Preventing Physician Suicide
Identify and Support At-Risk Physicians

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How Will This Toolkit Help Me?

Learning Objectives:

1. Identify risk factors and warning signs for suicide
2. Apply standardized processes for physicians seeking support in your practice
3. Create an environment of support and wellness within your organization
Introduction

Eight hundred thousand deaths worldwide were attributed to suicide in 2016. In the same year in the United States, age-standardized suicide rates were 21.1 and 6.4 deaths per 100,000 persons, for men and women, respectively. Historically, data collected up to the 1980s showed age-standardized suicide rates were significantly higher for physicians than the general population, including much higher rates for female physicians and moderately higher rates for male physicians. However, more recent data suggest that while female physicians continue to have higher suicides rates than the general female population (standardized mortality ratio of 1.46), male physicians actually have a lower suicide rate than the general male population (standardized mortality ratio of 0.67). Further research on this digression based on sex is crucial.

Physicians are not at greater risk for suicide than the general population because they are “weaker” or less resilient; rather, the opposite is true. Despite their high levels of personal resilience, physicians are often placed in situations of recurrent stress. Recurrent stress can lead to physiological and physical exhaustion, otherwise known as burnout. Burnout now affects almost half of US physicians. Physician burnout is often characterized by depersonalization, including cynical or negative attitudes toward patients, a feeling of decreased personal achievement, and a lack of empathy for patients. Physician burnout and distress have been associated with higher rates of alcohol use disorder and depression, increased risk for suicide, lower quality of life, reduced cognitive functioning, and poor quality of patient care. While burnout and suicide are very much organizational-level problems and not individual ones, this toolkit addresses both individual actions (obtaining and offering support) as well as organizational ones (promoting an environment of wellness).

Even though physicians agree they have an ethical obligation to intervene when they believe a colleague is impaired, many fail to report it appropriately. Taking proactive steps to identify and address physician distress can help to ensure the well-being of physicians, reduce the risk of suicide, and support patient care by protecting the health of the physician workforce. Although the information in this toolkit may be applicable to other clinical team members, the focus is on physicians’ vulnerability and treatment needs. Furthermore, physicians-in-training, a vulnerable population with potentially higher risks of depression and suicide, are not specifically addressed in this toolkit; there are separate toolkits discussing medical student and resident/fellow burnout and well-being.

Four STEPS to Identify and Support At-Risk Physicians

1. Identify Suicide Risk Factors and Warning Signs
2. Promote Care-Seeking Behaviors
3. Train a Physician Advocate
4. Make it Easy to Get Help

Identify Suicide Risk Factors and Warning Signs

Suicidal behavior is a complex problem with no single cause or absolute predictors. Risk factors for physician suicide include:

- Diagnoses of major depressive disorder, bipolar disorder, alcohol use disorder, anxiety disorder, or borderline personality disorder
Prior suicide attempt
- Adverse childhood experiences, such as experiences or witnessing violence, abuse, or neglect
- Family history of mental health issues and/or suicidal behavior
- History of physical, psychological, and/or sexual abuse
- Major life events that affect a person’s stability and support network
- Relationship problems or domestic violence
- Situational stressors, including:
  - Being named as a defendant in a lawsuit
  - General career concerns (e.g., job security, increased demands)
  - License restriction
  - Financial problems
  - Professional isolation
  - Recent patient with a poor outcome

“Because of [the physician health program’s] attention, I have my self-esteem, confidence, and health. My license, too. Now my career is taking off in new directions, for which I am grateful.”

—Anonymous

Many physicians closely tie their identity to their professional image, making these physicians more vulnerable to distress when problems arise at work.19 It is important for all physicians to be aware of the warning signs of suicide, which can include19–21:
- Increased substance (alcohol or drug) use
- Feeling or expressing that there is no reason for living; no sense of purpose in life
- Anxiety and agitation
- Changes in sleep patterns, such as difficulty sleeping or sleeping all the time
- Feeling trapped, like there’s no way out
- Expressions of hopelessness
- Withdrawal from friends, family, and society
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Mood changes
- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, pills, or other means
- Talking or writing about death, dying, or suicide
[The doctor] was amazing in helping me work through my depression and issues with residency...I cannot thank [her] enough for her support and assistance during what was a very difficult decision and time of my life.

—Anonymous

It is vital to take action if you suspect a colleague is demonstrating warning signs for suicide. While not every suicide may be preventable, people with suicidal feelings can be helped. Speaking directly with your colleague is a good first step. You can say, “I'm concerned about you. Have you had any thoughts of harming yourself?”

You do not need to be an expert to offer to help. Often, a simple recommendation to talk with a mental health professional can be an important first step. Facilitate confidential referrals to mental health care professionals by keeping an updated list of local and national resources that physicians can access discreetly (see further guidance in STEP 4). Physicians may be hesitant to talk to a colleague or supervisor because of the stigma or privacy concerns and may be more willing to access help from an outside source.

Suicide Risk Screening Questions
This document developed by the Columbia Lighthouse Project includes a brief questionnaire to uncover the risk of suicide.
(PDF, 727 KB)

Sample Script for Approaching a Distressed Physician
This document prepares you to approach a colleague who seems distressed.
(DOCX, 47 KB)

Sample Scenario 1: Monique

This scenario illustrates the treatment process and the impact of care for physicians with suicidal ideation and behavior. Some details have been changed to ensure the confidentiality of the individuals involved.

Monique is a 28-year-old in her second year of residency. She is doing well at work and is rated highly on her performance evaluations; however, away from the office, she struggles with several personal issues. During an annual meeting with her resident advisor, Monique is not as cheerful as usual, her mood is down, and she does not want to talk about her personal feelings. Concerned, the advisor encourages Monique to contact the state physician health program (PHP).
After contemplating this advice for several weeks, Monique calls the program to schedule an appointment. Approximately 2 weeks after her call, Monique presents for her appointment at the PHP on time. She completes a detailed, computer-assisted intake tool in a private room. The tool includes the Medical Outcomes Study, Short Form-36 to assess physical and mental well-being, and the Montreal Cognitive Assessment (MoCA) to assess cognitive functioning. Later, Monique speaks with a clinician in a thorough, in-person interview. During the assessment, Monique reports that she experienced physical and mental abuse as a child, which she has never previously disclosed. Monique states that she has severe anxiety as well as great difficulty connecting with others and maintaining stable relationships as a result of the abuse. She admits to the clinician that she has thought about suicide in the past but does not have any immediate plans or access to lethal means. She expresses to the clinician that she would like help learning to cope with her abuse history.

The peer-assistance program connects Monique to a therapist who specializes in childhood trauma and a psychiatrist. Initially, Monique struggles in treatment and her mood worsens during the first few months. Early into therapy, her roommate finds a suicide note and confronts Monique, who then reports it to her therapist. The therapist consults with the PHP clinician, who recommends that she take a brief hiatus from work. Over time, Monique learns strategies that help her cope with her abuse history. She begins medications to regulate her depression and post-traumatic stress disorder (PTSD) symptoms. Monique successfully graduates from her program on time and moves back to her state of residence, where she continues to practice medicine.

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Q&A

How can I teach my team to recognize and respond to physicians in distress or at risk for suicide?

- Include stress and distress as regular agenda items in team meetings to encourage dialogue about these issues and help to normalize care-seeking
- Use wellness as an indicator of professionalism and a component of patient safety efforts
- Incorporate information about distress and suicide in company newsletters to raise awareness around the issue and provide information to those who recognize a physician in distress
- Have one-on-one conversations about issues related to distress and suicide
- Offer colleagues who have sought treatment for suicide ideation or attempt an opportunity to share their journey
- Encourage fulfillment of CME through coursework on stress management and physician burnout

Promote Care-Seeking Behaviors

Although physicians recognize the value of obtaining treatment, they often are the most reluctant to access medical care and frequently receive poorer care than other patients (eg, fewer laboratory tests, less rigorous medical evaluations). Thus, it is essential for physicians to recognize the importance of self-care, model wellness behaviors, and encourage others to do the same.

As a practicing physician, start by taking steps to maintain your health, including:
• Get enough sleep, eat nutritiously, and exercise regularly.
• Allow yourself to recharge. Take personal time off and make time for relaxation with friends and family members.
• Learn to say “no” to requests that interfere with personal or relaxation time. Many physicians have difficulty turning down requests from work and the community. Sometimes saying “no” is the best medical care for both the patient and the physician.
• Learn to recognize signs of stress, depression, and burnout in yourself.
• Reach out to colleagues for assistance and support. Sharing your experiences with colleagues may help others in similar situations. Additionally, the support of colleagues can be a great source of comfort during difficult times.

If these self-care tips are not enough, it is time to seek additional help. Physicians should refer themselves or colleagues to internal or external programs that, in most cases, can provide confidential services for voluntary referrals (see STEPS 3 and 4).

As an organizational leader, foster a positive culture within your organization. Communicate widely and often with your team about the need to intervene if they suspect a colleague needs help. You can try some of these strategies:
• Encourage and model support for colleagues
• Support requests for time off for vacations or sick leave
• Support flexibility in schedule
• Provide mental health days, either mandatory or voluntary
• Use appreciative inquiry to create a more positive work environment
• Promote effective and healthy communications with positive feedback and praise

Q&A

What barriers prevent physicians from seeking mental health care?

Some physicians simply may not interpret their symptoms as distress. Instead, they attribute their feelings to general stress or burnout, which they may view as typical among their colleagues and thus unworthy of intervention. This mindset further underscores the need for widespread education about physician suicide and significant warning signs.

In other cases, physicians recognize their distress but fail to seek care due to various factors, including:
• Privacy and confidentiality concerns
• Stigma
• Fear of losing or having restrictions placed on their medical license or other practice privileges
• Concerns about losing health, life, disability, and professional liability insurance
• Concerns about permanent documentation on their records
• Concerns about subsequent professional advancement
• Lack of a primary care physician
• Lack of time
• Self-treatment
What difficulties do physicians face when caring for other physicians in distress?

Many physicians are uncomfortable treating their colleagues, especially when the treatment involves mental health issues. Not only are physicians notorious for being “bad” patients, but the treating physician may also be anxious about his or her own ability to treat a colleague. The person offering treatment may worry about how issues of confidentiality, privacy, or empathy may affect the care he or she provides. However, these concerns should not discourage a physician from seeking care or encouraging a colleague to seek care. When needed, state physician health programs (see STEP 4) may be able to identify someone with experience and expertise in treating distressed physicians. Additionally, several state and county medical societies provide confidential support services; it is worth checking with your own county/state medical society about this option.

Train a Physician Advocate

Creating a supportive atmosphere in the workplace can be instrumental in addressing physician distress. You may consider having a person within your organization serve as a physician advocate. Enlist an individual, such as a human resource professional or a hospital wellness committee member, whom physicians would feel comfortable approaching. This individual must be trustworthy, discreet, and knowledgeable.

Training the physician advocate is critical and should focus on explaining internal and external policies and implications regarding privacy, confidentiality, and care-seeking. The physician advocate should be prepared to answer physicians’ questions about the potential impact that receiving mental health care may have on job security, medical licenses, medical liability insurance, and disability coverage. The physician advocate is responsible for distributing guidance on physician distress and suicide—and where to find support.

Once a physician advocate is selected and trained, widely communicate this person’s role and what type of support services are available.
The past six months have been the most devastating, frustrating, and disappointing in my life. …Knowing you took the time to unravel and analyze my circumstances is maximally reassuring... My wife and I will land on our feet sooner because of you.

—Anonymous

Forms of support include:

• Screening physicians for depression, distress, and burnout
• Encouraging physicians to establish and use a regular source of health care
• Reducing the physician’s patient caseload in the short term
• Developing internal peer network programs and opportunities for physicians
• Referring to internal and external assistance programs (see STEP 4)

Make It Easy to Get Help

Your organization should keep updated referral lists for confidential resources inside and outside your organization and make them readily available to all team members, including physicians. Almost every state in the country has a physician health program (PHP). Although programs vary, physician health programs provide or facilitate in-depth evaluations, appropriate treatment referrals, and, if necessary, monitoring for residents, physicians, and sometimes medical students. Because physician health programs are not affiliated with clinical practices or hospitals, they allow physicians to access private and confidential care. The Federation of State Physician Health Programs maintains a list of state physician health programs with a description of the services
Suicide Prevention and Support Resources
These resources provide free and confidential support for those in distress.
(DOCX, 43 KB)

Self-Assessment for Medical Malpractice Stress Syndrome
This self-survey is designed to assess the impact of litigation on physician distress.
(DOCX, 49 KB)

Identify policy barriers to care-seeking in your organization and take steps to minimize them. Work with organizational leadership to examine and modify (if necessary) your internal policies to encourage care-seeking by physicians.

In this review of organization policies, ask yourself:

- Can physicians receive care confidentially?
- What type of information is recorded when physicians seek treatment?
- If a physician receives care internally, are the records private? Is access to these records controlled?
- Are physicians’ jobs secure if they seek extensive care for mental health treatment? If so, is this job security widely known by physicians within your organization?
- Is access to mental health care on par with access to other forms of health care?
- Are physicians in your state required to report a history or diagnosis of mental health illness or treatment when applying for or renewing their medical licenses?
- Are physicians in your organization required to report a history or diagnosis of mental health illness or treatment during credentialing or recredentialing?
- Are your policies visibly posted (online and/or in print) and easily accessible for physicians in your organization to review?

If concerns about confidentiality prevent physicians with distress from seeking care, their condition may worsen. Policies allowing confidential access to treatment are more likely to encourage physicians to seek the care they need. Organizational leadership should consider this factor when developing confidentiality policies, as the risks of untreated physician distress often outweigh the potential benefits of mental health disclosures.

Q&A

How can confidentiality for physicians seeking care be maintained?

One of the principal reasons that physicians do not seek care is confidentiality concerns. Your organization’s policies should encourage early, confidential access to care. Many physicians fear that others may learn about their medical visits, and that they may have certain restrictions placed on their ability to practice if their care-seeking becomes known. Organizational leadership should voice their
support for the confidential nature of care-seeking within your organization and describe the importance of this approach. If confidentiality cannot be ensured, leadership should be upfront about the limitations.

Are their state laws requiring disclosures for physicians seeking mental health care?

The licensing applications for each state differ in the information collected and what an applicant must disclose about a condition or treatment history. Some states restrict the medical license of physicians who report mental health conditions, while others use a probationary period or require extensive assessments before granting a license to a physician who has disclosed a mental health condition. Because of this variation, individuals need to educate themselves about the parameters of their state laws. To learn about a state’s disclosure requirements, individuals can contact their state medical board anonymously. They may also review their state’s licensing application to be aware of the specific mental health questions that are asked of applicants.

Confidentiality policies vary among PHPs as well. If a physician presents to a PHP for care, it is appropriate for the physician to ask about the PHP’s confidentiality protections and any conditions or situations that would result in disclosure.

Finally, depending on state law, a physician or other care provider may be a mandatory reporter if a patient indicates that they are likely to harm themselves (or someone else). It is appropriate for a physician seeking care to inquire about the treating provider’s reporting obligations that would result in a disclosure of treatment information.

How can I take additional steps outside my organization to advocate on behalf of physicians in distress and at risk for suicide?

Offer to give presentations or lectures on this topic or assist your organization in identifying an expert speaker to present. You can educate state licensing boards, state and local medical societies, hospitals, group practices, malpractice insurers, patient safety groups, and academic medical faculty about the problem of physician suicide.

You can communicate to external organizations, such as regulatory bodies, hospital boards, medical schools, and residency programs, about how early care for physicians in distress can benefit physician health and patient safety. Consider advocating for the needs of medical students, who have recognized stressors and may not know about the various mental health resources available to them throughout their training.

Educate the leaders of these organizations by informing them that outreach and care for physicians in distress should be early, timely, comprehensive, and above all, confidential. Advocate for eliminating the required disclosure of health diagnoses on medical license applications.

Encourage academic leadership (e.g., training directors, department chairs, faculty) to educate students and residents about suicide and where and when to seek help. Research shows that physicians who become more skilled at caring for patients with depression or suicidality are more likely to get care for themselves.33
Conclusion

Physicians have a higher risk of suicide than the general population, yet they are often reluctant to access care. It is our obligation to look out for physician colleagues, and reassure them that they deserve to care for themselves as they would their patients—this can be accomplished by simply approaching and speaking with a colleague experiencing distress. This toolkit will help you teach your team to identify at-risk physicians, normalize care-seeking in your organization, and facilitate access to appropriate care.

 AMA Pearls

- Do not feel like you have to be an expert to offer help to a distressed colleague
- Learn to recognize signs of distress in yourself so that you can encourage and model self-care for others
Review your organization's policies to minimize barriers to care-seeking

Further Reading

Journal Articles and Other Publications


Videos and Webinars


Websites


- This page features a number of targeted resources for suicide prevention and postvention for health care professionals and medical educators, including videos, webinars, factsheets, and more. Individuals who work with medical students, residents, and/or fellows may find 2 resources particularly valuable: After a Suicide: A Toolkit for Medical Schools and After a Suicide: A Toolkit for Residency/Fellowship Programs.
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The AMA Professional Satisfaction and Practice Sustainability group has been tasked with developing and promoting innovative strategies that create sustainable practices. Leveraging findings from the 2013 AMA/RAND Health study, "Factors affecting physician professional satisfaction and their implications for patient care, health systems and health policy," and other research sources, the group developed a series of practice transformation strategies. Each has the potential to reduce or eliminate inefficiency in broader office-based physician practices and improve health outcomes, increase operational productivity, and reduce health care costs.

References:


