

Effects of Patient Suicide on Residents: How We Can Help

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Agenda for Workshop

- Personal narratives of patient suicide: Drs. Jawandha and Dr. Nand
- Data on psychological impact on residents, discussion of support systems and working with family survivors - Drs. Anzia and Jawandha
- Role of training directors and supervisors - Drs. Anzia and Nand

Agenda for Workshop (con't)

- Workshop projects (30 minutes)
 - Create a program-wide orientation and curriculum aimed at prevention
 - Develop a “postvention” plan for particular suicide vignette, and implement as policy
 - Develop a research proposal for assessment of a prevention plan
- Presentation of ideas, discussion (10 minutes)

What do we know about incidence?

- Only a handful of studies of resident encounters with suicide have been conducted in the US, Canada, Europe, New Zealand, Australia and the UK
- Estimates range from **14% to 68%**

INCIDENCE

- **14 – 68%** experience patient suicide while in residency
- **53 – 62%** occur in PGY 1-2

Incidence

- 31% (74/239) experienced suicide of a patient while in training
- 61% (121/197) of residents encountered suicide during residency (61% of these were committed by a patient)
- 43% (23/53) in training in London had encountered a patient suicide

Ruskin, R. [Impact of patient suicide on psychiatrists and psychiatric trainees](#). *Acad Psych*, 28:2 (2004)

Pilkinton, P. [Encountering suicide: the experience of psychiatric residents](#). *Acad Psych*, 27:2 (2003)

Yousaf, Farida et al. [Impact of patient suicide on psychiatric trainees](#). *Psychiatric Bulletin* 26: 53-55 (2002)

Incidence

- 47% of 103 psychiatry residents in Scotland had at least one patient suicide
- 33% and 37% of residents in Brown's survey

Dewar, Ian et al. Psychiatric trainees' experiences of, and reactions to, patient suicide. *Psychiatric Bulletin*, 24: 20-23 (2000)

Brown, H. Impact of suicide on therapists in training. *Comprehensive Psych*, 28(2): 101-112 (1987) and Patient suicide during residency training (1): incidence, implications, and program response. *Journal of Psych Educ*, 11(4): 199-262 (1987)

Incidence

- While most residents who encountered patient suicide had done so only once, 2 studies had responses from residents experiencing **up to 5 suicides**
- **53%** of suicides occurred during the PGY-1 year (Ruskin)
- **62%** suicides occurred during the PGY-2 year (Brown)

IMPACT ON RESIDENTS

- **39%** report impact on professional life
- **9%** contemplated changing careers

IMPACT ON RESIDENTS

- Common reactions
Anxiety, guilt, insomnia
- Traumatic reactions
PTSD, ASD

Studies of Symptoms

Study	Yousef, F. <u>Impact of patient suicide on psychiatric trainees.</u> <i>Psychiatric Bulletin</i> 26:53-55 (2002)	Ruskin, R. <u>Impact of patient suicide on psychiatrists and psychiatric trainees.</u> <i>Acad Psychiatry</i> 26:53-55 (2004)
Initial reactions/symptoms	<p>SHOCK 83 %</p> <p>GUILT 70%</p>	<p>HELPLESS 71 %</p> <p>SHOCK 69%</p> <p>ANXIETY 44 %</p> <p>RUMINATIONS 33 %</p>
Results	<p>“Clinically stressed” 52%</p>	<p>ACUTE STRESS 22 %</p> <p>PTSD 20%</p>

Impact on Residents



SUPPORT SYSTEMS

- Prevention vs. “postvention”
- Lack of formal training and guidance
- Very little data exists about postvention practices for patient suicides in psychiatry residency programs nationwide

Support Systems

- Three Goals of Postvention
 - Needs of trainees
 - Quality assurance
 - Avoiding a “witch hunt”

Survey of Support Systems

- Comprehensive survey of psychiatry residency programs postvention practices
- 296 residency programs were surveyed
- 166 programs responded (56.1%)

Ellis, Thomas. Psychiatric trainees' experiences - Patient suicide in residency programs: National survey of training and postvention practices. *Academic Psychiatry*, 22(3): 181-89 (1998)

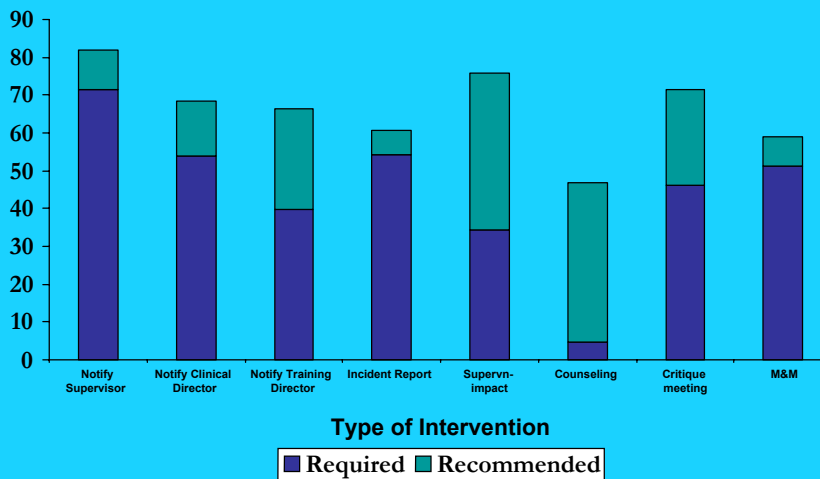
Support Systems

- Do training programs include specific instruction on steps to follow if a patient should commit suicide?
- Are these interventions were required or recommended?

Results of Survey

Training site (n)	Training includes postvention instructions	Postvention procedure specified in manual
University Medical Centers (112)	39.3%	17.0%
Hospital / Medical Center (36)	72.2%	22.2%
VA / Military Medical Center (7)	42.9%	14.3%
Psychiatric Center / State Hospital (6)	33.3%	33.3%
Other (5)	60.0%	20.0%
Overall (166)	46.9%	18.6%

Results of Survey Postvention Practices



Support Systems

- 50% likelihood that a program will provide residents with advance guidance for a possible patient suicide
- Discrepancy between requiring and recommending supports
- Greater emphasis on administrative and clinical review procedures than on supportive measures

Support Systems

Common postvention practices:

- Notifying supervisor, training director, clinical director
- Additional supervision
- Incident report
- Critical incident review/ "M&M"
- Counseling

“There are two kinds of psychiatrists:
those who have had a patient commit
suicide and those who will.”

Brown 1987

Contacting the Family

- Lack of literature discussing contacting the family as part of clinical practice
- Brownstein M. **Contacting the Family After a Suicide**. Can. J. Psychiatry. 37:208-212 (1992).
- One study involved a two-part survey
- 1st part: contacting psychiatrists and residents
- 2nd part: contacting families of patients who had committed suicide while in active treatment with a psychiatrist

Brownstein 1992

Methods

Families were asked:

- To rate the care the patient had been receiving
- Whether or not they had been in contact with the psychiatrist prior to suicide
- If so, who initiated the contact and how helpful was it
- If no contact, would they have appreciated it, and why they felt they were not contact
- Was a lawsuit considered or initiated

Results

- Of 10 psychiatrists, 7 had a patient who had committed suicide
- Of 32 residents, 5 had a patient who committed suicide
- Only **one** psychiatrist had contacted the family

Results

- Reasons for not contacting the family:
- “I had never met them before.”
- “They lived out of town.”
- “I was away on holidays when it occurred.”
- “I only saw the patient briefly.”
- One psychiatrist explicitly stated, “I thought they would blame me and be angry with me.”

Results

- 12 of 20 family members responded
- Only 3 had experienced contact with the psychiatrist after suicide - 2 initiated contact themselves
- 8 of 9 families who had not been contacted wished they had
- 3 families thought the psychiatrist felt guilty and was afraid to call; 6 thought they did not care

Results

- Litigation: in 3 cases, the respondent considered litigation but did not proceed; 8 never considered litigation
- 8 of the respondents felt the psychiatrist could have done a better job and that the suicide was partly their fault; includes the two who initiated contact and the one who was contacted
- 4 respondents in no way blame the psychiatrist

Discussion

- Limitations of study
- Reasons for not contacting the families: feelings of responsibility and guilt, fear of being blamed and being seen as incompetent
- Post-trauma symptoms - Primitive defenses of both psychiatrists and victim's families

Discussion

- Psychiatrist must first resolve the guilt and projection of blame to be able to reach out in a non defensive, non-fearful manner
- Survivors often turn to the medical profession but find that doctors often feel guilty or angry and they must turn elsewhere
- Rationale for contacting the family

Guidelines

Kaye, NS and Soreff, SM. The psychiatrist's role, responses, and responsibilities when a patient commits suicide. *Am J Psychiatry*, 148(6): 739-43 (1991).

- Contact the family as soon as possible
- If possible, the contact should be in person and be in a quiet and private setting
- The family should be allowed as much time as they need to ask ?'s and begin grieving
- Sharing ones own feelings may help family members to open up
- Tell the family realistically that all that could have been done for the patient was done

The Role of the Program and Training Director

- The particular impact on trainees because of the stage of professional development
- Predictors of distress, general and specific reactions of trainees
- Coping methods: how to promote and facilitate
- General suggestions for creation of “preventive” education and effective “postvention”

Specific reactions to patient suicide

Gitlin, “Suicide Assessment and Suicide Management” 2006

- Initial phase: shock, disbelief, denial
- Second phase
 - Grief
 - Shame
 - Guilt
 - Fear of blame
 - Anger
 - Relief
 - Findings of omens

Elements of Grief

- Loss of the close relationship with the patient
- Impact on the trainee's growing confidence and professional identity -
loss of "fantasies of power, influence, and ability to make a difference in patients' lives"
Gitlin 1999
- Can the loss and grief promote growth/maturation? If it occurs too early in training, can the event be damaging?

Shame, blame and fear

- Concern that faculty will find him/her at fault and that there will be training consequences
- Shame about "exposure" within the department and program
- Fear that fellow residents will have less confidence in their judgment and/or avoid them
- Fear that their reputation is forever damaged
- Fears about litigation

Anger, relief, looking for omens

Gitlin, 2006

- Anger may be directed at patients, family/survivors, nursing staff - or the program if support and help is perceived as not sufficient
- If victim was chronically suicidal -->relief
- Omens: searching for signs to predict suicide the next time

What factors can predict more distress after patient suicide?

- The age and level of training of the psychiatrist: residents are just beginning to develop identities as competent psychiatrists
- Gender: women are twice as likely to develop symptoms following traumatic event Hendin 2004
- Setting, quality of relationship w patient, overall resilience of resident
- The response of the program and department

General goals for interventions

- Cognitive and educational approaches : this is our “worst outcome”, it will occur, limits on predictability, philosophy and “moral” dimensions of our work - “clinical failures do not make them personal failures” Gitlin 2006
- Decrease the resident’s isolation: peers, supervisors, training director. Faculty and peers who share their stories can offer special support.

Later general goals

- Monitor and discuss with resident changes in his/her judgment and clinical decision-making following the event.
- Foster resident’s efforts to further process the event through writing, supporting others, or presenting his/her experiences

Specifics about prevention

- Education should occur early in residency - ideally as they begin their inpatient psychiatry work. Consider having residents discuss a “mock” event.
- Residents should have handout in their manual about post-suicide process and listing supports/phone numbers.

Postvention specifics

- Site supervisor and training director should meet with resident immediately to offer support.
- Support session with resident class should be considered
- Critical incident review should be delayed for at least a week, till initial shock/denial fades. Supervisor or TD should attend with the resident

Other postvention specifics

- Personal therapy can offer support outside the program, content is non-discoverable
- More senior residents, especially those who have experienced patient suicide, can provide valuable peer support.

Thank you! Now, workshop tasks

- Create a program-wide orientation and curriculum aimed at prevention
- Develop a “postvention” plan for particular suicide vignette, and implement as policy
- Develop a research proposal for assessment of a prevention plan