# Physician Suicide Prevention

WELLToolkit

**Version 1.0**: Updated February 2021

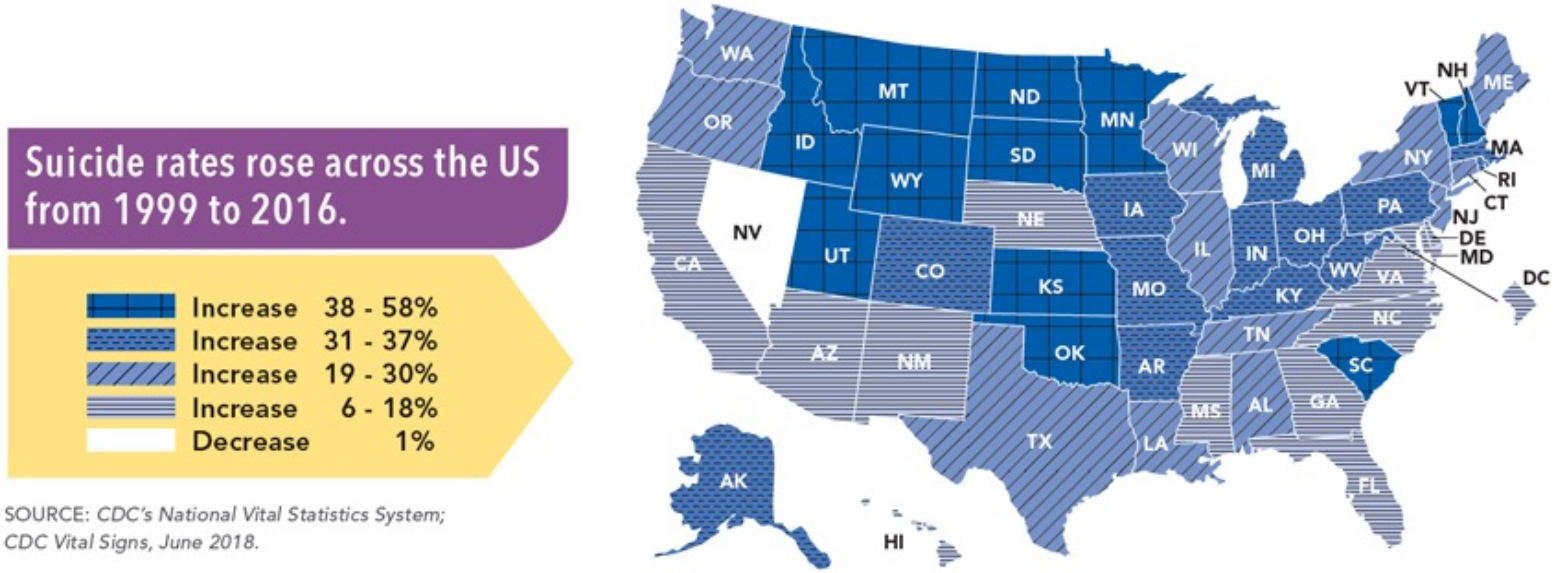
# Agenda

- Suicide epidemiology
- Facts on physician suicide
- Risk and protective factors
- Suicide assessment basics
- What you can do to help

# Learning Objectives


1. Be aware of the unique factors that place physicians at increased risk for suicide
2. Feel confident in knowing how to ask the tough questions about suicide if you are worried about a physician colleague
3. Know where to get additional help for crisis support and intervention

# Suicide epidemiology




- Suicide is the 10th leading cause of death in the U.S.
- Per the CDC, the rate of suicide in the U.S. has increased over the course of a decade in 49 of the 50 states

CDC Data on Suicide: https://www.cdc.gov/vitalsigns/suicide/index.html

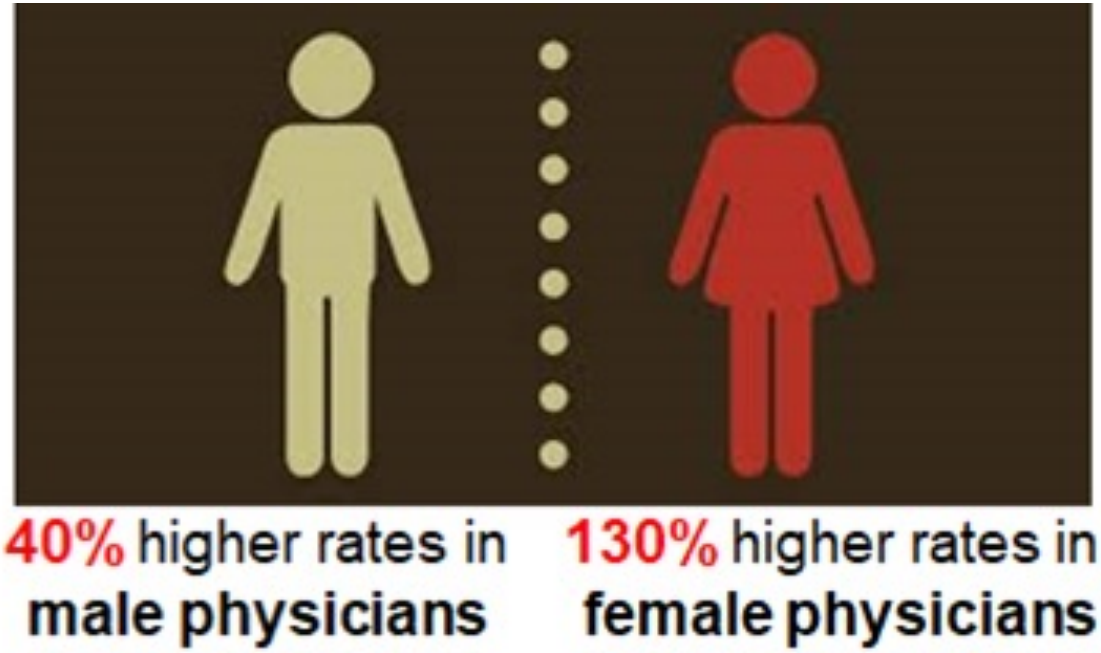
# Physician Suicide Rates

- While the often-quoted statistic of “400 physician suicides per year” may not be accurate, we do know that physicians are at notably higher risk than most professions

- The physician suicide rate is estimated at 28 to 40 per 100,000 (2x the risk of the general population)


Kishore S, Dandurand DE, Mathew A, et al. Breaking the culture of silence on physician suicide. National Academy of Medicine; 2016. https://nam.edu/breaking-the-culture-of-silence-on-physician-suicide/

# Physician Suicide – By Gender




- **Male doctors** are 1.41x the risk of the general male population
- **Female doctors** are at 2.27x the rate of non-physician females (and equivalent to male physicians)

# Physician Suicide – By Stage of Career

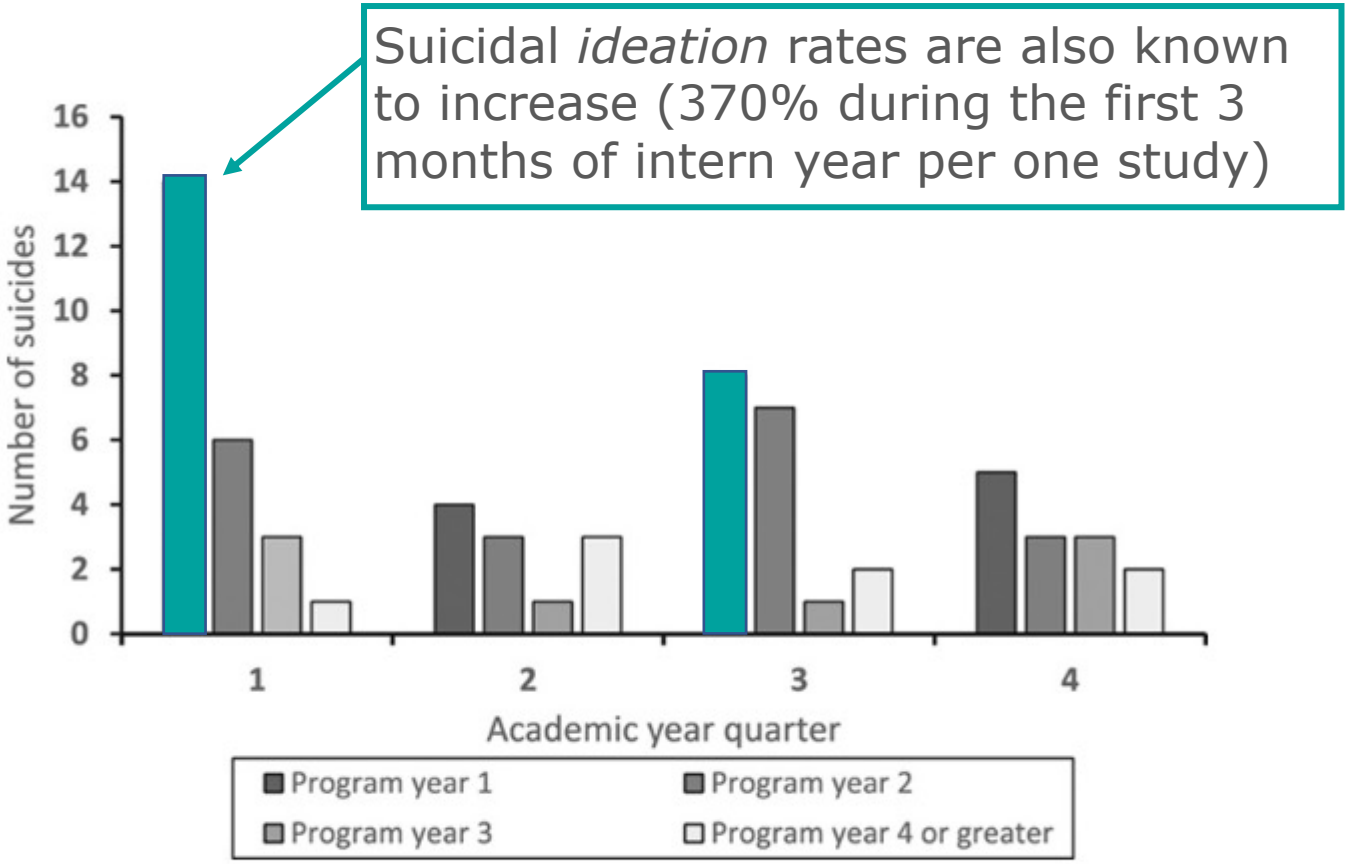
- The risk of death by suicide in physicians appears to be **highest mid-career and later**

- While medical trainee suicide is relatively rare, it remains the:
  - #1 cause of death in **male residents**
  - #2 cause of death for **female residents** (following neoplastic disease)

# What is known about suicide risk during residency?

An ACGME study (N=381,614) across 9900 programs in 2000-2014 showed the highest risk period for resident suicide was in the *intern year* with a temporal pattern:

- **1st** quarter (July-Sept)
- **3rd** quarter (Jan-Mar)




NA Yaghmour, TP Brigham, T Richter, et al. Causes of Death of residents in ACGME-accredited programs 2000 through 2014: implications for the learning environment. Acad Med, 92 (2017), pp. 976-983.

# Physicians have low rates of help-seeking

- Research repeatedly shows that physicians identify low rates of help-seeking even when high levels of distress

- In a 2008 cross-sectional survey of surgeons (N=7905, Response Rate=31.7%), 1 in 16 admitted to suicidal ideation in the past year, but only 1 in 4 sought professional help

*Shanafelt TD, Balch CM, Dyrbye L, et al. Special report: suicidal ideation among American surgeons. Archives of Surgery. 2011;146(1):9.*

**Table 2. Suicidal Ideation and Use of Professional Mental Health Resources**

| Variable | No. (%) (N=7905) |
|---|---|
| Ever had thoughts of taking own life | |
| Yes | 1163 (14.9) |
| No | 6658 (85.1) |
| Missing | 84 |
| Had thoughts of taking own life in previous 12 mo | |
| Yes | 501 (6.4) |
| No | 7324 (93.6) |
| Missing | 80 |
| Sought psychiatric/psychologic help in previous 12 mo | |
| Yes | 561 (7.2) |
| No | 7261 (92.8) |
| Missing | 83 |
| Reluctant to seek depression help because of repercussions for medical license | |
| Yes | 3046 (38.8) |
| No | 4800 (61.2) |
| Missing | 59 |
| Used depression medication in previous 12 mo | |
| Yes | 461 (5.8) |
| No | 7435 (94.2) |
| Missing | 9 |
| Person who prescribed depression medication | |
| I prescribed for myself | 41 (8.9) |
| Colleague prescribed even though I am not his/her patient | 34 (7.4) |
| Professional of whom I am a patient | 358 (77.7) |
| Other | 23 (5.0) |
| Missing | 5 |

# A need to break the culture of silence

"As physicians, acknowledging distress in our colleagues and ourselves can be difficult.  We want to believe that we can handle any problem that comes our way. But the reality is, being a doctor can be difficult and there are many stressors that we face on a daily basis – heavy workloads, lack of autonomy, high patient and self-expectations, and personal responsibility for life-threatening situations.  **A distressed colleague may not ask for help, but that doesn't mean it isn't wanted or needed**."

-AMA STEPS Forward

# Physician Suicide How to Help

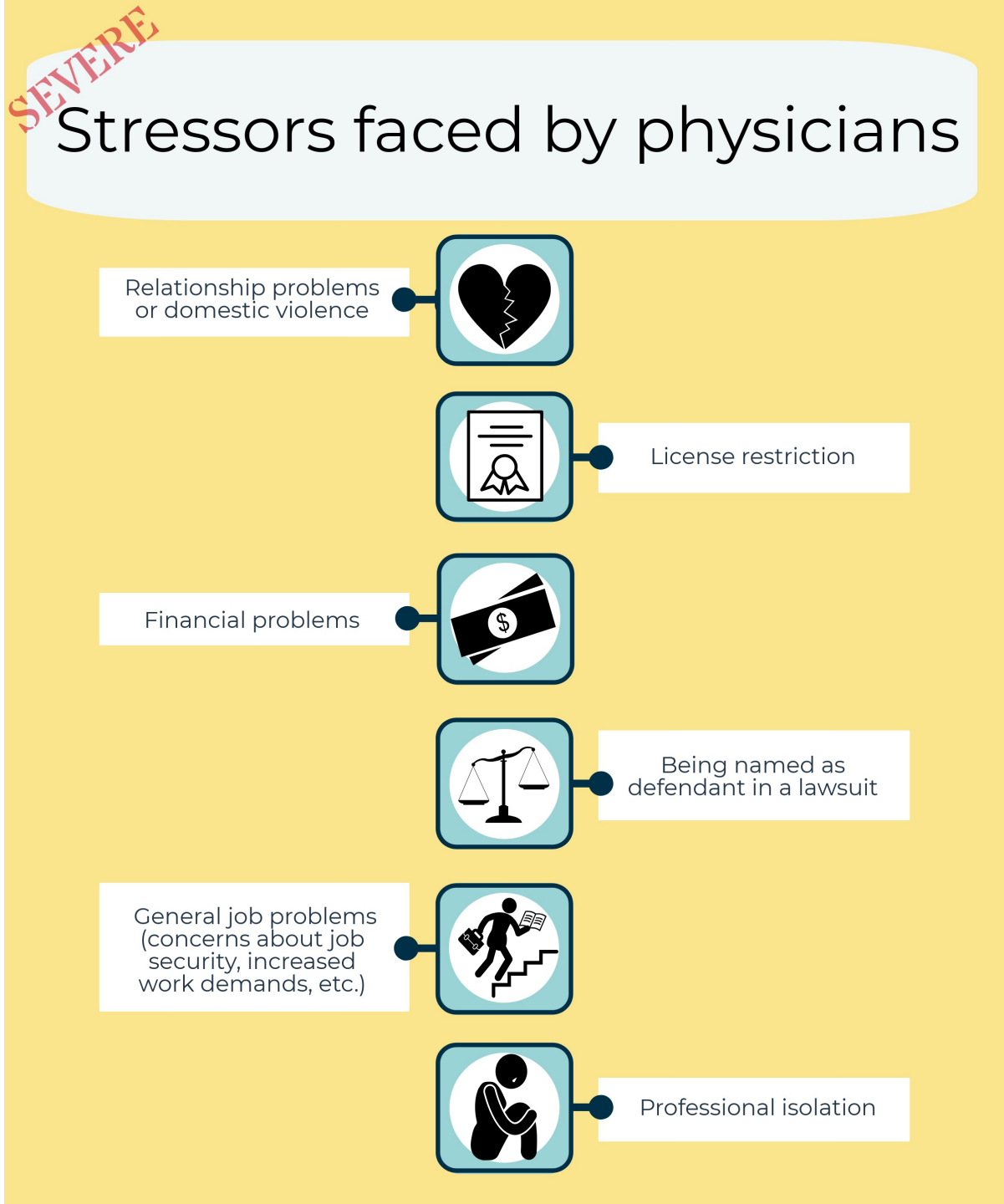
- This 4-minute video “Make the Difference: Preventing Medical Trainee Suicide” from Mayo Clinic and the American Foundation for Suicide Prevention (AFSP) explains how we can help our colleagues and prevent suicide.

# Unique Stressors

Physicians have unique work-related stressors:

- **Acute stressors** (e.g. patient deaths, medical error, job insecurity, patient and/or system dissatisfaction, license restrictions, malpractice lawsuits)

- **Chronic stressors** (e.g. difficulty unplugging from job, workload compression, professional isolation)



# Risk Factors

Physicians also are not immune to factors of the general population:

- Financial problems
- Relationship Problems
- Domestic Violence
- Personal/family history of mood disorder
- Prior suicide attempt
- History of sexual abuse
- Difficult childhood

# What about the relationship between physician suicide and burnout?

- Physician burnout has many potential negative outcomes, and yet has been shown to NOT be an independent risk factor for suicide (Shanafelt, 2020)

# The Role of Mental Health Treatment for Physicians

- Physicians who die by suicide are less likely to have been receiving mental health treatment compared with non-physicians who die by suicide, even though rates of depression are equivalent
- Unaddressed mental health conditions are more likely to have a negative impact on one's professional reputation and practice than seeking help early
- Suicide is more likely to occur when multiple risk factors pile up, and most importantly unaddressed mental health issues


Guille C, Zhao Z, Krystal J, Nichols B, Brady K, Sen S. Web-Based Cognitive Behavioral Therapy Intervention for the Prevention of Suicidal Ideation in Medical Interns: A Randomized Clinical Trial. JAMA Psychiatry. 2015;72:1192–1198. .

# Knowing warning signs can save lives

- Agitation and increased conflict
- Increased anxiety
- Sleep changes
- Increased use of D&A
- Social withdrawal or loneliness
- Talking or writing about death
- Loss of meaning or sense of purpose
- Feeling trapped
- Hopelessness

# Protective Factors

## Internal resources

- Problem-solving, frustration tolerance, ability to cope with stress, optimism, positive coping skills, sense of hope, cultural factors, spiritual beliefs, sense of hope, future-oriented goals, sense of responsibility to family, children, pets, etc.

## External factors

- Engagement in career and/or training, supports within work and personal community, able and willing to develop a safety plan and engage meaningfully in help-seeking behaviors and treatment

# Starting the conversation

You might feel uneasy about starting a conversation where you are expressing concern for another physician. The likelihood is, however, your colleague will feel grateful that you cared enough to ask.

**Instead of "How are you?" Perhaps try:**

- "You don't seem yourself. How can I help?
- "I have to be honest, I've been concerned about you lately."
- "What was today like for you? What brought you joy? Did anything derail you?


Ad Council. Seize the Awkward. https://seizetheawkward.org/

# Keep the conversation going

Now that you've established that you're interested in helping, there are a variety of ways to continue the conversation. Sample language could include:

**Validate:**

- "We physicians are really good at taking care of others, but not always the best at seeking help for ourselves."

**Inform:**

- "Seeking help can be confidential and doesn't have to impact your practice [or training]."

**Normalize:**

- "I've talked to somebody about my own problems, and it really helped."


Asking about suicide does not increase the risk of suicide.

(Gould, 2005)

# Ask the tough questions

Now here's the important part. All too often the conversation ends prematurely. If you're concerned, don't be afraid to ask specifically about suicide. It is important to be supportive, but also direct.

## Sample language:

- [illegible] living?"
- "Have you contemplated suicide?"
- "Have you had thoughts about killing yourself?"

# Some tips on asking about suicide

- **Asking directly** communicates that you're open to discussing suicide in a non-judgmental and supportive way
- **Actively listen** without judging or dismissing
- **Avoid imposing your own reasoning**, and instead help them express aloud what they are weighing in their own mind
- **Specifics inform level of risk** (e.g. is there a method or plan, have they taken steps towards acting on the thoughts, do they have access to lethal means)

# THE CONTINUUM OF SUICIDAL THOUGHTS

# Crisis Intervention

- **Stay with them!** If someone is having active suicidal thoughts, don't leave them alone until you've connected them to help
- **Involve crisis experts** and local professional supports to determine next steps to help keep the individual safe

**At UPMC**, call Life Solutions **(412-647-3669)** or resolve Crisis **(1-888-7-YOU-CAN)**

**Nationally**, call the National Suicide Prevention Lifeline at **1-800-273-8255** or text **"HELP" to 741-741**

# Safety Planning

- As a concerned colleague, it is not advised that you would be the one to conduct the next steps of the crisis intervention.
- It is important, however, to know how to access the appropriate help so that an appropriate intervention occurs.
- If the individual is not requiring acute hospitalization, a trained mental health professional will know how to conduct an evidence based suicide prevention intervention, such as a safety plan.

## Brown Stanley Safety Plan

http://www.sprc.org/sites/default/files/Brown_StanleySafetyPlanTemplate.pdf

# Evidence-Based Interventions

**SAFTY PLAN:** a personalized tool to help an individual be aware warning signs, and preventatively list coping strategies and resources/supports to use in a crisis to help reduce suicide risk.


**NEVER USE A "No-Suicide Contract"** or "Contract for Safety" as these concepts are outdated and without any evidence base!

# Other things you can do

**Let them know that they are not alone and offer hope!**

- Remind them that seeking help has benefited countless other physicians in similar circumstance
- Reassure them that treatment can be affordable, confidential, logistically possible even with job demands, as well as, safe and effective
- Increase connectedness by encouraging contact with natural supports
- Contact the person in the days and weeks following the crisis and encourage them to follow through with mental health referrals

PLEASE refer to the following WELL Toolkit resources for more details:

## INTRODUCTION

- ❑ Tips for Supervisors (pdf)
- ❑ How to decrease barriers to physician help-seeking (ppt)
- ❑ UPMC Well-Being Resources – Resident and Attending Versions (pdf)
- ❑ UPMC Guide on what happens when a physician seeks help (ppt)

## DEPRESSION SECTION

- ❑ Recognizing Signs of Depression in Physicians

# Thank you!


**For more information:**

GME Wellness Website

https://www.utoledo.edu/med/wellness/residents/

**Please email questions to:**

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