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SUPPORT IN CRISIS: *Ensuring Well-Being for the Second Victim in Adverse Events*

Introduction

The term 'second victim' was first coined in 2000 to refer to doctors involved in medical errors. It refers to the psychological distress and myriad of challenges that doctors face after being involved in adverse events or safety incidents. The world of medicine may be unforgiving when an error occurs. Doctors involved often face the judgmental eyes of the public, amplification of errors by mass media and receive silent treatment or criticism by their own fraternity. Although patients are the first victims of medical misadventures, healthcare workers involved are wounded by the same errors. Healthcare professionals at all levels are potential second victims in these situations. The level of emotional injury becomes exponential in the event of medicolegal suits or disciplinary hearings.

Psychological injury of disciplinary hearings and lawsuits on healthcare professionals

The stress of a medicolegal case is beyond comprehension for the doctors involved. For some, it rivals the stress of facing the death of a loved one. It has been shown that doctors who face complaints have around double the risk of developing moderate to severe depression, anxiety, or suicidal thoughts versus those with no complaints.[1] The emotional trauma that comes with a lawsuit lasts even after the lawsuit has concluded, irrespective of the outcome. It has been associated with burnout, defensive practice in medicine and doctors leaving the profession. These experiences have also been shown to affect the doctors' personal, family, social and professional lives. A case in point is the data from Australia revealing that between 2018 and 2021, 16 health practitioners died by suicide after being the subject of complaints. Understanding these implications, support measures for the second victims become even more imperative. In this article, I have divided these measures into four levels: personal, organisational, social, and regulatory.

Personal level: seeking help

Doctors are often 'silent' patients, prone to underestimating the seriousness of a condition when it affects him or her. This is even truer when a doctor is faced with a mental health crisis. Coupled with the potential stigma and fear of loss of status that comes with being branded emotionally unable to cope and being not strong enough to face the vigorousness of an investigation, most doctors with mental health problems do not seek help. However, recognising the problem is the first step in rectifying it. If a doctor facing a malpractice claim suspects that his personal wellbeing and professional judgement are affected by his mental health, there is a need to seek help by consulting a suitably qualified colleague (e.g., a psychiatrist). Sometimes, the presence of an expert listening ear is all that is needed to navigate the stress of medicolegal challenges. When professional judgement is compromised, medical practices may need to be adapted so as not to compromise patient safety. This will invariably require a supportive working environment for a period of time. The practice of self-prescribing for symptom alleviation (e.g., anxiety, depression) should also be avoided.

Organisational level

At the organisational level, peer support's importance cannot be over emphasised. Organisational leaders (e.g., in the department or the hospital) should facilitate an environment that promotes compassion and a sense of belonging among health practitioners. When a colleague faces a lawsuit, fellow doctors must offer support, which enables the sharing of emotional burdens and makes the litigation process less frightening. Support comes in many forms, and the purpose is not to sweep the problem under the carpet but to find a path forward. The critical thing to avoid is the isolation of the doctor involved, which will exacerbate the mental stress and lead to more damaging issues. An example of a tiered organisational support programme by the University of Missouri Health Care System is shown in Table 1.

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Table 1: Example of a tiered support system (adapted from The Scott Three-Tiered Interventional Model of Second Victim Support, from https://www.muhealth.org/about-us/quality-care-patient-safety/office-of-clinical-effectiveness/foryou, assessed 8/3/2024)

Tier 1
(basic, immediate emotional support provided by supervisors/colleagues within the same department as the affected individual)

- Promptly check on potential second victims to assess their well-being immediately following a critical clinical event.
- Conduct basic awareness training for unit leaders and colleagues, equipping them with essential knowledge on actions to take post-event.

Tier 2
(guidance and support for second victims by colleagues with specialized training in the second victim experience)

- Incorporate peer supporters with specialized training into departments facing elevated clinical risks.
- Guide second victims to internal resources, such as patient safety experts, when necessary for assistance.
- Extend support for legal issues if needed.
- Conduct group debriefings when the entire team is impacted.

Tier 3
(guarantee timely availability and accessibility to professional counselling and guidance)

- Facilitate expedited referrals to individuals specially trained in crisis intervention, if required.
- Grant access to supplementary hospital resources, including religious support, social workers, and clinical psychologists, if the need arises.

Reference

1. Bourne T, Wynants L, Peters M, Van Audenhove C, Timmerman D, Van Calster B, Jalmbrant M. The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey. *BMJ Open*. 2015 Jan 1;**5**(1):e006687

Roles of MSA

With the widespread concerns over the recent Federal Court case on Siow Ching Yee v Colombia Asia Sdn Bhd involving a fellow anaesthesiologist who was judged to be negligent, the Malaysian Society of Anaesthesiologists (MSA) has stepped up to address the concerns of members of the Society. First, fraternity members who may be involved in medicolegal challenges are advised to contact the Director of Member Affairs of the MSA via the secretariat email or phone number. This officer will serve as a point of contact for the society to provide guidance and support in a time of need. In addition, the MSA will endeavour to enlarge the available pool of expert witnesses capable of responding to the increasingly complex and different contexts where errors are deemed to have occurred. More are discussed in the 'Anaesthesiologists in the Firing Line' article in this edition of Berita Anestesiologi. Again, knowing that you are not alone if you are involved in a potential patient complaint or medicolegal suit is essential.

Regulatory reforms

Moving forward, MSA and the broader medical fraternity, under the umbrella of the Malaysian Medical Association, aim to champion regulatory reforms to reduce the harms of prolonged and traumatic medicolegal processes. Conversations have been started to encourage doctors involved in medicolegal cases to seek mediation instead of going through a protracted and damaging court hearing.

Conclusion

Recognising the immense stress of every medicolegal case, it is vital to know that one can find many avenues of support. The process starts with one's own recognition that help is needed and a willingness to seek that help. From there, organisations and MSA can provide support and guidance to navigate a court case's psychological and material complexities. Finally, remember that this saying always holds true: "You will never walk alone".