The Second Victim: Ignored in the Indian Perspective

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The Institute of Medicine's report, "To err is human", estimated that medical errors caused 44,000–98,000 deaths annually in the USA [1]. In the year 2000, Andrew Wu, from Johns Hopkins Institute in his seminal paper entitled "Medical error: the second victim" drew attention to the fact that when adverse outcomes are noted during treatment, two victims can be identified—the patient *the first victim* and the involved health care professional *the second victim* [2]. The second victim has also been described as a traumatised health care provider who, following an adverse medical event, feels responsible for the unexpected patient outcome and begins to question his or her knowledge and skills [3].

The impact of the error on the first victim is often experienced by the second victim empathetically. The effect of this feeling may manifest physically: fatigue, palpitations, sleep, or appetite disturbances; or psychologically: frustration, anger, grief, second guessing oneself, or anxiety; or socially: fear of reputation damage, avoidance of patient care, reduced interaction with peers, isolation, or seeking solace in alcohol or drugs [3, 4].

The coping mechanisms described include seeking support, self-criticism with acceptance of responsibility, emotional self-control, and escape or avoidance [3]. The various stages of recovery that have been identified are chaos and accident response stage, intrusive reflections, enduring inquisition, obtaining emotional first aid, and moving on, which have

three possible trajectories: dropping out, surviving while being plagued by the event, or thriving by figuring out a way to avoid such adverse events in the future [4–7].

To aid the smooth transition of this process, a strong support system consisting of trained personnel is essential. Chaplains, social workers, holistic or mental health clinicians, child life therapists, and palliative care practitioners are trained to provide emotional support. A four-phase programme called RISE (Resilience in Stressful Events) has been developed at the Department of Paediatrics, Johns Hopkins Hospital to form a team of support staff to address the needs of "second victims". A pilot study conducted showed that 88% of peer responders reported benefit from the programme, and the number of medical professionals seeking help quadrupled over a period of 4 years as the awareness of the existence of the programme increased [8].

Situation in India

In the Indian setting, reliable statistics aside, discussion and awareness about the impact on the health care professional of a medical error, within or without the medical community, are lacking. There is no acknowledgement of the needs of the medical professional under such a stress.

The increasing tendency of individual patients and institutions to resort to legal means of taking redressal to such events compounds the trauma to the medical professional. The Register of Karnataka Medical Council available on the web reveals an average of 100 case hearings in a month and often repeat hearings of cases dating back to 3–4 years since the initial filing of the petition. This quasi legal proceeding itself may be a harbinger of much more stressful legal proceedings, especially when the Medical Council agrees with the petitioner that the event was indeed due to "negligence". This is increasingly

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being perceived as a licence to seek criminal liability on the professionals, judgements to the contrary by the Supreme Court notwithstanding [9]. The increasing tendency to resort to physical violence under the pretext of uncontrollable grief is an unfortunate reality, even recognised by statutory laws.

We cannot expect the populace at large or the legal profession to recognise the negative psychological effects of the events and those of the mandatory procedures following medical error identification whether peer driven, institutional driven, or quasi legal proceedings such as Medical Council Hearings or Legal proceedings.

It is therefore imperative for the medical profession in general and the Medical Council in particular to shed its inquisitorial cloak and don its supportive cape to help fellow professionals face up to this ever-increasing problem.

The formulation of an awareness campaign will promote an open dialogue about the prevalence of second victims among our fellow professionals. The development of surveillance, support strategies, and the setting up of help desks at health care facilities could help in mitigating suffering amongst second victims in the Indian setting [5, 6]. A mandatory visit by all medical students to a hearing of the Medical Council would be far more effective than endless didactic lectures asking those in the early stages of their career to be aware of the consequences of improper documentation and inadequate consent.

The senior authors believe that in the context of physician burn out, suicide and the increasing tendency of the best and brightest to select other professions which carry less risk and more monetary gain, and those within the profession to practice defensive medicine, recognition of this problem is of utmost importance to the profession and indeed to society.

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