physicians who care most, who hold themselves to the highest standard, are precisely the ones most exposed to existential shame when something goes wrong. The very things that make a doctor good — conscientiousness, perfectionism, a deep sense of responsibility — can become the engine of the most brutal self-punishment.

Existentials

Lived body:

The body is the first register. Helena's hands draw a lifeless child from the womb. Susan's hands manually ventilate a patient on a transatlantic night flight. The body carries the event before the physician has words for what happened.

Lived time:

Time does not flow normally after an adverse event. Helena's holiday is a rotten one. Susan's months in Bonaire are a period of non-processing. Counterfactual thinking pulls the physician back into a past she cannot change, while the present demands that she show up and function.

Lived space:

The hospital changes. The delivery room becomes a place of memory. The operating theatre carries a different weight. Helena describes hesitation before going back in. Susan could not take on complex cases in the early months. Familiar spaces become marked.

Lived relation:

Every relationship shifts. With the patient, the family, colleagues, and the self. The physician feels alone and judged. The question 'who can I turn to?' becomes urgent. Sophie needed someone who could recognise what she had known at the time, not what everyone now knew looking back. Susan needed someone who named her suffering before evaluating her choices.

Theme 2: The First Reaction

The first reaction is not a single moment. It is an episode — unfolding across hours, days, sometimes weeks — and it sets the course for almost everything that follows.

Meaning Units

Quotation	What is lived / done?	Meaning
I picked up the phone and called her. She screamed at me for ten minutes. I was trembling. (Helena)	Active engagement despite fear	She moved towards the patient rather than away. That took something.
Basic rule: if someone is angry, let them be angry. Listen and do not defend. Not everyone manages it yet. (Thomas)	A principle learned, not instinctive	The word 'yet' matters. Thomas knows this is not where most people start. It is where years of practice land you.
My first reaction: it's Friday, I want wine. My second: we don't have enough people in the building. (Sophie)	Human and professional, simultaneously	Both voices are real. Neither cancels the other. That co-existence is what the first reaction actually feels like.
I went along a little with the cynical tone, almost laughing — while it was anything but funny. (Anna)	Gallows humour as a way of coping	Not indifference. A survival mechanism. Dark humour is what you reach for when the actual feeling is too much.
Half the hospital was involved. At that point I lost all overview. (Susan)	Cognitive tunnel under extreme pressure	The tunnel is not panic. It is a systematic narrowing of attention. Compassion cannot co-exist with it.

The moment the anger becomes incomprehensible — that is when you draw a line. (Thomas)	Compassion reaching its limit	There is a difference between tolerating hard emotions and absorbing aggression indefinitely. The line is not selfish.
I switch myself off somewhat — without losing the thread of empathy. (Helena)	Deliberate self-regulation	Not suppression. A dampened presence that can still receive the other. This is a skill she developed over years.

Sub-Themes

Switching into clinical mode

The reflex of many physicians is to activate protocol: organise the debrief, file the report, gather the team. This creates structure when everything else has dissolved. But it can also bury the emotional impact under procedural competence, sometimes for years. Susan built an improvised ICU in the business class of a KLM 777. Sophie drew up a contingency plan on a Friday afternoon while also wanting wine. Clinical control is protective. It is also, sometimes, a way of not feeling what happened.

Staying composed while coming apart inside

The gap between what shows and what is experienced was a consistent theme. Helena remained calm on the phone while trembling. Anna adopted the register of dark humour to keep things manageable. David put it plainly: when you are overwhelmed, it is almost impossible to be compassionate, because you are occupied with yourself. That is not a character failing. It is the neurophysiology of acute stress.

Waiting for certainty before speaking

Several physicians held back — waiting for a diagnosis, an autopsy result, an investigation — before saying much to the patient or family. The impulse is understandable. But the suffering was already present. The person in front of the physician did not need the full explanation first. They needed to feel that someone was there.

Silence as a form of self-protection

Anna said nothing about the drain for years. Claire's senior colleagues in training stayed quiet out of fear of being criticised. Thomas described a whole layer of 'silent specialists' carrying doubt they never voice. Silence protects against exposure, but it also prevents anything from being processed. And it makes it harder for those around the physician to offer what she needs.

Moving towards the patient anyway

Not everyone retreated. Helena picked up the phone. Noor returned to her patient that same evening. David stood before his colleagues and described his own errors. Sometimes the first reaction is courage — the choice to remain present when everything in you is pulling the other way.

The reflex to defend

The most universal first response in the complaints encounter was defensive: explaining, justifying, contextualising. Sophie tried to take the parents through the events step by step. Noor described the circumstances to the complaints committee. This is not dishonesty — it is an internalised reflex from a professional formation that treats failure as inadmissible. But it is also the reflex that, more than almost anything else, prevents connection from forming.

Phenomenological Narrative

In the moment when the monitor shows something alarming, or the baby does not respond, or the ECG comes back and you already know — the physician is not a figure in a system. She is a person who is struck. There is a fraction of a second before the professional reflex floods back in. In that fraction there is only the reality: something has gone wrong.

For most, the first reaction is a composite of doing and numbing. Protocols engage. Teams are assembled. Feeling gets set aside — not from indifference, but because full feeling and full functioning cannot coexist in that moment. The body knows this before the mind does. The hands keep working. The voice might speak slightly too quickly, or go slightly too quiet for slightly too long.

Only later — sometimes hours, sometimes weeks — does the return come. The holiday that gives no rest. The case that won't close. The film playing again with the same unanswerable question. The first reaction is not a single moment. It is an episode that moves through the body and colours everything that comes after.

Existentials

Lived body:

The body reacts before the mind catches up. Trembling, silence, the reflex to defend — these are not chosen. Physicians learn to master this body. It never fully cooperates.

Lived time:

The first reaction spans radically different temporal scales: the ninety-minute sprint of Susan's flight preparation, and the months of Helena's silent self-doubt. Time after an adverse event does not move the way it usually does.

Lived space:

The space of the first reaction is sometimes a specific room — a telephone, a complaints committee, a cockpit — and sometimes entirely interior. Sophie described a lack of inner space. Susan described losing all overview. The inside and the outside collapse into each other.

Lived relation:

The physician is alone and in relation at the same moment. Alone in the guilt and the doubt. In relation to the patient's reaction, to the colleague who is or isn't there, to the institution that will or won't offer cover. How that relational field is configured in the first hours shapes everything that follows.

Theme 3: The Presence and Absence of Compassion

This is the central theme of the thesis, and the most complex to write about. When compassion is present, it tends to be visible in a specific act or moment of presence; when it is absent, what is visible instead is

defensiveness, exhaustion, or numbness — and inferring the absence of compassion from these requires interpretive care. The coding scheme below makes that inference explicit and auditable.

Operationalisation

Compassion, throughout this analysis, means; awareness of suffering plus an emotional response to it plus motivation to act (Gilbert, 2019; Strauss et al., 2016). Importantly, compassion requires enough distance from the other's pain to see it clearly, and enough proximity to be genuinely moved. Too close, and you get sympathy — swept away, unable to help. Too far, and you get clinical detachment. Three categories structure the coding:

1. Compassion present — the physician perceives, responds, and acts from a genuine motivation to help.
2. Compassion absent due to fatigue — blocked by cumulative exhaustion from sustained exposure to suffering.
3. Compassion absent due to distress intolerance — blocked by the physician's own acute emotional state after the adverse event.

Compassion Coding

Quotation	Category	What it shows
I stood alongside those people as a representative of the organisation — sharing facts, but also genuinely there. (Thomas)	1 — Present	Thomas had distance from the case. That distance let him bring warmth without losing objectivity. The two are not opposites.
I listened to their account without immediately correcting or explaining. First let them exhaust it. (Thomas)	1 — Present	Sitting with a story until it is spent — not fixing, not redirecting. That takes patience and real presence.
She said: My goodness, what a dreadful time you have had. And then it was settled. (Anna, on the complaint officer)	1 — Present	One sentence. From someone with no stake in the outcome. That is what the formal procedure could not produce.
I stayed calm and gave her space to rage. I tried not to interrupt. (Helena)	1 — Present	Endurance as compassion. Staying in the fire without putting it out. That is a skill, not a reflex.

If you are the only one being open and she keeps firing arrows — at some point you reach your limit. (Noor)	2 — Absent: Fatigue	Generosity asymmetrically used until the reserve runs dry. Not a character flaw. A human limit under sustained pressure.
Ten minutes at the outpatient clinic is not enough time to make a connection. (Anna)	2 — Absent: Fatigue	The system — not the physician — prevents connection. Those two should not be conflated.
I didn't really make contact. I think I simply had too little inner space. (Susan)	3 — Absent: Distress	She was not indifferent. She had nothing left to give. That distinction matters enormously.
I went along with the cynical tone, almost laughing — while it was anything but funny. (Anna)	3 — Absent: Distress	Dark humour as distress management. Costly, functional, not chosen freely.
The moment the photograph was placed on the table — look what you did to him — at that point you lose it. (Thomas)	3 — Absent: Distress	The encounter tips from grief into assault. The physician's self-protective reflex is not a failure of compassion — it is a human response to being attacked.
I gave her ten minutes to rage, then made a decision: do I hang up, or can I find a way through? (Helena)	1 — Present (after regulation)	Compassion as a deliberate act, not a spontaneous feeling. She regulated herself and then chose to stay. That is what practice looks like.

Sub-Themes

Compassion as staying with suffering

The clearest cases of compassion in this data share one feature; the physician remained. Did not defend, did not explain, did not redirect. Just stayed. Helena stayed on the telephone. Thomas sat with families until their account was spent. David described developing genuine care for patients even when they fell in what he called his allergic zone — not because it was easy, but because staying is what the work requires.

The defensive reflex as compassion's opponent

In most complaint encounters, the reflex to defend precedes any compassionate response. The physician explains, justifies, contextualises. Noor could not be compassionate in the complaints committee — not because she doesn't have it in her, but because the structure of the process made it impossible. The format that is meant to process harm often amplifies it.

Compassion fatigue as a system failure, not a personal one

Anna's ten-minute consultations. Thomas's hospital without a dedicated contact person for affected families. These are not stories about burned-out individuals. They are stories about institutional conditions that exhaust compassionate capacity before any specific adverse event even occurs. Fatigue is the system's fingerprint on the physician's chest.

Compassion distress: when the physician's own pain takes the room

Susan's conversation with the patient after the flight is the starkest case. She is, by her own account and the account of colleagues, a compassionate physician. But she could not make contact. She had no inner space left. Sophie captured the mechanism precisely: 'My own emotion — the parents have nothing to gain from that. If you have distance from your own emotion, there is more room for theirs.' Without a regulated nervous system, compassion is structurally unavailable (Porges, 2009). This is physiology, not character.

When the colleague is absent

Susan's department head. The intensivist who stated publicly that the patient had been transferred too late. The complaints committee that wanted only facts. The absence of compassion is not only individual — it is institutional. The system that surrounds the physician is itself failing to offer what it will then demand she provide.

Defensiveness where tenderness should be

When compassion is unavailable, defensiveness fills the space. The lawyer's instruction: never concede. The specialist's rationalisation: I did what was correct, it is unfortunate. The institution's reflex: send the report to the inspectorate. None of these are immoral choices. They are just protective responses in the absence of the conditions that would make something better possible.

Essay: Compassion as Possibility — and Its Opposite

Compassion after an adverse event is not a default. It is something that opens under specific conditions and closes when those conditions fail. The participants in this study demonstrate every point on that spectrum — from Thomas sitting with a family for months, to Susan's flat, disconnected encounter with the patient she had carried across an ocean.

What compassion costs is real. It requires the physician to regulate her own pain sufficiently that the other's pain can enter. That is not suppression — it is the kind of active management that Helena describes as 'switching herself off a little without losing the thread of empathy.' David calls it drawing from the toes when the patient sits in your allergic zone. These are not poetic descriptions. They name something specific about what compassionate presence means, requires and what it costs.

The setting matters enormously. A complaints committee with a lawyer as chair makes compassion structurally impossible — the questions are about facts, the family's anger has legal significance, the physician is defending a position. A colleague who sits alongside the physician and can carry the compassion when the physician cannot — that makes the opposite possible. Research cited by one participant suggests compassion is contagious: when one person shows it, it becomes easier for others to follow. But someone has to go first. And at the beginning there is always a choice — to stay, to listen, to remain even when it hurts.

Existentials

Lived body:

A regulated nervous system is the somatic prerequisite for compassion. When Susan's body was in sustained alarm, she could not make contact regardless of intention. The body does not allow compassion on demand.

Lived time:

Compassion requires time — to listen, to let the anger exhaust itself, to return when the first encounter was too charged. Helena's returning patient and Noor's second conversation both came after time had done its work. Hurried compassion tends not to have the results one hopes for it.

Lived space:

The complaints committee room closes compassion down. The private office where Thomas met the parents allowed it. The delivery ward corridors, full of expectant mothers, were too confronting for Helena's bereaved patient. Space helps co-determine what is possible in an encounter.

Lived relation:

Compassion is relational by definition. It requires two people who can reach each other — not two legal positions facing off. Prior trust, a shared history of openness, the absence of an adversarial frame: these are not luxuries. They are the substrate of clinical work.

Theme 4: Outcome — Reconciliation or Escalation

Where does this all end? That is what Theme 4 tries to answer. Across the eight cases, the outcomes range from genuine reconciliation — a patient who returned and trusted again — to what Thomas calls the silent death: no complaint, no claim, no repair.

Outcome Mapping

Participant	Trajectory	Turning point	Where it landed
Helena	Near-escalation → reconciliation	Stayed on the telephone for ten minutes of rage, then opened a conversation	Patient returned for her next pregnancy
Thomas (twins)	Potential conflict → guided repair	Became independent contact with no stake in the investigation's outcome	Parents presented to the board; no formal complaint
Thomas (dermatologist case)	Escalation → silent death	Anger became incomprehensible; the organisation drew a line	Letter to inspectorate; lasting resentment; nothing repaired
Susan	PTSD → slow recovery	The colleague who named her suffering before judging her decision	Full recovery; employer invested in her return

Noor (sepsis)	Formal complaint → committee → no connection	Lawyer as chair foreclosed any relational encounter	Complaint processed; relationship not restored
Noor (intraoperative)	Initial anger → reconciliation	Returned the same evening for a second conversation	Patient brought chocolate; relationship deepened
Sophie	Silent processing → systemic learning	External inquiry gave partial acknowledgement	No complaint; enduring guilt; expanded systemic awareness
David	Openness as deliberate strategy	Publicly disclosed his own errors before colleagues	Strong team culture; low threshold for further openness
Anna	Shame → silence → belated processing	This interview, years later	No formal outcome; a personal reckoning
Claire	Unsafe training → disciplinary proceedings → recovery	Presenting the case to the department as processing strategy	No sanction; persistent doubt; recovery through openness

Meaning Units

Quotation	Direction	What it means
I think the greatest compliment was that she wanted to come back to me. (Helena)	Reconciliation	She chose the face that had delivered the worst news. That does not happen without sustained, genuine presence.
We did not resolve it and could not have resolved it. The aftercare was offered; it was not taken up. (Thomas)	Silent death	The limit of what an organisation can do when the fracture has gone too deep. Naming that limit is not failure — it is honesty.
He said the stress must have been truly indescribable. Then something broke through. (Susan)	Beginning of recovery	Not reassurance. Not advice. Recognition. That is what opened her.

I had to think about it. I actually found this a very good conversation. (Surgeon, cited by Sophie)	Unexpected opening	Even within resistance, curiosity can find a crack. But only if someone genuinely listens first.
A colleague-neonatologist to whom we said farewell last year. (Claire)	Burn-out; no recovery	The system consumed someone it never adequately held. That is what structural absence of compassion produces.
Removing guilt is a prerequisite for learning. Only when you are no longer trapped in it do you begin to learn. (Helena)	Condition for reconciliation	Guilt holds the physician in the past. Reconciliation requires a present. The two cannot coexist.

Sub-Themes

Reconciliation as being heard

Every case of genuine reconciliation in this study has a moment at its centre in which the patient or family felt heard — not processed, not explained to, not formally apologised at, but heard. For Helena's patient, the entire pregnancy had been a series of moments of feeling unheard. The telephone conversation broke that pattern. For Thomas's parents, he was the first person in the entire process who was not simultaneously defending something “while doing?”. Being heard is not a communication technique. It is a quality of presence.

Procedure as the enemy of repair

When legal procedure took over, reconciliation narrowed. Noor describes how the complaints committee made genuine connection impossible. Claire describes being told, before the meeting, never to concede anything. The procedure that is designed to handle harm ends up compounding it: the physician defends, the family attacks, the shared space where something might have been repaired is occupied by process before anyone has a chance to be present in it.

The second blow

Susan described how her department head's response — 'best wishes with processing the incomprehensible decisions you made' — added suffering to someone already suffering. The intensivist's public pronouncement that the patient had been transferred too late did the same. The complaints committee's indifference to anything relational. These were not neutral events. They added suffering to a physician who was already suffering. A system that does this to its own people cannot then expect those people to remain open enough to be compassionate with patients and families. The two are connected.

Time as part of the structure of reconciliation

Helena said it plainly: after a case like this you need twenty-five good cases before you feel calm again. Reconciliation is not a conversation. It is a process with its own temporal structure, which institutions rarely account for. Expecting repair within the timeframe of an investigation is like expecting grief to follow a deadline.

Learning as something that gives meaning

Several families in this study did not want punishment. They wanted their loss to mean something. Sophie describes families who sought the not as a precursor to sanctions but as recognition that something real had happened to them. Claire presented her case to the department as a way of ensuring the loss was not wasted. When learning is visible, it gives the loss a direction. That is a form of reconciliation too.

Phenomenological Narrative

Where does this end? — That question sits over every case in this analysis, and the answer is almost never simple. Reconciliation does not result from one good conversation or one compassionate gesture. It emerges from a convergence of timing, tone, distance, and structure. Where it did happen, there is almost always a turning point to identify — a telephone call that was not put down, a colleague who showed up before judging, an employer who invested in a person's return. The turning point is rarely spectacular. It is usually a choice to stay, to listen, to name the feeling before the fact.

Where reconciliation did not happen, there is also a turning point — but the other kind. A procedure that overtook a conversation. A colleague who voiced an opinion before anyone understood what had actually happened. A photograph placed on a table to make a point. Escalation is rarely a deliberate choice. It is a sequence of small moments in which connection was missed.

The silent death — no complaint, no claim, no formal harm recorded, no repair — is the outcome that nobody measures and many people carry. The family retreats. The physician closes. The institution moves on. That is, in a real sense, the most common outcome of adverse events that lack a compassionate interlocutor. Not dramatic. Just quietly unresolved.

Existentials

Lived body:

The outcome registers physically. The physician who can stand in the delivery room again. Who can sit across from a difficult conversation without trembling. Who sees a patient return and feels something ease in the chest. Reconciliation has a somatic dimension that no formal procedure produces.

Lived time:

Susan was unwell for a year. Anna processed her case in this interview, decades after it happened. Helena is still waiting for the case that will tell her whether her confidence has returned. Reconciliation has its own timeline, which does not map onto institutional calendars.

Lived space:

David has built something — in his team, in his culture, in the everyday conversation of his department — that is different from the default. That space is not accidental. It is the result of years of deliberate cultivation. Space for compassion does not organise itself.

Lived relation:

The outcome is measured in relationships. A patient who returns. A colleague who grows milder. A team that can say hard things to each other without the whole thing fracturing. These are the living fruits of reconciliation. Legal outcomes often are not.

Cross-Thematic Synthesis

The four themes are not separate phenomena. They are stages in a single movement: an adverse event disrupts the physician's capacity for compassion precisely at the moment it is most needed; how she responds in the first reaction determines whether the path to compassion stays open or closes; and what happens next — reconciliation or its absence — depends heavily on whether compassion was possible at all in those critical early hours.

The analysis also shows that compassion is not individual. It is relational and structural: blocked or facilitated by the training physicians received, the culture of their department, the format of the complaints encounter, and the presence or absence of someone who can help carry the burden. The conditions for compassionate presence are not something any physician creates alone; the system either enables them or prevents them.

Essential Structure

"The lived experience of compassion after an adverse event is essentially a fragile opening — possible only when the physician has sufficient inner space to hold the suffering of the other alongside her own, structurally enabled by the presence of a trusted witness, the absence of a defensive institutional frame, and the time to let the wound breathe before it is named."

Back to the Research Question

Does compassion in the first reaction influence reconciliation?

The data support an affirmative answer. The cases where reconciliation occurred share one feature: someone chose to remain with the patient's suffering rather than account for the event. That choice

created the relational space in which trust could begin to regenerate. Where defensiveness occupied that space instead, the encounter either escalated or reached no resolution.

What blocks compassion — fatigue or distress?

Both, but they are different problems. Fatigue accumulates over time and across a career: too little time, too little support, too little renewal. It calls for systemic intervention. Distress is acute: the physician's own unprocessed emotion consuming the attentional and regulatory resources that the encounter requires. It calls for immediate interpersonal support — specifically, someone who accompanies the physician and can help carry what she cannot. Conflating the two leads to interventions that address the wrong problem.

What are the ethical and clinical implications?

Ethically: if the system renders compassion impossible — through juridification, time pressure, or the absence of psychological safety — the individual physician cannot bear sole responsibility for its absence. Responsibility is distributed across training programmes, institutional cultures, and the architecture of disclosure and complaints procedures.

Clinically: the most immediately actionable implication is the practice described by six of the eight participants — never entering a serious conversation alone. Not because the physician cannot handle it, but because at the moment of her own wounding she cannot simultaneously regulate herself and hold space for another. Alongside this, the analysis points towards the need for an independent contact person — distinct from any investigative procedure — who can accompany affected families from the first moment, without a stake in the outcome, and who is trained not in the facts of adverse events but in the skills of compassionate accompaniment.

The deepest implication of this analysis may also be the simplest: the path to a compassionate hospital runs through the compassion the system has built in for its own people.

Discussion

This study set out to examine something the patient safety literature has largely passed over: what happens to compassion — concretely, in the body, in the room, in the encounter — when a physician is involved in an adverse event? The analysis across four themes converges on a finding that is simple to state and difficult to act on: whether compassion is available in that moment is not primarily a function of who the physician is. It is a function of what conditions surround her. Those conditions are physiological, relational, institutional, and cultural all at once.

The Physician as Second Victim

Wu (Wu, 2000) coined the term second victim to name what happens to clinicians after medical errors — the significant emotional and professional consequences that the healthcare system largely fails to recognise or support. Scott et al. (Scott et al., 2009) mapped six stages that second victims tend to move through, from the initial chaos of the event to the slow, non-linear process of moving on. The present study supports that trajectory while extending it in two directions that the existing literature has not yet fully addressed.

The first extension concerns the social production of the second victim experience. What the interviews make clear is that the trajectory is not internal to the physician alone. Susan's account is instructive here. The flight itself was survivable — barely, but survivable. What broke her was the response of her department head, whose words ('best wishes with processing the incomprehensible decisions you made') arrived at the moment when she was most exposed. Claire's experience from her training years tells the same story in a different register: when people look away, she said, you have no support, and then you are defending rather than being compassionate. The second victim experience is co-produced by the system's response. Where the system withholds recognition, the trajectory stalls — and the physician's capacity to be present for the first victim stalls with it.

The second extension is more specific to this study's focus. The second victim experience does not just leave the physician damaged. It directly impairs her capacity for the compassionate communication that the patient and family need from her. Susan describes her post-flight encounter with the recovered patient: she could not make contact. She attributes this, accurately, to the absence of inner space — not to

indifference, not to avoidance. The polyvagal theory (Porges, 2009, 2022) offers neurophysiological reasons: social engagement, which compassionate communication requires, depends on a regulated autonomic nervous system. When the physician is in chronic stress or unresolved traumatisation, the relevant neural circuits are not available. This means that asking a second victim to conduct an open disclosure conversation without support is not merely demanding. It is, at the level of physiology, asking her to do something she cannot do. Sophie put it succinctly: if you have distance from your own emotion, there is more room for theirs. The logic runs in both directions.

Compassion Obstructed: Three Mechanisms, Not One

The study identifies three distinct mechanisms through which compassion fails, which are often conflated into a single problem. Treating them as one leads to interventions that address only part of what is happening.

Compassion fatigue — first described by (Figley, 1995) — refers to exhaustion from cumulative exposure to others' suffering. In Anna's account, it appears as the structural impossibility of making a real connection in ten-minute outpatient slots. In Thomas's, it is the organisational absence of anyone whose job it is to accompany affected families over time. These are not stories about tired individuals. They are stories about institutional conditions that drain compassionate capacity before any specific adverse event occurs. Figley's original framing emphasised the cost of caring through repeated exposure; this study adds the cost of caring without support, in an environment that treats compassion as a personal attribute rather than a shared and renewable resource.

Compassion distress, or distress intolerance (Gilbert, 2015; Simons & Gaher, 2005), is different in kind. It is not cumulative — it is acute. It refers to the inability to tolerate the difficult emotions that arise when witnessing suffering, or, in this context, when being responsible for harm. Susan's encounter with the patient after his recovery, Noor running dry in the complaints committee room — in both cases, the physician's own emotional state consumed the attentional and regulatory resources that compassionate communication requires. (Klimecki & Singer, 2012) demonstrate precisely this mechanism: empathic distress, when unregulated, overwhelms rather than enables — the physician is flooded by the other's suffering before she can respond to it. Regulation of one's own distress is not the result of compassion but

its precondition. You have to be able to sit with your own pain before you can hold space for another's. That ordering matters for how we design support.

The third mechanism — the defensive reflex — is, perhaps surprisingly, the least addressed in the existing literature. All eight participants described it: the trained impulse to explain, justify, and contextualise rather than acknowledge and stay. David named the cultural substrate most precisely. We work against a baseline of zero, he said. That baseline is perfection. In a professional culture where failure is existential, the defensive reflex is not irrational — it is entirely logical. But it also forecloses connection in precisely the moments when connection matters most. Addressing it requires not just individual awareness but a transformation of professional formation: the cultivation of what Neff (Neff, 2003) calls self-compassion — the capacity to meet one's own fallibility with the same kindness one would extend to a suffering patient.

This finding resonates with an older, structural account of how surgical culture converts guilt into shame. Bosk's (Bosk, 2003) ethnography of surgical residency distinguishes technical and judgmental errors, which are treated as forgivable byproducts of an uncertain craft, from normative and quasi-normative errors, which implicate the resident's character and conscientiousness and are met with far less tolerance. Bosk's account of a training culture organised around the norm of “no surprises” — an intolerance of anything less than perfect diligence — echoes David's description of a professional baseline of zero in the present study. Where Bosk describes the sociological machinery through which a hierarchy enforces this standard on residents, the present study describes its felt, first-person consequence for the practising specialist: a defensive reflex activated not by the error itself but by the anticipation of exactly the moral judgment Bosk's surgeons learn, early and thoroughly, to fear.

Reconciliation: Relational before Procedural

The word reconciliation, in this study, means something more than the absence of a complaint. It means the restoration of trust and relational connection — between physician, patient, and, by extension, institution. The analysis shows both what makes that possible and what consistently prevents it.

Across every case where reconciliation occurred, the turning point was the same: someone stopped accounting for the event and started acknowledging the person. Helena's patient had felt unheard

throughout her entire pregnancy — a pattern broken not by explanation but by Helena's decision to stay on the telephone through ten minutes of rage. Thomas's parents identified him as the first person in the entire process who was open without simultaneously defending something. Iedema et al. (Iedema et al., 2011), in their study of a hundred patient accounts, found that being heard was consistently more important than factual explanation or formal apology. This study adds a phenomenological dimension: what carries that experience of being heard is not disclosure technique but compassionate presence. The two are not the same.

Conversely, juridification was the most consistent obstacle to reconciliation. Noor's complaints committee is the paradigm case: led by a lawyer, structured around fact-finding, devoid of relational space. The format designed to process harm ended up compounding it. The physician was in a defensive posture. The family was positioned as adversary. The space where connection might have grown was occupied by procedure before anyone had a chance to be present in it. The medico-legal literature has long established that the quality of the physician-patient relationship, not the severity of the outcome, is the primary predictor of whether families pursue legal action (Hickson et al., 2002; Levinson et al., 1997). Physicians who communicated poorly were significantly more likely to be sued, regardless of whether an error had occurred. This study adds the phenomenological explanation: what families experience as a broken relationship is, in most cases, the felt absence of compassion in the initial encounter, amplified by the procedural response that followed it.

The silent death deserves naming. Thomas described it: no formal complaint, no claim, no recorded harm, but also no repair. The family retains its distrust privately. The physician carries her guilt privately. The institution moves on. This outcome does not appear in most measurement systems, which track legal and formal outcomes, not the quality of relational repair. It is, in the present data, probably the most common outcome of adverse events without a compassionate interlocutor. Not dramatic. Just quietly permanent.

Reconciliation also has a temporal structure that institutions tend to ignore. Helena said it plainly: after a case like this you need twenty-five good cases before you feel calm again. For the patient or family, the equivalent process may be equally extended and equally non-linear. Expecting repair within the timeframe of a formal investigation is a fundamental misreading of how human healing works. A restorative approach

(Wailling et al., 2022) must build in continuity — repeated contact, the willingness to return to questions that could not be answered the first time, and the patience to wait for the moment when the patient or family is ready to receive what the physician has been ready to offer for some time.

Taking Someone Along

Six of the eight participants described the same practice: not entering a serious adverse event conversation alone. Sophie called it 'taking someone with you who has distance.' David's department had formalised it as a team norm. Claire and Anna both described the value of the complaint officer at their side. The practice recurred too consistently to be coincidental.

The companion in these encounters served two functions. The first was regulatory: when the physician became overwhelmed, the companion could step in — as David's colleague did, simply saying 'you are too deep into this, go and walk around the block' — while the physician recovered himself. This is co-regulation in the sense described by (Porges, 2011): the presence of a regulated other helps restore regulation in someone who is dysregulated. The second function was compassionate: the companion, at greater distance from the event and therefore at lower risk of compassion distress, could carry the empathy the moment required — an achievement the physician herself could not sustain. In this sense, the companion embodies the compassion of the institution. Not as a formal representative. As a human being present in the room.

Anna's complaint officer, who said 'My goodness, what a dreadful time you have had at home,' resolved with one sentence what the formal procedure had failed to address. Claire's complaint officer introduced a well-timed intervention that allowed both parties to reset the register of the conversation. These accounts point towards a specific role: not a mediator in the legal sense, but someone trained in compassionate accompaniment — available from the first moment of contact with affected families, remaining available across the full period of repair, and carrying the compassion of the institution without carrying a stake in the outcome of any investigation.

David's vascular surgery department has made this a norm: you never enter a serious conversation alone. This study suggests that formalising and extending that practice — with explicit training in the role differentiation between the involved physician and her companion — could change both the experience of

second victims and the likelihood of reconciliation with first victims. It is also, in practical terms, one of the most immediately implementable changes any system could make.

Self-Compassion and Learning

Helena said it most directly: removing guilt is a prerequisite for learning. Only when you are no longer trapped in it do you begin to learn. Research on the psychology of error (Tangney et al., 2007) supports this: shame — which implicates the self — is associated with defensiveness and reduced motivation to repair. Guilt — which is focused on the action — supports acknowledgement and the desire to make amends. The problem in medicine is that the conditions of professional training, of the calamity investigation, and of the complaints procedure systematically convert guilt into shame. The physician is not asked what she knew at the time and why her decision was reasonable then. She is shown what everyone now knows and asked to account for the gap.

Anna, Susan, and Sophie all describe prolonged periods of self-punishment — suppression, avoidance, counterfactual rumination — that resolved nothing and produced no learning. For Susan, the turning point was a colleague who named her suffering before evaluating her decisions. That recognition did not immediately fix anything. But it was, as she describes it, the first moment something broke through — and the first moment at which she could begin to reflect constructively on what had happened. The compassion of the colleague operated as an enabling condition for self-compassion, which was itself the enabling condition for learning. That chain matters.

Neff's tripartite model of self-compassion (Neff, 2003) — self-kindness, common humanity, and mindfulness — fits the data well. Common humanity is especially visible: the moment at which the physician recognises that what happened to her could have happened to any competent colleague in the same situation — what Sophie calls local rationality, the logic that was reasonable given what was known at the time — is typically the moment at which the loop of self-punishment begins to loosen. David's effort to teach this to younger colleagues ('when you are in that situation, what would any of us have done?') suggests that this insight is not only a personal resource but something that can be cultivated in teams and in training.

A Different Architecture

The current model of adverse event response in most Dutch hospitals, and in comparable systems internationally, rests on open disclosure and calamity investigation. Both have real value. Neither however adequately addresses the relational and emotional dimensions that this study identifies as central to whether reconciliation occurs or not.

Open disclosure, as currently practised, tends to be a single conversation, conducted by the involved physician, following a structured protocol, with success measured by whether the required information was communicated and whether a formal complaint followed. This model misreads the experience of affected families. Helena's patient was not primarily asking for factual information — she was carrying years of feeling unheard across an entire pregnancy. The most meaningful moment for Susan's patient and her family was not the formal debrief but the human encounter in which someone simply said: this was very difficult. For Thomas's families, what mattered was the sustained, non-defensive presence of an independent contact over months. Open disclosure is not a conversation. It is a relationship. Measuring it as a conversation systematically undercounts what it requires.

The calamity investigation model similarly orients towards institutional accountability rather than the needs of those affected. Sophie's observation about the calamity label — that families sometimes wanted it as acknowledgement, not as a precursor to sanctions — points to a fundamental misalignment between what the system offers and what people actually need. A restorative approach (Waillling et al., 2022) would replace the sequential investigation model with a relational one: bringing together all those affected, with skilled facilitation, to speak about what happened and what is needed for healing.

Based on the findings, five changes suggest themselves. First: an independent contact person, appointed immediately after a significant adverse event, who accompanies the affected family without stake in the investigation's outcome, trained in compassionate accompaniment rather than in the facts of the case. Second: a clear norm that no physician enters a serious disclosure or complaint conversation alone, with explicit role definition between the involved physician and her companion. Third: formal recognition of the second victim experience as an expected consequence of involvement in adverse events, with peer contact beginning within hours, not weeks. Fourth: the replacement of counterfactual questioning ('why didn't you do X?') with local rationality inquiry ('what did you know at the time, and

what made your decision reasonable then?') as the governing framework for learning conversations. Fifth: measuring the quality of adverse event response not only by claim rates but by whether the affected family felt heard, whether the physician recovered her capacity, and whether the organisation demonstrably learned.

Limitations

Eight interviews provide depth, not breadth. The findings cannot be generalised across healthcare systems or professional cultures without caution — the Dutch configuration of calamity regulation, complaints procedures, and medical training is specific, and findings from it should be transferred carefully to other contexts.

The interviews were retrospective. Participants reconstructed emotionally significant events from memory, which means some degree of narrative shaping is inevitable. The accounts reflect current understanding as much as they reflect the experience as it occurred. The researcher's own position — as a physician with direct experience of adverse events — shaped both the interview dynamic and the interpretive choices, despite the effort at bracketing. That influence cannot be entirely eliminated; it can only be acknowledged.

The limits of pseudonymisation became apparent during the analysis itself: as researcher I recognised one participant's case from a quotation and a few words of her account, despite the identifying details having been generalised. A reader with prior knowledge of a case may do the same. Anonymisation in phenomenological research is therefore best understood as risk reduction rather than as a guarantee.

The study also heard only from physicians. A fuller account of reconciliation — or its absence — would require the perspectives of patients and families, complaint officers, and institutional actors. Future research using a multi-perspectival design would make the relational dynamics visible from more than one side. A longitudinal design, following cases through the full trajectory rather than relying on retrospective reconstruction, would add further rigour.

Finally, the relationship between compassion and measurable outcomes — complaint rates, claim frequency, investigation duration — remains to be established quantitatively. This study identifies the mechanisms. It does not measure their magnitude. Mixed-methods research that combines

phenomenological depth with administrative and quantitative breadth would allow those questions to be addressed.

In Summary

Compassion in the physician's first reaction is not an optional quality. It is a structural condition for both the physician's recovery as a second victim and the patient family's experience of being genuinely received as first victims. Its presence does not guarantee reconciliation; its absence makes reconciliation structurally improbable. The conditions that enable it — inner space, relational safety, a trusted companion, and sufficient time — are not naturally occurring. They must be deliberately created by institutions, by teams, and by a professional culture willing to respond to fallibility with support rather than only with judgment.

Laméris writes, in the poem at the front of this thesis, that we are so far from tribe and fire and have only these brief moments of exchange. After an adverse event, physician and patient stand together in one of the most testing of those moments: suffering is real, accountability is necessary, and the path forward is unclear. This study suggests that the quality of human presence in that moment — the willingness to stay, to listen, to remain without defending — is not incidental to what follows. It is constitutive of what follows. A system that creates the structural conditions for that presence is, in this sense, a compassionate one.

Conclusion

This thesis began with a question that was difficult to formulate precisely: why does compassion so often fail in the moment it is most needed? Eight semi-structured interviews with medical specialists have clarified the contours of an answer, though not a complete one. The question is not primarily about the physician's character. It is about the conditions that make compassionate presence possible or impossible. This chapter draws together the findings from the analysis and states their implications.

What the Research Question Was Really Asking

The formal question was straightforward enough: is compassion in the physician's primary reaction a factor in whether reconciliation follows an adverse event? The short answer, from the data, is yes. But that answer is less interesting than the question it opens.

Every case where something resembling reconciliation occurred shares the same structural feature: someone — the physician, or a colleague alongside her — chose to stay with the patient's suffering rather than explain the event. They listened instead of accounting. They acknowledged instead of justifying. That presence, however brief or imperfect, created a relational opening. Trust does not grow from information transfer. It grows from the experience of being genuinely received by another person.

Where defensiveness occupied that space instead, the trajectory moved towards escalation or what Thomas called the silent death: no complaint, no claim, no repair, and no one measuring the damage because it left no formal record. This outcome is probably the most common result of adverse events that lack a compassionate interlocutor, yet it falls outside most measurement systems, which track legal and formal outcomes rather than the quality of relational repair.

The more important finding is that framing compassion as an attribute of the individual physician misidentifies the problem. The same physicians who showed clear compassionate presence in one situation could not sustain it in another — when they were in acute distress, when the institutional format closed the relational space, when they had no one alongside them. Compassion, as this study treats it, is a state rather than a trait. States are condition dependent. The relevant research question is therefore not whether the physician had compassion, but what creates or destroys the conditions under which compassion becomes possible. That reframing has direct implications for how adverse event response is designed.

Five Findings, Stated Plainly

The first finding, and perhaps the most underestimated one: an adverse event is an existential rupture for the physician involved, not a procedural problem or a communication challenge. The moral shock, the bodily weight of guilt, the loop of counterfactual thinking that replays the same unanswerable questions — together these constitute a form of suffering that is real, prolonged, and largely invisible to the institutions in which it occurs. That suffering does not diminish the physician's responsibility. But it explains why compassion is so often unavailable in the immediate aftermath, and why asking the physician to provide it without any support is asking her to pour from an empty cup.

The second finding concerns how the second victim experience is shaped. Wu (Wu, 2000) and Scott et al. (Scott et al., 2009) described the trajectory of the second victim as something that unfolds inside the physician. The interviews suggest it also unfolds between the physician and the system around her. Susan's department head wished her 'every success with processing the incomprehensible decisions' she had made. That sentence landed at the worst possible moment. Claire's training environment looked away entirely. These were not neutral responses. They added weight to people who were already bearing too much. The second victim is not healed in isolation. The trajectory stalls or continues depending on what the surrounding system does.

The third finding is that compassion fails in three distinct ways,and conflating them produces interventions that miss. Compassion fatigue — the slow depletion of Anna, who has ten minutes per consultation and no structural support — calls for systemic change: workload, dedicated roles, institutional investment. Compassion distress — the acute state of Susan, who could not make contact with her patient because she had no inner space left — calls for immediate interpersonal support at the moment of the encounter: someone present who can carry what the physician cannot. The defensive reflex — the trained impulse to explain and justify that all eight participants described — calls for something slower and harder: a cultural shift in how medicine relates to fallibility, towards the self-compassion that Neff (Neff, 2003) describes as meeting one's own mistakes with the same kindness one extends to a suffering patient. These are three different problems. Addressing one rarely helps with the others.

The fourth finding is that reconciliation is relational before it is procedural. Being genuinely heard — not processed, not apologised at according to a protocol, but actually heard by another person — is the precondition for the restoration of trust. Open disclosure addresses the informational dimension of harm. It mostly misses the relational one. Complaints procedures, with their juridical architecture, close the relational space before anyone has a chance to enter it. A restorative approach (Wailling et al., 2022) would treat reconciliation as a relationship that unfolds over time, not an event that can be completed in a single conversation.

The fifth finding is the most immediately actionable. Never enter a serious adverse event conversation alone. Six of eight participants said some version of this. A companion in the disclosure encounter does two things: they help regulate the physician when her distress threatens to overwhelm the conversation, and they carry the compassion she cannot sustain in that moment. This is probably the single change that could most quickly shift the experience of adverse event encounters, for physicians and for the families they are trying to reach. It costs relatively little. It is not yet the norm.

What This Study Adds — and What It Doesn't

Within compassion science, the study shows the value of treating compassion as a state in this specific context. The three-component model (Gilbert, 2019; Strauss et al., 2016) — awareness, emotional response, motivation to act — is useful, but the interviews show how each component can be blocked by distinct mechanisms. Treating those mechanisms as a single problem ('the physician lacks compassion') is both empirically wrong and practically unhelpful.

Within the second victim literature, the study extends Scott et al.'s trajectory model (Scott et al., 2009) by showing that the trajectory is shaped at every stage by the relational environment, not only by the physician's internal resources. It also connects the second victim experience to compassionate communication capacity — a link that has direct implications for how disclosure conversations are organised, and one I have not found explicitly made elsewhere.

Within the restorative justice and patient safety literature, the study provides — as far as I can establish — the first phenomenologically grounded account of how compassion shapes the trajectory of adverse events from initial impact through to reconciliation or its absence. That is a gap. There is substantial work

on second victims, growing work on restorative approaches, and almost nothing connecting them through compassion as a state produced or prevented by conditions.

What the study does not do is establish the magnitude of these effects. The relationship between compassion and measurable outcomes — complaint rates, claim frequency, investigation duration — remains to be quantified. Eight interviews provide depth and generate hypotheses. They do not settle empirical questions about how large these effects are relative to other factors. Mixed-methods research, and ideally longitudinal designs that follow cases rather than reconstructing them from memory, would be the logical next step.

The study also heard only physicians. A complete picture of reconciliation — or its absence — would require the perspectives of patients and families, complaint officers, and institutional actors. What I have described is one side of a relational process. The other sides would look different, and might not confirm everything the physician accounts suggest.

Five Recommendations, Without Overselling Them

The findings suggest five changes worth making. I present them as recommendations rather than conclusions because implementing them involves institutional decisions, training commitments, and cultural shifts that no study can simply mandate.

Every significant adverse event should trigger the appointment of an independent contact person — someone distinct from the investigation and from the involved physician, whose sole function is to accompany the affected family over time. Not to represent the institution's legal position. To be present, to listen, to return. The role requires training in compassionate accompaniment, not in the facts of adverse events. Anna's complaint officer resolved a complaint with one sentence. That is the scale of impact this role can have when it is filled by the right person.

No physician should conduct a serious disclosure or complaint encounter alone. The companion's role needs to be explicit — co-regulating when the physician's distress takes over, carrying the compassion when the physician cannot — and trained, with clear differentiation from the role of the involved physician. This should be an institutional norm, not an informal workaround that some departments happen to have developed.

Second victims need recognition within hours, not days. The most effective support described in these interviews was not formal — it was a text message, a brief question, a colleague who knocked on a door. Formal peer support programmes can supplement that. They cannot substitute for it. Waiting a week to check in is, in most cases, waiting too long.

Learning conversations — mortality reviews, debrief sessions, calamity investigations — should stop asking why the physician did not do something they could only have known to do in hindsight, and start asking what they knew at the time and what made their decision reasonable given that knowledge. This is the shift from counterfactual critique to local rationality inquiry. It does not reduce accountability. It relocates it — from individual blame to systemic understanding — which is the only place from which genuine learning is possible.

Institutions should measure adverse event response quality by something other than whether a claim was filed. Did the family feel heard? Did the physician recover? Did the organisation visibly learn? These are harder to count than legal outcomes. They are also, for everyone involved, the outcomes that actually matter.

A Personal Note

My interest in this research question came from direct clinical experience. I had been involved in adverse events. I had apologised and explained. What I kept observing was that explanation was not what those moments required, and that I was often unable to offer what was. My initial assumption was that the problem was primarily cultural — rooted in how physicians are trained to relate to failure. The interviews suggest that is part of the explanation. The deeper issue, however, is structural: systems that require compassion from physicians while failing to create the conditions that make compassion possible are making demands that the system itself has rendered nearly unachievable.

The eight physicians in this study are not people who lack compassion. They are people who were placed, repeatedly and without adequate support, in situations that made compassion structurally difficult or temporarily unreachable. Several of them found ways through — by taking a colleague along, by staying on the phone despite trembling, by returning the same evening for a second conversation. Those responses

are significant and they matter clinically. However, they should not need to function as acts of individual resilience. They should be what well-designed institutional systems make possible as a matter of course.

Last Words

Laméris describes, in the poem at the start of this thesis, the small unremarked gestures through which people sustain each other: pulling legs in so someone can pass, picking up spilled lemons from the floor. These acts of care are not calculated. They arise from something more immediate than deliberate decision.

After an adverse event in a hospital, those same impulses — to not harm, to stay, to help — run into conditions that make them very hard to act on. The physician who has caused harm, however unintentionally, has to find a way to stand in the presence of those she has harmed and remain. The family has to find a way to receive what she offers, even through anger and grief that make receiving feel impossible.

Compassion is what makes that encounter workable. Not comfortable — workable. It is what opens, however slowly, the path towards reconciliation: a gradual, imperfect, and non-linear process of restored trust between people who have been through something together that neither of them chose.

Medicine involves harm. That will not change. What can change is whether the people on both sides of that harm are adequately held and heard — whether the physician is supported enough to remain present, and whether the patient or family encounters someone who genuinely receives them rather than manages them. A hospital that creates those conditions is not only safer. It is more honest about both risk and care.

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