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What weighs most is what we do not say

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I am 68 years old, and every morning I still put on the same blue hospital scrubs. Dark blue. Scrubs that no longer try to look young; they simply try to last one more day. They carry the weight of years—mine and theirs—and the quiet comfort of something that no longer needs to prove anything. They are not just a uniform; they are a silent witness. They endure blood, bile, cold coffee, and nameless emergencies—and, above all, they endure all of us: the frightened patient, the team that projects calm when it is necessary, and ourselves when we pretend that nothing affects us.

In my pockets are a few small certainties. A pair of scissors that circulate through the unit as communal property, always there when you need to cut something during a PEG or open a stubborn package. I also carry a 3M mask that I had to buy during the COVID-19 pandemic. With my own money. Like buying a helmet to walk into a fire you did not choose. I still wear it, because some periods leave the calendar but never leave the body. They remain in your breathing, in your memory, in the automatic gesture before entering the procedure room.

These are the visible things. They weigh very little.

What truly weighs—the part that accumulates day after day—does not fit into any pocket.

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What weighs most is what we do not say.

We do not say it at home, because how do you explain that you still see a face, a name, a complication, years later?

We do not say it to our trainees, because we do not want to frighten them too early. Sometimes we do not even say it to ourselves, until one night we find ourselves ruminating again: the scene that returns uninvited and refuses to switch off—not with evidence, not with statistics, not with the familiar locker-room phrase: "It doesn't happen to those who don't do it."

But we know the truth. A complication in a paper is a percentage. In real life, it has a name, a family, an interrupted biography, and an empty chair. And that chair is never truly empty.

When someone doubts that this experience exists—when it is framed as excessive sensitivity or personal weakness—the numbers ground the discussion. In *The INNOCENT Study*, conducted internationally among interventional endoscopists, nearly eight out of ten had experienced severe adverse events (78.97%), and almost three out of four reported a significant psychological impact (72.82%). Perforation was the most impactful event (46.47%), followed by patient death (26.76%). Particularly striking is that only seven centres reported having a structured support programme after such events, compared with 120 that did not (1).

We also have preliminary data of our own. In a cross-sectional study conducted among attendees and faculty at advanced endoscopy meetings, using the validated PCL-5 questionnaire, we observed a prevalence of post-traumatic stress disorder (PTSD) of 12.94%, with an additional 31.76% presenting clinically relevant symptoms without meeting full diagnostic criteria. Participation was voluntary and anonymous, and the survey was administered in an educational setting. These findings are preliminary and hypothesis-generating and should not be interpreted as national prevalence estimates (2).

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Rather than an issue confined to a single discipline, the second-victim experience appears to affect clinicians who perform invasive procedures, where technical failure and patient harm coexist at close range. This has been documented not only in endoscopy but also through systematic evidence in surgery, underscoring a shared professional vulnerability across invasive specialties (3,4).

Guilt has two faces: one that allows learning and improvement, and another that silently erodes confidence. At times, the trauma is not even perceived as emotional, but physical—fragmented sleep, nocturnal rumination, somatic symptoms without analytical correlates. A form of post-traumatic stress that has been extensively described among healthcare professionals involved in adverse events (5–7).

Over time, we learn techniques and solutions. We learn to manage complications and to teach others. What is taught less clearly is that caring for patients may involve carrying, for years, those we could not help as we would have wished. As Captain Jean-Luc Picard once said, “It is possible to commit no mistakes and still lose. That is not a weakness. That is life” (8).

In medicine, losing does not always mean making a mistake. But remaining silent after the blow almost always means remaining alone—and that is something we can change.

For me, this reality crystallises every day in ERCP, probably the most hazardous procedure we perform routinely. I do not say this to frighten anyone, but to avoid self-deception. ERCP combines a slow learning curve, significant morbidity and mortality, and a high frequency of legal claims, with a considerable personal burden for the endoscopist (9). Technical success rates range from approximately 80% in low-volume centres to 95% in expert hands, while complication rates remain between 10.2% and 13.6%, depending on centre volume and experience (10–12).

To orient myself in this landscape, I carry an intellectual compass attributed to Freeman Dyson: “The beauty of science is that the important things are unpredictable” (13).

Among everything we carry, the most useful tool is experience—built from successes, errors, complications, and shared learning. It guides decisions about when to persist, when to stop, when to refer, and when to ask for help. Experience does not eliminate risk, but it does reduce self-deception and unsafe persistence (14,15).

What I no longer accept, for myself or for those who come after us, is that the price of progress should be silence. This is not resolved with a dismissive "it will pass." It requires organisational culture: structured debriefing, peer support, honest audit, and teams that are able to speak openly after adverse events (5,16,17).

To our knowledge, formally established and systematically evaluated second-victim support programmes are not widely implemented or reported in Spanish endoscopy units. Collegiality and goodwill may exist, but identifiable and measurable programmes remain uncommon. Recognising and sharing existing initiatives would be an important first step, not as "soft psychology," but as patient safety, talent retention, and serious medicine.

What we carry that is visible has weight.

But what we do not say weighs far more.

REFERENCES

1. Holzwanger EA, et al. Psychosocial impact of endoscopic procedural complications on gastroenterologists: the second victims. *Gastroenterology*. 2025;169:1510–1512.

2. Rodríguez-Muñoz S, et al. Psychological impact and post-traumatic stress symptoms among advanced endoscopists in Spain. Manuscript in preparation.

3. Bryan J, et al. Second victim syndrome in surgeons: systematic review and meta-analysis. *Br J Surg*. 2025;113:znaf258.

4. Shanafelt TD, et al. Burnout and medical errors among American surgeons. *Ann Surg*. 2010;251:995–1000.

5. Wu AW. Medical error: the second victim. *BMJ*. 2000;320:726–727.

6. Scott SD, et al. The natural history of recovery for the healthcare provider second victim. *Qual Saf Health Care*. 2009;18:325–330.

7. Seys D, et al. Health care professionals as second victims after adverse events. *Eval Health Prof*. 2013;36:135–162.

8. Roddenberry G. *Star Trek: The Next Generation*. Episode "Peak Performance". 1989.

9. López-Rosés L, Rodríguez-Muñoz S, et al. ERCP in a low-volume hospital. *Rev Esp Enferm Dig*. 2013;105:68–73.

10. Kapral C, et al. Case volume and outcome of ERCP. *Endoscopy*. 2008;40:625–630.

11. Cotton PB. Are low-volume ERCPists a problem? *Gastrointest Endosc*. 2011;74:161–166.

12. Verma D, et al. Assessment of competence in ERCP. *Gastrointest Endosc*. 2007;65:394–400.

13. Dyson F. Quoted in *Nature*. 2020;579:19–20.

14. Jowell PS, et al. Quantitative assessment of procedural competence. *Ann Intern Med*. 1996;125:983–989.

15. Baron TH, et al. Quality indicators for ERCP. *Gastrointest Endosc*. 2006;63:S29–S34.

16. Edrees H, et al. Implementing the RISE second victim support programme. *BMJ Open*. 2016;6:e011708.

17. García-Cano J, et al. Psychological impact of a failed ERCP on the endoscopist. *Gastrointest Endosc*. 2020;91(Suppl):AB284.