CHAPTER 24

Working Together in the Aftermath of an Unforeseen Event

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Abstract: The frame of this chapter is how clinicians and leaders employed in psychiatric departments in hospitals experience and cope with patients who commit suicide while undergoing treatment. The major focus is the phenomenon which in the Bow-tie model is called "stabilization". To explore this phenomenon in an empirical analysis, two concepts of *samhandling* are introduced, these being coordination and cooperation. These two concepts are used in an interpretation of what eight leaders and clinicians report on how they handle working together after a patient during treatment in a psychiatric hospital has unexpectedly committed suicide. The findings are that leaders and clinicians have different views on what stabilization is. Stabilization to the leaders seems to be something they can handle by using mandatory organizational procedures of coordination. To the clinicians (psychologists and psychiatrists) however, stabilization is less straightforward. Professional stabilization is, to them, more important than organizational stabilization, and it requires another form of interaction – namely, cooperation. Cooperation is, in its simplest and purest form, a symmetrical way of working together, based on equality in competence and an unforced relation between the parties. For the purpose of professional stabilization, this is the form of interaction preferred by the clinicians. However, these findings are tentative and more research is needed to elaborate why leaders and clinicians respond as they do after a patient suicide.

Keywords: *Samhandling*, interaction, suicide, coordination, risk, stabilization, recovery, unforeseen.

Introduction

The subject matter of this chapter is how clinicians and leaders employed in psychiatric departments in hospitals experience and cope with patients who commit suicide while undergoing treatment. Thoughts and plans of causing one's own death are not unusual amongst people who suffer from mental disorders, but very few of the patients actually carry out their plans of suicide. Based on data obtained from interviews with a selected group of psychiatrists, psychologists, heads of department and sectional leaders, all of whom have experienced the suicide of at least one of their patients, we seek answers to the following question:

> After a patient undergoing treatment has committed suicide, how do leaders and clinicians at psychiatric departments in hospitals work together? And how do they handle the elements of unpredictability in their work?

The analytical aim of this chapter is to explore if, and how, the two organizational-theoretical terms, 'coordination' and 'cooperation' (Axelsson & Axelsson, 2006) can be used to illuminate differences between leaders' and clinicians' understanding of an unexpected suicide. From the Bow-tie Model (Chapter 1, Torgersen, 2018), our point of departure is a phenomenon called 'stabilization'. 'Stabilization' is illustrated in the right field of the model and correlates to 'prevention' in the left field. 'Stabilization' can occur over a longer or shorter time span. The stabilization process starts right after, or in some cases, almost at the same time the unexpected incident occurs. The model suggests that 'loss of control' amongst those who have to cope with the incident, and are affected by it, is temporary.

Cooperation and coordination

Working together after a patient has committed suicide during treatment can be done in multiple ways. Cooperation is, in its purest and simplest form, a symmetrical way of working together, based on equality in competence and an unforced relation between the parties (Axelsson & Axelsson, 2006). In our context, the concept 'cooperation' describes, for example,

what the person responsible for the patient's treatment, e.g. a psychiatrist or a psychologist, is seeking if he or she asks an entrusted colleague with the same professional background for help to go through the case history of a patient who has committed suicide. Cooperation between professionals usually involves a small number of people. In favorable cases, this way of working together can result in the development of new knowledge, without the need for a larger organizational apparatus. However, coaction in small professional groups has, as some scholars have observed, a 'clan element' about it (Ouchi, 1980). The 'clan element' describes inner solidarity between group participants, which tends to develop over time. The flip side of the coin of this professional, in-group solidarity, especially in critical situations, is that the group is sometimes inclined to reject external evaluations. Different variations and degrees of coaction, based on a voluntary and symmetric relation between experts in the same field, is what we will further on describe as cooperation.

Coordination is a different way of working together. Unlike cooperation, which in its purest form does not involve any division of labor, this is a prerequisite for coordination. In this context, coordination may be described as when, for example, one leader or a small number of leaders get a large number of workers, who perform small and specialized functions within a department, section or organization, to pull in the same direction. This form of coaction has an element of hierarchy in it (Axelsson & Axelsson, 2006). The integration is based on dependency, which occurs when each contributor only works on a small and specialized task within a larger organizational entity (Durkheim, 2000). For this entity to work properly, coordination is required. The leader who coordinates is to be found in the upper level of the hierarchy, and has the final authority to decide in cases where there are mixed opinions. The workers, some with higher professional acquirements, are to be found in the lower level of the hierarchy. Coordination is, for example, used in bureaucracies to carry out a wide array of routine tasks, involving a large number of people with different skills.

The difference between coordinating leaders and cooperative clinicians can be further explored by adding Michael Power's distinction

between first-order and second-order risk (Power, 2004). First-order risk is addressed when a peer group of psychiatrists or psychologists cooperate to reconstruct the individual medical history of a patient who has committed suicide, in order to learn more and in the long run, ideally to strengthen professional evaluation so that there is less likelihood of new patients committing suicide. The aim of the leader's coordination and second-order risk evaluation is not to reduce future incidents of suicide, but to reduce future chances of not discovering administrative mistakes and omissions in the department, section or in the overall internal control system.

Before we present and analyze our findings from the study of the terms cooperation and coordination, we will briefly explain the status of knowledge concerning suicide amongst patients, and the administrative provisions that leaders and clinicians in the Norwegian specialist health services are subject to when a patient undergoing treatment commits suicide.

Administration of suicides in the specialist health care services

Suicide prevention amongst psychiatric patients is an important priority of the Norwegian Board of Health Supervision (NBHS). The national cause of death statistics from 2016 show that the number of registered suicides in Norway was 614; 418 of these were men and 198 were women. The most common method is hanging, followed by poisoning, shooting and drowning. Suicide attempts are more common amongst women, and the number of suicide attempts is assumed to be between 5000 and 6000 each year (Folkehelseinstituttet.no). Mental illnesses increase the chance of committing suicide, but even so, the suicide rate amongst people with psychiatric diagnoses is low. Each year, there are approximately 50 registered suicides among patients admitted to psychiatric institutions. In addition, there is an unknown number of suicides amongst patients undergoing outpatient treatment and those newly discharged from a psychiatric institution. We do not know how many unreported suicides there are among psychiatric patients.

According to specialist health care legislation in Norway, it is the leaders at hospitals who are formally responsible for detecting different kinds of adverse events and also initiating changes when mistakes that put patients at risk are made. When a patient commits suicide during treatment, an inspection unit investigates the case on behalf of the NBHS. The inspection unit is a multidisciplinary team with members from the health profession, the legal system and the police. According to the law, the inspection unit from the NBHS must be informed about the suicide within 24 hours. In the most complicated cases, the inspection unit conducts an inspection in the department in question, to collect information from clinicians, leaders, and the patient's family or dependents. The purpose is to clarify the causes of actions and to prevent similar cases from happening in the future. The requirement of patient safety has always been integrated in the professional ethics of clinicians, but it was first in 1980 that the law regarding professional advisability was passed. In our context, meeting the requirements of professional advisability involves both leaders serving an administrative system designed to expose and correct mistakes which may have a potential impact on patients' health and safety, and psychiatrists or psychologists who carry out satisfactory clinical evaluations and acceptable treatment of each individual patient. The shared legal responsibility between leaders and clinicians does not, however, prevent them from experiencing a patient's suicide very differently.

Statistics, suicide risk and discretionary assessment

To reduce the chances of suicide committed by patients undergoing treatment, suicide risk is measured. Complex relations between a person and a situation must be discretionary evaluated up against suicidal thoughts and plans, in addition to many other factors of risk. The risk factors for suicide are estimated according to studies of previous suicide cases. At the group level, it is possible to predict the suicide rate in the population from statistical examinations, but at the individual level, it is not possible to predict accurately who will commit suicide (Motto & Bostrom, 1990). Suicides are so rare that as a clinician, in the long run one will make

less mistakes without even trying to use one's professional discretion on the individual patient and instead make a general assumption that no patient will commit suicide, even in a population where a lot of risk factors are present (Kapur, 2004). This does not mean that data from group statistics is completely irrelevant for clinical purposes, but it must be critically rather than casually interpreted (Larsen & Teigen, 2015). Different methods for improving our knowledge about suicide risk in Norway are suggested. We do not have a personal register over suicides committed by patients in psychiatric health care, and according to Rønneberg and Walby, we should look to Denmark, which has introduced this kind of register, to improve our clinical prognostic accuracy of suicides in Norway (Rønneberg & Walby, 2008).

There is no unified agreement between experts on the potential of increasing the utility of suicide statistics for clinical purposes in the future. The statistical basis of knowledge used today to predict suicide gives a low grade of specificity and sensitivity. Because of its low grade of specificity, the risk evaluation can cause 'fake positives', namely patients whom the clinician believes will commit suicide and actually do not. The same applies to its low grade of sensitivity, causing 'fake negatives', referring to patients the clinician believes will not commit suicide but actually do (Larsen, 2012). Despite the fact that many risk factors for suicide are well known, it is not possible to predict the individual cases.

Method

We have conducted individual interviews with eight clinicians and leaders, who have experienced at least one suicide committed by one of their patients while undergoing treatment in a psychiatric department in a hospital. To recruit informants who made it possible to collect informative data on sensitive content, it was important to build trust between the researchers and respondents. The method we used was firstly, to ask for permission from the leaders of the psychiatric department in the hospitals where the study was planned to be carried out. Then we asked for permission to use the internal e-mail systems at the hospitals to inform our potential respondents about the project, and also to send an interview request

to the current leaders and clinicians who had experienced the suicide of at least one of their patients during treatment. The e-mail was used to reduce external pressure to take part in the study. Ten people volunteered; amongst these were six psychiatrists and psychologists, and the remainder were heads of departments and sectional leaders. For the clinicians, it was a prerequisite to have experienced the suicide of at least one of the patients whom they were mainly or partly responsible for under treatment. For the leaders, it was a prerequisite that they had experienced leading a section or department where the suicide of a patient under treatment had occurred. Two of the volunteering leaders did not meet these requirements, and were therefore not included in our group of respondents.

Each interview was conducted at the respondent's workplace during working hours. To be interviewed about a serious case at the hospital can be experienced as a burden. It was important for us to treat the interviewees with respect while interviewing them, as well as in the presentation of data and in our analysis. To protect the anonymity of the individuals, we have avoided using longer quotes which might make it possible to recognize them by their form of expression. The transcription of the interviews was made verbatim, and to systemize the transcript material we used systematic thematic text analysis (Malterud, 2012).

Results

Below (Table 24.1) is a thematic collection of quotes, illustrating some main tendencies from the interviews with the clinicians and leaders who took part in the study. We have chosen to emphasize themes relevant to clinicians and leaders' perspectives on coaction after a patient has committed suicide.

Analysis

The patient's suicide came unexpectedly to all the informants in our study. Despite the fact that both the clinicians and the leaders at a general level knew that patients in crisis tend to have a higher suicide risk, they did not see the individual suicide coming. The clinicians in our study had the

Table 24.1 Clinicians and leaders' experience and handling of a patient suicide.

THEME	CLINICIANS	LEADERS
FIRST REACTION TO THE SUICIDE	"It was a shock when it happened. It could not be possible. How could it happen?" "The despair of understanding that everything had gone wrong, questions about what we could have done differently, and should we have seen this coming?"	"The leader phones the clinicians and says 'This happens, and it is a part of our job.'" "Everyone on the shift gets information and each individual person reacts differently." "Within 24 hours, I had a meeting with the closest leaders and the clinical leaders. After the meeting, I reported the case further to the appropriate instances."
WAYS TO COPE WITH UNCERTAINTY	"There will always be many thoughts and self-examinations." "There could be a patient that resembles the one that took his or her life. And it makes you react differently. The atmosphere is changed and you are more careful, and observe the other patients more closely."	"In the first period we were scared. That is for sure." "When a suicide happens, we all of a sudden get the need to go through (the internal control system) to ensure that we do everything right."
WAYS TO COPE WITH RESPONSIBILITY	"The heaviest burden is when the dependents come.... I have experienced a clinician having a physical reaction. It probably had to do with the discomfort he/she felt in the meeting. The superior sent this person home and talked to the dependents instead."	"We sent all the papers to NBHS, and we got no comments back from them. Everything was documented and evaluated well enough, so there were no comments on the way we had handled this." "We were examined about how my employees did their job. And that is possibly why it was easier for me, because I'm not the responsible person. It wasn't me who wrote the journal, and it wasn't me who made the decision to unlock the door and let the patient go."
WHO EXAMINES THE SUICIDE?	"Suicide examination? No, we don't have any culture for doing that."	"The emergency team is established, and we assume they examine what happened concerning the suicide."
RIGHT TIMING OF AN INTERNAL EXAMINATION OF THE SUICIDE	"At least two months, then you get a sense of distance without it being forgotten. You've had time to go through it over and over again, and at the same time you are less emotionally involved with it."	"I think it is smart to have a systematic examination closely following the suicide." "An examination after 4 weeks is okay, but preferably as soon as possible. We continuously admit many new patients, and for me it is good to get things done."

(Continued)

Table 24.1 (*Continued*)

THEME	CLINICIANS	LEADERS
COACTION EXPERIENCED AS INADEQUATE	"I had a need to explain my role, but it was never talked about. " "I couldn't bring up my issues at a meeting. They don't belong there. To take care of the nurses is one of our tasks as doctors, and it would have been a burden to bring up my own issues there ." "The workplace is mostly concerned with protecting itself legally, and a list of suicide risk factors must be put in the journal, without it necessarily being good for the patient, the dependents or the therapist."	"My experience is that doctors are not good at reporting their needs, and it is easy to miscalculate them. They usually say things are fine, and that they have full control over the situation; then I discover that they have a need for support that they have not conveyed." "It is very important for us to show how well the patients have become, and a part of the treatment is to be allowed to go out on their own undertaking. But we can become even better at coping with what this does to the clinician who lets the patient go, when the patient then commits suicide."
COACTION EXPECTED TO BE ADEQUATE	"I would prefer an examination (of the suicide) to include only clinicians and leaders. I think that an interdisciplinary examination (including nurses) is more uncomfortable, and that the risk of ending up shooting at each other increases." "For me, I think it would have been expedient if it was only the clinicians who had the meeting."	"I doubt if the person responsible for treatment is comfortable with everyone being present, but at the same time, this suicide examination should be interdisciplinary because it is the way we work." "We have pretty good guidelines for evaluating suicide risk. It was maybe a bit random at the start, but after the first episodes… then we decided to have very good control over this… and that is good to have, and to know that the evaluation is documented."

overall strongest emotional reaction to the suicide, but the feeling of fear and the need for self-examination affected both the clinicians and the leaders. After being informed about the suicide, the clinicians describe thoughts about what they could have done differently in the treatment of the patient. Fear of contravening the law was a central issue, both for the leaders and the clinicians' self-examination. But in contrast to the leaders, whose first reaction was to focus on checking organizational routines, the clinicians' attention was drawn to the personal 'me and you' relationship with the patient.

The clinicians describe the first period after the suicide as a time for questioning themselves on what they might have done differently to prevent this particular individual from committing suicide. Some clinicians

describe the discomfort before the upcoming meeting with the patient's dependents, as an overwhelming experience, and doubt about one's own professional competence as a clinician is linked to fear of what the future holds regarding meetings with new patients. During the first period after the suicide, the clinicians in our study seek to reduce first-order risk, namely, the chances of another patient committing suicide. One of the informants also mentions that after the suicide, he experienced a period of increased awareness of potential signs of danger occurring in the treatment of new patients, and that he more closely observed patients who reminded him of the one who committed suicide.

Compared to the leaders in our study, it seems like the clinicians to a lesser extent come to accept the genuinely unpredictable aspects of the individual suicide. Thoughts about what they could have done better persist longer for the clinicians. The clinicians describe a need to wait several months before the emotional pressure decreases and they are ready for an examination of the suicide. When, and if, the suicide is examined systematically, they describe a need for a 'closed circle', where guilt and scapegoating are put aside. For the clinicians in our study, the preferred way of working together is to cooperate in a peer-review, to find out more about what actually happened with the individual person who committed suicide. When the clinicians in our study are stuck and seek help, they prefer a small group of peers with equal responsibility and/or equal qualifications. In this preferred peer-group, the members have either personally experienced, or realize that in the future they might experience, the suicide of a patient they were responsible for.

'To cooperate' is a term we have previously used to describe a voluntary relation between experts on the same subject who are working together. However, the meaning of the term 'cooperation', in our particular context, must not be confused with the organizing principles of interdisciplinary teams. The different professions involved in the interdisciplinary teams in our study have an asymmetrical relation to each other and, in accordance with the principles of division of labor used in all complex organizations, the members of the interdisciplinary teams help out with their unique skills in the treatment of a patient. The asymmetrical relations between the members of an interdisciplinary team is what concerns some of the

clinicians in our study. After a patient has unexpectedly committed suicide, the psychologists and psychiatrists we interviewed describe a need to step out of their roles as professional leaders at the top of the interdisciplinary team hierarchy. To replace the asymmetrical relations, they seek peers with equal competence or an equal formal responsibility, to develop more systemized knowledge about the individual patient's suicide. 'To cooperate' is, for some clinicians, something that can *only* occur in the absence of a formal hierarchy defining the different positions of group members in the hospital's interdisciplinary team. The psychologists and psychiatrists we met were seeking to prevent the pursuit of the 'guilty' person, or 'shooting at each other' as one of them puts it.

For the leaders who are responsible for coordination of all the internal and external bodies which must be informed consecutively after the suicide, the fact that documentation of risk evaluation is performed means something more than a simple technical analytical praxis with the aim of preventing suicide. Documentation is a key element for heads of departments and sectional leaders, who must cope with both internal and external claims for accountability after the suicide.

For the leaders, the response from the Emergency Services team from the State Health Authority is important. It reduces their uncertainty about the quality of the documentation, and gives them an answer to the question of whether the evaluation of the patient was good enough. The Health Authority's administrative vocabulary, where expressions like no comments or everything was documented well enough are used also by the leaders, to show that an external state-controlled inspection has ensured them that their responsibility for the organization's second-degree suicide risk evaluation has been properly handled.

The leaders in our interviews describe their coordinating function after an unexpected suicide as a 'leader-organization' relation, where the organization's internal control system is at the center of their overall administrative responsibility, while they also try to give attention to 'the human factor,' by protecting the individual clinicians who only to varying degrees express their personal needs after the suicide of one of their patients. The hospital's mandatory way of organizing work is regarded by the leaders as binding, and the interdisciplinary teams are seen as

the right forum for an examination of the suicide. If the present way of organizing teamwork makes things harder for the psychiatrists and the psychologists, it might be possible to adjust the interdisciplinary teamwork on a smaller scale; "we can look at who's participating", but the leaders do not give permission to deselect the interdisciplinary teamwork.

For the clinicians, it is of crucial importance to understand what actually happened to the individual patient who committed suicide. They are not always satisfied and done with a case even though the State Health Authorities have not found any formal faults in the documentation of their treatment of the patient. The leaders, on the other hand, are more impatient and eager to close the case. They focus on standardized procedures which are mandatory after the suicide, and on the general organizational demand to get things done. Unlike the clinicians, the leaders in our study do not question the assumption that the Emergency Services team from the State Health Authority is the right organ to evaluate the case and provide learning from the individual suicide. The leaders seem to have a quite well-defined set of standardized procedures to put into action when a patient commits suicide in their section or department. In contrast, the psychiatrists and psychologists in our study describe fewer adequate, organized routines to guide their coaction as clinical experts after a patient has committed suicide under treatment.

The fact that the statistical foundation for knowledge about suicide-risk evaluation is based on a weak prediction of individual suicides, was not reflected upon by our informants. Another issue, of silence, was explicitly noticed by one of the clinicians, who described an urgent need to explain his or her role after the suicide, but says, "it was not mentioned". The mute space which sometimes surrounds the responsible clinician after a patient has committed suicide, was also pointed to by some of the leaders.

Discussion

By using the two terms, 'coordination' and 'cooperation', to study coaction in the meeting with the unexpected, we have discovered things and asked questions in accordance with organizational theory. Coordination is an organizational function that leaders are responsible for. The

leaders in our study experience their coordinating work as effective. The success criteria for their coordination work after a patient's suicide is to facilitate organizational communication between a formally-defined set of positions at different hierarchical levels, in a quick and correct way. The leaders coordinating tasks are guided and supported by the hospital's administrative routines and established ways of working. When the unexpected suicide occurs, the leader knows exactly what he or she must do, since the principles of coordination are the same in all cases of suicide.

Cooperation is a different way of working together. Compared to coordination, it is to a lesser degree practiced in the hospital's departments and sections. However, some of the clinicians in our study describe their experiences or needs for cooperation in situations when they are stuck and need help from colleagues who share their competence and responsibility. The principles of voluntary participation and equal expertise or responsibility are important qualities for this type of coaction between peers. Only some of the clinicians have succeeded in initiating cooperative networks with their peers. Cooperation is when an expert who has experienced the loss of a patient as a result of suicide, asks one or more experts who have had the same experience, or who may be likely to have it, to go through the patient's history thoroughly from start to finish, in order to understand it better and to learn more about what happened. This way of working together as experts has the potential to strengthen the involved parties' clinical judgment, but our respondents have not seen many examples of this way of coaction after a suicide from their own experience.

Whether the use of clinical judgment has any effect at all on the prediction of suicide is uncertain. The experts think differently about the effect of clinical predictability. Rønneberg and Walby (2008) advocate that psychiatry, as well as other medical specialties, can become, in the long run, a fairly trustworthy prognostic science. In their opinion, Norway should follow Denmark's example and establish person-identifiable patient records, which show that in Denmark, the population's attributable risk of suicide is approximately 40% of those who have been hospitalized in a psychiatric daycare department. Nikolas Rose positions himself on the other side of the continuum, and thinks that suicide amongst patients under psychiatric treatment is a genuinely unpredictable phenomenon; this fundamental

unpredictability cannot be eliminated by psychiatrists or psychologists (Rose 1996, 1998). Berg and Teigen disagree that the efforts in regard to clinical predictions are a waste, but the problem with these predictions is that they make us more pessimistic than necessary (Berg & Teigen, 2003). Larsen and Teigen remind us that suicide, after it has happened, will always seem to have been forewarned, even though it could not be predicted in the past (Larsen & Teigen, 2015). This difference in perspectives does not show up in statistics, but can cause unfair scapegoating of clinicians, and unrealistic hopes for scientific studies promising suicide prevention.

Concluding remarks

As we have seen in the analysis above, the leaders and clinicians in our study have different ways of coping with the unexpected. The leaders stabilize the organization after a patient has committed suicide, by using administrative routines which are the same in every suicide case. As *coordinators*, our leaders experienced that their past knowledge could be used in new cases. Over time, they accumulate trust in the procedures connecting all the different participants at multiple hierarchical levels, both inside and outside of their own section or department. Together, all these participants coordinated in formalized relations to each other have a capacity to handle even the most complex and unpredictable events, according to the leaders.

The clinicians in our study have fewer ready-made guidelines for action in the face of an unforeseen suicide. As opposed to the leaders, who already know what to do, the clinicians seek to learn from the case as it unfolds. They do not want to close the case before they understand it. If the suicide is reviewed systematically, which rarely happens, according to our respondents, the clinician wants it to take place in a closed collegial circle where issues of responsibility and guilt are set aside to work together, to cooperate.

In the Bow-tie Model (Chapter 1, Torgersen, 2018), 'loss of control' is a phenomenon that is closely linked to the moment the unforeseen occurs. To the leaders in our study, this way of picturing the unpredictable matches the experience and the way of coping with it. The leaders practice ways of working together which effectively stabilize the organization

after a suicide, while the situation for the clinicians is different. 'Loss of control' for them is not a phenomenon lasting for a short period after the moment of the incident. On the contrary, for the clinicians in our study it looks like the 'loss of control' is a long-lasting condition. Our study indicates that professional recovery after a patient's unexpected suicide is not a 'straight-forward process' after the examination of the individual suicide has been taken out of the clinicians' hands and transferred to an external investigation body, The Inspection Unit of the NBHS.

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