Peer Review Report

Review Report on The European Researchers' Network Working on Second Victim (ERNST) Policy Statement on the second victim phenomenon for increasing patient safety

Policy Brief, Public Health Rev

Reviewer: Ana Azevedo
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EVALUATION

Q 1 What are the main findings and conclusions reported in this manuscript?

The manuscript summarizes discussions and experience exchange within a COST action. There are not exactly original results, given the nature of the work, but general needs and principles are identified and organized across 6 "components" in an intuitively sound way.

Q 2 Please highlight the limitations and advantages.

Limitations: The paper falls short in the announced intention of "addressing critical research questions" and "offering actionable strategies" (as stated in the section CONTRIBUTION TO THE FIELD).
Many points such as for example "5.1. (...) The promotion of just culture principles within healthcare organizations is essential." are too vague and generic, and not original.

Advantages: it is a summary of evidence and consortium members' opinions and perceptions, on a topic of importance which is still undervalued, at least from the point of view of intervention and support provision. The size of the consortium and the funding of the COST action are good news per se and it is important to produce outputs of the investment made so that learning and translation is leveraged.

Q 3 Are there objective errors or fundamental flaws? If yes, please detail your concerns.

The manuscript's content is not compatible with the title allegation to be a "POLICY STATEMENT", since it is a summary of evidence and consortium members' opinions and perceptions (and it would be useful as such) but it does not provide a clear and intentional expression of objectives and strategy. The dimension number 2, in particular, summarizes data and facts regarding the ensurance of healthcare provider capacity, but it does not clearly state what needs to be implemented, what the recommendaions are in this matter.

The method used for the organization of the content of the "polity statement" points into the 6 components is not described so that its theoretical foundation can be appreciated.

In the Introduction, third paragraph, the final sentence reading "However, recognizing that the majority of adverse events stem from systemic failures, equal consideration must be given to the collateral trauma experienced by healthcare professionals (11–13)." is not clear in its reasoning. The contrasting word "however" must result from an assumption from the authors' whose logic is not clear to me at all.

Q 4 Check List

Is the English language of sufficient quality?
Yes.

Does the manuscript provide an appropriate context for a non-technical audience?
Yes.

Does the manuscript use language that can be understood by a non-technical audience?
Yes.

Is the quality of figures and/or tables satisfactory?
No.

Is the evidence presented appropriate, sound and objective?
No.

Are the action points provided based on the evidence?
Yes.

Are the action points provided reasonable and feasible?
No.

Are there any ethical issues with the recommendations provided?
No.

Q 5 **Please provide your detailed review report to the editor and authors (including any comments on the Q4 Check List):**

Figure 1 must be extensively revised (redesigned). There seems to be an intention to represent a meaning of severity of "incidents" in a vertical axis, at least in the lefhand side, but this representation does not link with the rest of the elements of the figure in the same vertical axis, at least beyond the second element ("Emotional impact in healthcare professional...").
The width of the box "Patient impact...", narrow at the top and wide at the bottom, intends to represent probability or "impact"? Mentioning both terms introduces a contradiction in my interpretation. Isn't patient death at the highest impact extreme of the putative range?
The box "Avoidable adverse event" at the righthand side is flawed in 2 ways: a) the concept "avoidable" appears here for the first time in the paper and it is not necessarily true that this applies only to avoidable events, and b) the arrow linking to "patient death" is obviously a misrepresentation of the scheme (I assume the authors wanted the arrow to lead to all itens together at the left, representing the vicious circle idea).
Also, in Figure 1, the 3 paths (thriving, surviving, leaving) are confusing, because: a) "thriving" is in the middle of the vicious circle as a "dead end" instead of being represented of a "negative feedback" effect to reduce patient events (increasing patient safety/safety of care is synonymous with reducing all the occurrences at the lefthad side box), and b) the order of the three outcomes from top to bottom is opposite to the "severity" of patient harm at the left.
Maybe trying to represent the potential interventions (by who and how) to break the vicious circle would be useful and add value to previous knowledge, since this manuscript intends to provide guidance on what needs to be done and not only review the knowledge on the phenomenon.

It would be useful to present the type of organic unit within the healthcare providing institutions that are expected to intervene in providing support to second victims, or at least to name the necessary competences to do so without disrespecting the institutions' autonomy in their organization (e.g. psychology, occupational health, etc...).

Although the list of references is long, I miss reference to existing programs and initiatives and recommendations, to provide support to healthcare professionals who are involved as second victims in patient safety events.

Page/line numbering would have been useful for the peer-review process.

QUALITY ASSESSMENT

Q 6	Originality	■■■□□
Q 7	Rigor	■■□□□
Q 8	Significance to the field	■■■□□
Q 9	Interest to a general audience	■■■□□
Q 10	Quality of the writing	■■■■■
Q 11	Overall quality of the study	■■□□□

REVISION LEVEL

Q 12 Please take a decision based on your comments:

Major revisions.