Adverse patient events: it's complicated

Dr Helen Wilcox
Medical Director, Doctors' Health Advisory Service Western Australia (DHASWA)

Working as a doctor is demanding. We are required to be expert clinicians, often in resource-limited environments, demonstrating technical proficiency and complex non-technical skills. There are stressors inherent within each area, but no greater stressor than complication – the clinical adverse event. It is of little comfort to know that complications are an inevitable outcome of clinical care, occurring in state-of-the-art health services, with best-practice care. A complication can have devastating consequences for the doctor.

Recovery for the doctor after adverse patient events follows a familiar course.[1,2] Immediately after, there is the accident response: a sense of detachment, almost dissociation. The doctor completes pressing tasks: finishing the list, speaking with the family, communicating with others involved in the patient's care, and dealing with other clinical work.

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In the hours afterwards, there are intrusive reflections while trying to write comprehensive, contemporaneous notes. Then, there is questioning one's personal integrity. This may be guilt – "I did something bad"; or a more pervasive shame, by failure to live up to one's core personal or professional identity – "I am a bad person."[3,4]

People respond in different ways to the threat of shame.[5] They may withdraw in order to conceal shame; they may attack others and deflect blame elsewhere; they may attack the self, feeling unworthy of being a doctor; or they may sink into denial and find other ways to soothe themselves. Few of these responses are healthy or useful. They can generate secondary problems, but explain to some extent why people behave a certain way after an incident.

We can see adjustment in practice. In performance environments, there can be reduced technical ability and cognitive processes.[7] Doctors may show changes in investigation, prescribing and referring patterns, and avoidance of certain types of patients. Relationships with patients and colleagues can alter.[8] Internally, doctors can experience sleep disturbance, and symptoms of anxiety, depression, burnout.[9] Alcohol and drug use can become more frequent, and suicidal thoughts can occur.

The intensity of feeling reduces, but flares while the investigation is endured, with scrutiny from peers, the patient, the family, the hospital, the regulator, and the lawyers. Time does pass and the doctor can move through the event: they may leave this field of medicine, stay and survive only, or undergo positive personal growth in the months ahead.

After a complication, the doctor needs wraparound support. An MDO to interface with investigators. A senior colleague to debrief and assist with internal processes. The employer, by providing continuity of employment, timely processes, and any work adjustments. Psychological supporters and colleagues inside or outside the hospital reinforce personal integrity, and the doctor's own GP is key to risk and distress management.

Doctors' Health Advisory Services provide crisis support and peer validation, describing and supporting the development of a path for them to move through.

What can a colleague do? In the initial phase, facilitate other work being performed, providing clinical cover if requested. Reinforce the importance of avoiding isolation to lessen opportunity for rumination. Prompt and, if required, organise other aspects of wraparound support. Help to restore personal integrity: remind them of their value and contribution, steering them away from shame.

Help with practical aspects: the apology and investigation. Consider whether you can influence the structure and culture of subsequent safety meetings towards providing support for safety improvements. Keep in contact with the doctor. Ask permission to ask how they are doing. Support whatever form of moving through they choose – leaving, surviving or thriving. The doctor will not forget this complication. And they will not forget those who sat alongside them during this period of their life. ■

References available on request.