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Influence of external assessment on quality and safety in surgery: a qualitative study of surgeons' perspectives

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ABSTRACT

Introduction Transparency about the occurrence of adverse events has been a decades-long governmental priority, defining external feedback to healthcare providers as a key measure to improve the services and reduce the number of adverse events. This study aimed to explore surgeons' experiences of assessment by external bodies, with a focus on its impact on transparency, reporting and learning from serious adverse events. External bodies were defined as external inspection, police internal investigation, systems of patient injury compensation and media.
Methods Based on a qualitative study design, 15 surgeons were recruited from four Norwegian university hospitals and examined with individual semi-structured interviews. Data were analysed by deductive content analysis.
Results Four overarching themes were identified, related to influence of external inspection, police investigation, patient injury compensation and media publicity, (re) presented by three categories: (1) sense of criminalisation and reinforcement of guilt, being treated as suspects, (2) lack of knowledge and competence among external bodies causing and reinforcing a sense of clashing cultures between the 'medical and the outside world' with minor influence on quality improvement and (3) involving external bodies could stimulate awareness about internal issues of quality and safety, depending on relevant competence, knowledge and communication skills.
Conclusions and implications This study found that external assessment might generate criminalisation and scapegoating, reinforcing the sense of having medical perspectives on one hand and external regulatory perspectives on the other, which might hinder efforts to improve quality and safety. External bodies could, however, inspire useful adjustment of internal routines and procedures. The study implies that the variety and interconnections between external bodies may expose the surgeons to challenging pressure. Further studies are required to investigate these challenges to quality and safety in surgery.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Prior research has indicated conflicting results related to impact of external assessment on quality and patient safety. The existing knowledge about external assessment from a surgical professional perspective is scarce.

WHAT THIS STUDY ADDS

⇒ This study reports qualitative results of the experiences of surgeons being subjected to external assessment and scrutiny from regulatory bodies in the Norwegian healthcare system.
⇒ This study adds new knowledge about the influence of external assessment on surgeons' reporting and learning. External assessment may negatively influence reporting and learning by generating criminalisation and scapegoating. External bodies could, however, inspire surgeons to adjust internal routines and procedures.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Our results may indicate complex interconnections between external bodies following serious adverse events and the challenging pressure put on the surgeon. The outcomes have the potential to pave the way for more governmental attention to the application of expertise and up-to-date knowledge and competence in the inspectors and experts used in third-party assessment.
⇒ The results can inform medical training programmes to prepare future students and trainees on how to expect and respond to external assessment and provide them with knowledge about potential negative personal and professional consequences from a culture of individual shaming and blaming.

INTRODUCTION

Feedback and assessment from external sources may impact patient safety.[1 2] In the Norwegian healthcare system, transparency about the occurrence of adverse events is considered a governmental priority, with external feedback to healthcare providers defined as a key measure in improving the services and reducing the number of adverse events.[3 4]

Research on the effects of external feedback and assessment from healthcare is scarce, with studies showing conflicting results related to its impact on quality and patient safety.[4–11] We have previously found that embedded and

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multifactorial risks in surgery together with individual, technical skills could result in increased vulnerability to criticism which might contribute to decreased transparency about the causes and consequences of adverse events.[12] In this study, we focus on the experiences of the same surgeons included in the previously mentioned study[12] in relation to being subjected to external assessment and scrutiny from regulatory bodies such as external inspection performed by the Norwegian Board of Health Supervision (NBHS), the police, Norwegian System of Patient Injury Compensation (NSPIC) as well as media.

External assessment of quality and safety in the Norwegian context

Norway has a universal public healthcare system with 22 public Hospital Trusts, with surgical departments at 56 locations. A total of 3431 board-certified surgeons in 11 subspecialties are registered.[12 13] The hospital trusts are subjected to external assessment and evaluation that may be initiated after adverse events are reported by health professionals and managers through mandatory reporting systems or planned system audits addressing topics of significant risk potential.[14 15]

Different types of external assessments and evaluations are performed by various government bodies, sometimes in parallel. In addition to external inspection by the NBHS and county governors, investigation by the police and/or litigation processes through the NSPIC (see box 1 for details); the Norwegian Investigation Board may perform independent external investigation.[15] This government body was, however, not explored in this current paper.

The objectives entailed in these different types of external regulatory bodies vary. The main objective of external inspection is an assessment of quality and safety of patient care with focus on both prevention and intervention. External investigation by the police and prosecution authority is a mean of inflicting penalty and restoring justice, and if there is reason to suspect fatalities caused by natural causes, the medical practitioner is obliged to notify the police.[16–18] Litigation through patient injury compensation claims administered through the NSPIC is another option for restoring justice. The system's foundation is of joint medical-legal character and is based on objective 'culpa' and system accountability. Compensation for the costs affiliated with a patient injury is covered by this body's designated means.[19] For additional information about the Norwegian system of external inspection, police investigation and patient injury compensation, please see box 1.

The Norwegian regulatory frameworks for external inspection and patient injury compensation are designed to secure collective efforts, system level accountability and responsibility.[4] Police investigation and enforcement are less prominent features with regard to ensuring quality and safety.[4] Individual performance and individual blame in general are less prominent in the Norwegian healthcare system compared with other countries, although the possibility of imposing individual sanctions still exists by various means installed in the regulatory frameworks for both external inspection and police enforcement.[4 20]

While external inspection, investigation and litigation are all governmental measures of regulatory enforcement, media plays an important role in focusing on

Box 1 Facts about the Norwegian system of external inspection, police investigation and patient injury compensation

The Norwegian system of external inspection and police investigation related to patient injuries[4 15 23 52 58 73–76]

The Norwegian system of external inspection consists of the Norwegian Board of Health Supervision (NBHS) and 11 regional county governors. The Ministry of Health and Care Services provides the NBHS and the county governors with regulations and policies applied to the assessment of quality and safety provided by the healthcare services. External inspection is performed as planned inspection and system audits or case-based inspection.

4473 cases registered by the county governors in 2021. One or more violations of legislation were appointed in 38% of the cases that were assessed (856 out of 2241 cases). 225 cases were forwarded to the NBHS for potential administrative reaction against individual health professionals. 104 planned inspections/audits in the specialised healthcare services were conducted.

Where the NBHS establishes a case for external inspection based on information from the police, for instance, violence against a patient or theft of medication, police investigation takes precedence over external inspection. The NBHS must, therefore, clarify with the police whether the investigation is an obstacle to the establishment of an external inspection. Police investigation and potential criminal prosecution are, however, limited to cases where the Norwegian Penal Code is applicable, yet it sporadically occurs.

A recent and relevant alteration in the Norwegian regulatory system is the change in petitionary power. Up until 1 July 2022, the NBHS had the option for recommending a petition for prosecution. In 2019, the NBHS filed 12 police reports against health professionals and six police reports were filed against healthcare providers. Although the NBHS no longer can recommend petition for prosecution, the prosecuting authority may still request professional advice from the NBHS on matters of interest.

The Norwegian system of patient injury compensation[19 56 57 72 77 78]

The Norwegian system of patient injury compensation is a national, governmental body handling compensation claims of errors or injuries stemming from healthcare treatment. Compensation is based on objective criteria in accordance with the act relating to compensation for damages with no apportion of blame (Patient Injury Act). Patients have the right to submit their claims on certain conditions: (1) the patient injury must be due to treatment failure, (2) the patient injury must have resulted in financial loss, (3) the claim is submitted up until 3 years after the patient injury occurred or was discovered.

The objective of the Norwegian system of patient injury compensation is to dissolve healthcare professionals from individual accountability and responsibility. Any healthcare provider on account of its role as employer and on behalf of the healthcare professionals, pay annual grants to the Norwegian system of patient injury compensation. The grants cover the patient injury compensation. Cases of litigation against healthcare professionals may occur despite a regime of objective and collectively based patient injury compensation but such cases are rare. In cases where patients sue for redress, healthcare professionals may seek reduction of damages.

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accountability of these bodies. Media with investigative journalism plays the role of a watchdog, or 'a fourth state' to oversee, and increase accountability of democratic governance.[21 22] The links between external inspection, police investigation and the media are complex. Information about impaired patient safety may derive from the public, reported by the media and resulting in external inspection and/or investigation. In that sense, media reports may serve as important sources of relevant information. Matters that reach the NBHS through media are often of great public interest.[23] Sporadically, media outlets do close follow-up on investigations performed by some of the regulatory bodies. In several cases, new information derived from media reports leads to reopening of regulatory cases and police investigation, with assistance from an NBHS-based investigation unit.[3 24]

Although research on links between transparency and disclosure of adverse events and second victim phenomenon exists, only a few studies have focused on surgeons' individual experiences, and these are mainly based on quantitative data in Anglo-American settings.[12 25–28] A few studies have focused on surgeons' experiences related to external feedback and assessment. To the best of our knowledge, studies exploring surgeons' experiences with assessment of quality and safety performed by regulatory inspectors, media outlets and the police, are even less apparent. Our study, therefore, supplies the research field with a new perspective.

Aim and research question

This study aimed to explore surgeons' positive and negative experiences of assessment by external bodies, with attention to its impact on transparency, reporting and learning from serious adverse events. External bodies were defined as external inspection, police investigation, the system of patient injury compensation and the media.

The leading research question was: How do surgeons experience external assessment of serious adverse events?

METHODS

Study design and setting

This is a qualitative interview study on surgeons' experiences with the role and influence on transparency, reporting and learning from assessment by external bodies. The study setting was four Norwegian university hospitals located in all four health regions in Norway.

Participant Recruitment and Characteristics

Fifteen participants were recruited based on a strategic sampling. Based on the research team's preknowledge of the participants' in-depth insights into the phenomenon of adverse events in surgery, a strategy of purposive sampling was applied.[29 30] Individual participants were identified through clinical managers or the author team's pre-existing knowledge of participants having relevant insight into the phenomenon. Participants were approached by email.

The inclusion criteria were participants holding a minimum of 10 years of experience, and still clinically active in high-risk types of surgery. 11 men, 4 women, age between 38 and 65 years (median 59) with 11–38 years of experience were included. Seven of the participants were board-certified specialists in gastrointestinal surgery, six participants in cardiothoracic surgery, one in general surgery and orthopaedic surgery respectively. 12 of the surgeons held or had previous experience in various senior managerial positions (ie, senior consultant, head of department or division). The geographical distribution was reflected in the inclusion of participants from all four health regions in Norway: the northern region (3), the south-eastern region (9), the central region (2) and the western region (1). Please see 'Strengths and limitations of the study' for potential limitations associated with the inclusion criteria.

Data collection

All participants were subjected to individual interviews conducted in Norwegian language by researcher SFØ using a semistructured interview guide, targeting topics such as professional consequences from errors and misjudgements, transparency about adverse events in interaction with leaders and colleagues, transparency in terms of incident reporting of adverse events, learning from external inspection (see online supplemental appendix 1). The semistructured approach allowed the researcher to ask appropriate follow-up questions. The individual interviews (approximately 1-hour duration) were conducted digitally by virtual meeting software (teams), between December 2021 and February 2022. All interviews were recorded and subsequently transcribed. One of the participants had the transcript returned for comments and adjustments. Data were collected as part of an overall research project on adverse events in surgery, and the analysis in this paper was conducted independently.[12]

Analysis

Content analysis was chosen to reveal, understand and organise patterns of meanings found in the interview data. The content analysis was done inductively and consisted of seven steps, where researcher SFØ led the analytical work: (1) open reading process of all transcripts, (2) identifying and condensing of all meaning units, (3) proposing codes and categories, (4) suggesting overarching themes across transcripts, (5) making a digital matrix, one for each transcript, (6) manually marking of different topics, contrasts and similarities, done by paper and pen, and finally (7) setting up a complete matrix holding overarching themes and subordinate categories across the data material.[31 32]

We complemented the analysis by conducting deductive searches in the matrix for terms such as media, media publicity, TV, newspaper, inspectors, external inspection, police investigation, police, patient injury claims, compensation and the NSPIC. All the transcripts were additionally cross-checked for terms

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Table 1 Overview of the participants' encounters with external bodies

Participant	External inspection	Police encounter	Compensation claim	Media publicity
1	Yes	No	Yes	Yes, massive publicity
2	Yes	No	Yes	Barely
3	Yes	Yes	Unknown	Unknown
4	Yes	No	Yes	Unknown
5	Yes	No	Served as expert witness	Unknown
6	Yes	Yes	Unknown	Unknown
7	No	No	Unknown	No, but is familiar with a couple of cases as part of the work environment
8	Yes	Yes (notified the police several times)	Served as expert witness	No, but colleagues have
9	Not directly	Never notified the police but experienced colleagues who have turned themselves in	Not examined himself but experienced colleagues being examined	Yes
10	Yes	Never examined himself but experienced colleagues being interrogated	Unknown	Not directly
11	Yes	Yes (notified the police several times)	Yes	Yes
12	Yes	Yes (notified the police several times and questioned/interrogated)	Yes	Not directly, but as part of the work environment; experienced colleagues having unpleasant publicity
13	Yes	Yes (notified the police several times)	Yes	No
14	Yes	Unknown	Yes	Yes
15	Yes	Yes	Unknown	Not directly, but experienced many cases as part of the work environment

related to criminalisation and guilt, knowledge, expertise, competence, culture, quality improvement. A quantitatively cross-checking process of the participants' experiences of encounters, interaction and communication with inspectors, police, the NSPIC and the media was performed. The latter is reckoned to be a strategy of quantitative analysis of qualitative data.[33 34] Please see table 1 for an overview of the cross-check analysis, revealing participants' encounters with external bodies. The table demonstrates that experiences regarding external inspection were predominantly revealed. An example of the content analytical process related to one participant quote is demonstrated in online supplemental appendix 2. Themes were suggested by researcher SFØ and eventually refined and constructed in tight collaboration among the three researchers (SFØ, SW and OT). This collaborative analytical process was performed as validation of the results, hence ensuring the reliability of the study's results. In the wording of the overarching themes, reporting was seen in relation to transparency about adverse events, whereas learning was understood as part of quality improvement processes.

Trustworthiness

The transcripts displayed a wide-ranging amount of data, related to processes of transparency around reporting of and learning from adverse events, including findings related to external assessment.[12] The information power was considered strong, in the aspect of internal validity and supported our efforts to ensure trustworthiness throughout the process of analysis and cultivation of the findings.[35]

The researchers' understanding of data is dependent on subjective interpretation, and the role of the researchers may have influenced the data and their interpretation of it.[31] With respect to the trustworthiness of this study, the researchers made efforts to clarify their preconditions for preunderstanding of the data.

Patient and public involvement

The findings are based on individual experiences as expressed by surgeons included in the study, and patient involvement was not in scope. A late version of the manuscript was adjusted based on the feedback from a former Patient and User Ombud (see the 'Acknowledgement' section).

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RESULTS

Before we present the findings by summary of each overarching theme, with each category accompanied by quotations in boxes 2–5, an overview of the 15 participants' encounters with external bodies is given in table 1. The participant number is listed in brackets () after each quote.

The qualitative content analysis resulted in three categories and four overarching themes. The overarching themes were the role and influence of:

1. External inspection in relation to transparency and quality improvement following adverse events.
2. Police investigation in relation to transparency and quality improvement following adverse events.
3. Media publicity in relation to transparency and quality improvement following adverse events.
4. Patient injury compensation claims in relation to transparency and quality improvement following adverse events.

Each overarching theme was represented by three categories:

- The sense of criminalisation and reinforcing guilt (treating surgeons as suspects).
- Lack of knowledge among external bodies and clashing cultures (lack of added value to quality improvement).
- Added value to quality and safety following scrutiny conducted by external bodies.

Theme 1: external inspection in relation to transparency and quality improvement following adverse events

On one hand, external inspection was viewed as an added control mechanism of increasing attention to certain issues, with an analytical approach to system errors and improvement at an organisational level. The participants described that the results from external inspection usually were related to adjustments in internal procedures and/or routines. On the other hand, methods and approaches applied by the NBHS, were reported to depend on the professional competence, behaviour and communication skills of the inspectors. Some reported unpleasant encounters with inspectors, others described professional dialogue with a focus on structure and system-related elements. Lack of competence was viewed as a concern and as an element that contributed to reduce the trust in the inspectors' decision-making and conclusions. Participants called for more emphasis on 'up to date', third party expertise. One participant wished that the NBHS more actively passed on information about individual surgeons involved in repeatedly serious adverse events, as a measure to prevent ignorant surgeons from start working elsewhere.

Theme 2: police investigation in relation to transparency and quality improvement following adverse events

Participants gave examples of the mandatory requirement of alerting the police in cases where they found reason to suspect that a patient did not die of natural causes. The habit of notifying the police in serious and

Box 2 Categories for theme 1 accompanied by quotations for each category

Categories for theme 1 and quotations from participants

Sense of criminalisation and reinforcing guilt (treating surgeons as suspects)

It makes a difference who handles the case at the Norwegian Board of Health Supervision. Some are very sensible in strategic ways whereas others will cause unpleasantness (12).

I have been involved in a very serious case where the ambulatory team from the Norwegian Board of Health Supervision arrived with lawyers. I was completely unprepared and felt that everyone was against me (14).

I had a colleague who operated and informed the Norwegian Board of Health Supervision. It became a case, and he was seriously criticized, but after a second opinion, the surgeon was declared 'not guilty'. Everything was supposed to be okay by then, but for a young man it was a horrible experience to be blamed for making an error (9).

Lack of knowledge among external bodies and clashing cultures (lack of added value to quality improvement)

Mostly, lawyers are the ones evaluating these cases, and they may never even have put their feet into a hospital (3).

To some extent the external inspection body involves people they know or who have handled earlier cases. To me, it does not serve the case justice (9).

Many of us possess more expertise than the experts called in by the external inspection body. Their analysis, which becomes the basis for a decision, is not adequate. We are not impressed and roll our eyes (1).

From the moment a formal external inspection is established the language that applies is very formalized. A formal inspection is well organized, which calls for learning to speak in well-structured and clear ways. That comes natural to me (…) (5).

The Norwegian Board of Health Supervision is insufficiently specific, and they do not want to handle the individual responsibility of health professionals. When we violate the laws relating to health professionals, action is required. My feeling is that the Norwegian Board of Health Supervision is there to protect the profession, not the patient (11).

The external inspection body did not significantly help improve the system, because blame was so clearly directed at individuals (8).

We have an internal system where we discuss both formally and informally, but I believe that external inspection may hamper the process that actually does improve treatment (8).

Added value to quality and safety of having external bodies 'looking in'

In my view, the Norwegian Board of Health Supervision acted extremely well in the case that I was involved in. They did focus on system errors (14).

I participated in a meeting after a serious adverse event where there was criticism from the external inspection body, but we had the opportunity to present our views on the case, and I think that was good (10).

External inspection as such is positive. To have an outsider's view of what happened, through experts, is useful (3).

It (the incident) is taken seriously by the Norwegian Board of Health Supervision, and it becomes a bit more analytical, and one also gains more time to process and to explain the incident (13).

We are exposed to regular on-site inspections from the Norwegian Board of Health Supervision. These are very thorough and focused on details, but that is very good. It does improve our routines. We just need to 'switch channels' in ways of thinking (6).

Continued

Box 2 Continued

I believe that the main learning (from external inspection) is improved attention (to risk). (…) one does not learn anything about the medical side (of things), by inspection. One learns to focus on a problem such as anastomoses- leakages (…). Reporting to the external inspection body (revealed) more leakages than there should be, we checked (…) procedures, trying to correct it. That has succeeded somewhat (5).
Following adverse events (…) related to optical fiber surgery our clinic made changes to the training of the young doctors (for optical fiber surgery and procedures) (7).

dramatic events was discussed in different ways, where some of the participants described situations where they would be having discussions after the adverse event about whether to report, and others expressed that they notified the police more frequently now than in the past. Those having experiences of encounters with the police during their surgical careers, expressed a sense of unpleasant interaction. Participants who had experienced police involvement just by being part of a surgical work environment, where colleagues had been questioned, expressed concern about the process and communication in the investigatory interview setting. The contrast between the medical and legal aspects was reported to reduce the added value from police involvement in serious adverse events. Hence, category three associated with the second theme was not represented in the data.

Theme 3: media publicity in relation to transparency and quality improvement following adverse events

Publicity, scrutiny or critique conveyed by the media were perceived as a risk reducing the willingness report surgical errors, misjudgements or complications. The sense that the media does not treat the surgeons fairly and is more concerned with publishing clickbait narratives without

Box 3 Categories for theme 2 accompanied by quotations for each category

Categories for theme 2 and quotations from participants
Sense of criminalisation and reinforcing guilt (treating surgeons as suspects)
Here, we have a very low threshold for informing the Police. I have experienced that the Police arrived in the middle of the night and interviewed me and the other surgeon, (…). In general, talking with the Police is totally uncomplicated (12).[1]
Lack of knowledge among external bodies and clashing cultures (lack of added value to quality improvement)
It is very difficult in this kind of process to gain a complete understanding of the problem, and it often ends up on a side-track. In general, the Police has very little interest in engaging and the main motivation for reporting is that it cannot be claimed afterwards that we did not report (the incident). Reporting does not improve things (8).
I have never had to report to the Police, but I have had colleagues who have telephoned the Police to denounce themselves. Which turned into exciting exchanges because the Police asked: Did you do it on purpose? (9).

Box 4 Categories for theme 3 accompanied by quotations for each category

Categories for theme 3 and quotations from participants
Sense of criminalisation and reinforcing guilt (treating surgeons as suspects)
As a manager, I fear that the barrier for reporting becomes higher, because one is exposed to suspicion, criminalization. One prefers to hide incidents to avoid the experience and the risk of perhaps being featured in media and be branded (…); feeling like a murderer (1).
Media attention I would feel as a massive burden because it becomes tabloid news. Media coverage would not have contributed to helping me improve (2).
This is dangerous stuff. Someone might consider suicide after being accused both in a newspaper and in his/her professional environment and having had no support. Mentally I think I am strong enough to cope with it, but many would have felt crushed by that incident (14).
Lack of knowledge among external bodies and clashing cultures (lack of added value to quality improvement)
One might think that (the media's role) is that health professionals become a little bit more attentive. However, it rather looks like a way of presenting a story with a well-known dramaturgy, where there must be a victim and a villain. And then you sort of know that you will never win the case (presented) in the media (10).
The important thing is to improve treatment, and that is precisely what is not achieved, I think, or at any rate very rarely. There have been quite a few things in the press that have completely gone off track—I do not believe in that system (8).
One is often hidden behind a massive wall of professional secrecy (…) (9).
Added value to quality and safety of having external bodies 'looking in'
It is very important that the media directs attention to the system. I think that the media is incredibly important, and it is very important that the media focuses on transparency, but also: What do we do to prevent patient injuries? Because if it does not appear (in the press) no-one cares about it (11).

understanding the complexity of surgery, was all seen compromising to disclosure. Some of the participants argued that single-case focus is unfortunate, as it may reinforce the public's distrust in health services. and that it is challenging to get the public and 'the outside world' to fully understand the whole picture. Two of the participants, however, acknowledged the role of the media as important in putting patient safety issues on the public agenda.

Theme 4: patient injury compensation claims in relation to transparency and quality improvement following adverse events

Most participants had experienced compensation claims. Some had served as expert witnesses on behalf of the NSPIC. The collectively based patient injury compensation claim system is considered useful for the patients, as they get an objective assessment of their case, conducted by an independent body. Some believed that patients had become more aware of their eligibility to apply for patient injury compensation. Having a third party assessing the case was also considered useful, although assessment by

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Box 5 Categories for theme 4 accompanied by quotations for each category

Categories for theme 4 and quotations from participants

Sense of criminalisation and reinforcing guilt (treating surgeons as suspects)

The expert is not interested in who I am or how I will feel afterwards, he is just doing an objective job for the patient and the system (2).

I have been working in a specialty that may result in serious injuries, and if someone thinks that errors have been made, they may complain. The question is whether something can be pointed out. Little attention is paid to medical errors as such (13).

Lack of knowledge among external bodies and clashing cultures (lack of added value to quality improvement)

It is legitimate that a patient wants compensation. However, it does not improve treatment or procedures (8).

Added value to quality and safety of having external bodies 'looking in'

It is an important advantage in Norway that this is in a way handled anonymously, that is, the Norwegian System of Patient Injury Compensation decides whether malpractice has occurred, but does not blame the particular surgeon (8).

The Norwegian System of Patient Injury Compensation involves experts. This is an advantage because it provides an outsider's view of the case (3).

the NSPIC not necessarily resulted in quality improvement. The factor of anonymity was considered crucial, as it protects surgeons from being held directly responsible and accountable.

DISCUSSION

Principal findings

Based on the interviews, we found that external assessment may generate a sense of criminalisation and reinforcement of guilt, treating surgeons as suspects. Lack of knowledge and competence among external bodies corroborate the sense of the 'medical and the outside world' as cultures that clash, resulting in lack of added value to safety and quality improvement. On the other hand, having bodies on the outside 'looking in' could inspire adjustment of procedures or routines, and stimulate awareness about internal issues to quality and safety.

Positive influences from external assessment on quality improvement and learning in surgery

Previous research has demonstrated that a proper regulatory design may provide a fair and broad assessment of the complexity involved in the case.[9 15 36 37] Involvement of several stakeholders in the process may serve as a way of restoring trust between the healthcare provider and the patient or next of kin, as well as reinforcing the public's trust in the health services altogether.[9 38–45] The recently conducted internal audit across hospitals in the Western Norway Regional Health Authority's (WNRHA) included data showing that external inspections performed by the county governors were considered useful contributing to learning and improving services.[46] Adding to this does the recent procedural shift in petitionary power, where the NBHS no longer has mandate to recommending a petition for prosecution.[23] Perhaps this shift could be seen as part of a governmental push to reinforcing the idea of external inspection as an external contribution to internal improvement and learning.[47] Our participants' responses align with existing literature and data pointing to how getting an outside perspective on an adverse event, without a punitive objective, and may promote learning and improvement.

Independent media coverage is reckoned a central value to any liberal democratic society where, publicity and scrutiny may come as a result from the media living up to its role of 'fourth state power'.[21 22] In the context of patient safety, media has indeed played a role in putting issues in healthcare on the public agenda and may become increasingly important to patient engagement.[48–50] Specifically related to surgery, a recent study demonstrated how crowd-sourced hospital ratings correlated with patient satisfaction, but correlation with surgical safety was however not demonstrated.[51] These previous findings about the positive influence of media reports on patient safety issues were not predominant in our study. Although our interview data did not demonstrate much positive influence of media's external assessment nor added value to quality improvement in surgery, it was described as an important public agenda setter for patient safety overall.

Another prime democratic ideal is that responsibility for wrongdoings might be placed on the applicable legal subjects.[52] Accommodation and restoration of damage on behalf of the individual harmed are important aspects. In processes of patients and next-of-kin seeking redress and reconciliation, research has shown the importance of an empathic relationship between the different stakeholders as one of the key procedural elements to 'restorative justice'.[53] The system of legal responsibility and restoration may increase the public trust in the institutions holding power. Thus, the role of the regulator in enabling a just culture becomes essential.[54 55] However, individualised responsibility may contribute to causing fear of reporting serious adverse events which may refrain patients and next of kin from getting access to relevant information and hamper collective and individual learning opportunities. These results echo the foundation of the Norwegian litigation system, where the NSPIC represents a separate and independent system that deals with compensation claims outside the regular legal system.[19 56] No opportunity or mandate to instal subjective blame on individual healthcare professionals involved in the case exists.[57] Although a recent debate about the role of the NSPIC and individual liability has revealed different views, our participants perceived that the system of anonymity supported a blame free logic.

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In turn, it may have positive influence on transparency about causes and consequences from serious adverse events in surgery. Held together with previous studies, our findings, therefore, indicate that the current system should be protected.[58 59]

Roles, processes and decisions: minor influence of external assessment on transparency, reporting and learning in surgery

The environment of surgeons and health professionals, especially after serious adverse events may appear highly complex involving several formal, government bodies (as well as patients, next of kin and potentially the media).[36] Although many participants described external inspection as a positive third-party influence, it was not described as a mean increasing quality nor safety. This does not reflect the assumption where higher quality is seen as associated with externally promoted (by inspection/assessment) compliance to evidence-based standards.[5 6] The message from our participants were that lack of knowledge among inspectors or investigators reinforced the sense of different or colliding worlds and professional cultures. It was reflected in participant reporting how experience, background and knowledge may influence the interpretation of an adverse event, implying that the medical world and the culture of regulation are at odds with one another. This was reported to weaken health professionals' trust in the processes and decisions made. Literature indeed points to the important aspects of inspectors and the police having sufficient knowledge and competence as crucial factors to legitimacy and public trust.[46 60–62]

In general, psychological safety is perceived as a prerequisite for a 'fearless' workplace which facilitates learning and innovation.[63] Related specifically to healthcare, a culture of individual shame and blame has a history of being anticipated as contradictory to a culture of systemic learning and collective improvement.[64–67] Regardless of the system perspective, external inspection may be experienced as individualised punishment,[46 47 68] which may lead to less sense of responsibility in the healthcare provider; department; unit and lessen the sense of ownership of the measures put in place to improve the services.[9] Our participants confirmed that the professional competence, behaviour and communication skills of the inspectors played into whether they felt the encounters to be unpleasant, or useful to their work.

Previous findings have shown that ongoing police investigations were experienced as an obstacle to learning because the employees were afraid of self-incrimination, hindering them from being transparent.[46] It has been reported that health professionals' following exposure in the media have experienced pressure to adjust their understanding of the causes of a patient's death, before going into police interviews.[24 69] As corroborated by our findings, appointing guilt and perpetuating shame on the surgeons involved in the adverse event could have the opposite effect of transparency. The primary purpose of investigating legal responsibility has thus limited worth to learning, as it does not necessarily add value to or inspire internal improvement processes.

Most of the interviewed surgeons viewed media as tending to process cases that created 'scapegoats' and 'villains', wrapped in a 'juicy' narrative. The concept of scapegoating in media is well known.[70] Our findings pointed in addition to the risk of media presenting adverse events in ways that are less representative to the complexity issues involved, and sometimes based on inaccurate information. The latter has proven to be the case in prior media reports about adverse events.[3] 'Clickbait-driven' publications could have unfortunate and unintended consequences for the people involved in the case reported and add to the burden of guilt.

Our findings did not reveal any negative implications from the NSPIC. However, under-reporting has been indicated to be an issue in the past. In a retrospective study analysing 167 cases in one Norwegian university hospital receiving compensation by the NSPIC, findings showed that of the 80 patients suffering serious consequences of a patient injury, only 26% of the cases had been reported in the internal reporting system.[71] Although there is a substantial gap in internal reporting and external (NSPIC) awards, it could to some extent be explained by misconception, misjudgement, unawareness or late discovery of the patient injuries or errors.[72] These intricate and assumed explanations might be addressed by future research.

Implications of the complexity of thematic pressure in external assessment

The findings and discussions demonstrated in this paper display a variety of interconnections and existence of external bodies involved following serious adverse events. The complexity of bodies involved puts the surgeon(s) into a scenario of challenging and comprehensive pressure (see figure 1).

Although external inspection or third-party expertise assessment overall was described as a way of gaining momentum for improving procedures or routines, the totality of the different roles of external assessment seems indifferent to the surgeons' notions of influence on transparency and quality improvement. The many aspects described in figure 1 may counteract the surgeons' sense of valuable output from external assessment. This should pave way for an increased governmental attention to application of up-to-date knowledge used in third-party assessment. Moreover, media reports and involvement and communication related to police encounters should seek to minimise the shame and guilt narratives in ways that do not compromise the legitimacy of these institutions, nor undermine the public trust in the healthcare services. The results can inform medical training programmes to prepare future students and trainees on how to expect and respond to external assessment, of which they will become part of later during their careers. Medical training programmes should also learn

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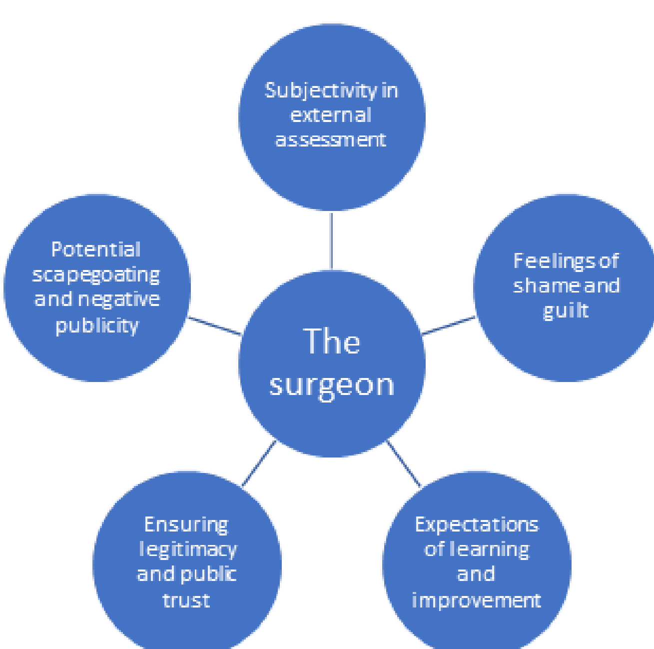

Figure 1 Pressure on the surgeon after an event.

students and trainees about potential negative personal consequences (eg, emotional exhaustion, burn-out) and potential negative professional consequences (eg, defensive medicine) from a culture of individual shaming and blaming.

Strengths and limitations of the study

The key strength of the study is the provided insight into a topic of external assessment of limited prior knowledge in a surgical professional perspective. To the best of our knowledge, this study is innovative in its display of some of the complex interconnections between external bodies following a serious adverse event and the challenging pressure put on the surgeon.

The study reports the experiences of surgeons limited to a Norwegian university hospital setting. No attempt was given to completely balance factors such as gender, age and clinical specialties in the participant distribution, and the sample does not fully reflect the current gender and generational balance among surgeons in the Norwegian university hospital setting.[12] However, considered the gender balance and median age of the included sample in the current context, four women reflected a representative number. An equal number from each health region was not one of the inclusion criteria. It was considered more important to include participants from regional university hospitals, where the population size and density is the highest in the southeastern region. Thus, it was sensible to include a higher number of participants from that specific region compared with the northern region.

The inclusion criteria concerning years of experience were set to 10 years minimum. The years of experience held by the individual surgeons may, however, have had an impact on their perceptions of external influence and the media, even though the data did not reveal such a link explicitly. The study's scope of exploration, with different subspecialties included, has implications on the conclusions made. The conclusions drawn from the data regarding surgeons' negative and positive experiences of the different external bodies, should thus be of generic art. The process of which some of the participants partly were identified by the researchers' self-selection may have influenced the data and interpretation. Likewise, the researchers' own experiences, backgrounds and knowledge may have influenced the selection process and interpretation. All interviews were conducted in Norwegian language before the transcripts were translated to English language. This process may have hampered linguistic nuances.

Further studies are required to investigate the multilevel implications of the challenges raised in our study, to fundamentally get to grips with how we can improve transparency about serious adverse events, learning from these events and increase quality and safety in surgery.

CONCLUSION

This study found that external assessment may generate a sense of criminalisation and reinforcement of guilt among surgeons, where lack of knowledge and competence among external bodies could cause and reinforce a sense of clashing cultures. The perception of the gap between the 'the internal vs the external world' might result in lack of useful input or added value to quality improvement. External bodies on the outside 'looking in' could, however, provide ground for adjustment of routines and procedures and stimulate awareness about internal issues to quality and safety, depending on relevant competence, knowledge and communication skills within the external bodies. Our study displays some of the complex existence of a variety of external bodies, including interconnections that may put the surgeon(s) in a scenario of challenging pressure.

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Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Not applicable.

Ethics approval This study involves human participants but the study was performed in accordance with relevant guidelines and regulations (ie, the Declaration of Helsinki). The study did not collect specific patient information. The experimental protocol was approved by Sikt–Norwegian Agency for Shared Services in Education and Research (formerly known as the Norwegian Centre for Research Data (NSD)) ref. nr: 594289. Sikt ensures that the research project adheres to ethical guidelines and regulations and provides the approval for information security and privacy services, as part of the HK-dir (Norwegian Directorate for Higher Education and Skills). Participants gave informed consent to participate in the study before taking part.

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Appendix 1. Interview guide

- Can you tell us a little about yourself, such as your position, how long you've been working as a surgeon, and what your work entails?
- Have you experienced making mistakes or errors in judgment in your job as a surgeon?
- Do you remember what the first mistake or error in judgment was?
- How do you feel about being open about mistakes and adverse events with colleagues?
- Who, for example, immediate supervisors, experienced colleagues, less experienced colleagues, or others, do you find it easiest to be open with?
- Have you heard other colleagues talk about difficult situations and their own mistakes?
- Why do you think it can be difficult for some, especially within the field of surgery, to openly discuss their own and others' mistakes?
- Can you tell us a little about what usually happens following a serious adverse event?
- After a serious adverse event, is it routine to contact and inform the patient/family about what happened?
- Can you talk about your experiences regarding being open about mistakes and adverse events with patients and/or family members?
- Do you have examples of specific changes in routines and procedures that have resulted from and in the aftermath of an adverse event?
- How can mistakes you've made affect your work after the adverse event?
- How has it affected your confidence in performing your job in similar situations afterward?
- Have experiences you've gained as a surgeon affected other aspects of your life outside of work?
- In what ways have experiences you've gained as a surgeon affected collegial relationships and communication?
- To what extent have you experienced support from colleagues when you've been involved in an adverse event?
- What type of mental competence do you consider crucial for you to be able to have/do the job you have/do?
- Have you been offered any form of training or education in coping strategies or tips for handling serious adverse events during your career?
- Can you say something about what you believe should be given more emphasis in the follow-up of healthcare personnel after a serious adverse event?
- What disadvantages can there be in reporting an adverse event?
- Have you ever thought that you should have reported something and refrained from doing so?
- During your career, have you encountered/worked with colleagues whom you've thought should not work as surgeons?

- How do you understand the term "foreseeable risk"?
- Can you say something about which factors you consider central to contributing to reducing the incidence of patient harm in surgery?
- What disadvantages and advantages do you experience with checklists?
- Do you use the Safe Surgery checklist? If yes, is this by your own initiative or mandatory in the department? If not, why?
- If yes, are there any parts of the Safe Surgery checklist that you think are more important than others? If so, what, and why?
- If you or your close relatives were to undergo surgery, would you want this checklist to be used?
- What are your experiences with external assessment after serious adverse events?
- Have you experienced any of the cases you've been involved in being picked up by the media?
- How do you feel the regulatory; external inspection authorities involve you and your colleagues in their processes?
- What, if any, learning benefits have there been from external inspection, in your opinion?
- Looking ahead, what changes do you think should occur, at the system level, management level, and individual level, to promote greater openness about mistakes among your colleagues?
- Closing comment: Is there anything you think is important to mention or say that we haven't discussed?

Appendix 2. Example of the analytical process related to one participant quote.

Meaning unit	Condensed unit	Code	Category	Theme
So, the way I experienced it was that they had a somewhat strange behaviour, like a police officer who comes without any obligation to identify themselves or explain why they were there in any way. And they act with a kind of police authority.	I experienced that the external inspectors had a police-like behaviour and did not inform why they were conducting the inspection at the hospital.	The police-like behavior of the inspectors	Sense of criminalization and reinforcement of guilt	External inspection in relation to transparency and quality improvement following adverse events.