



COLUMBIA UNIVERSITY  
MEDICAL CENTER

**Packet for resident whose patient  
committed suicide**

## **Introduction**

Having a patient commit suicide is one of the most difficult events to deal with during a psychiatrist's career, but is especially hard during residency. It is common for residents to blame themselves and to experience a myriad of emotions in response to the suicide.

This packet is intended to provide you with options for support to help you learn from the suicide and grow as a psychiatrist and as a person. It was initially developed by Columbia psychiatry residents who had patients who completed suicide. It was revised by several faculty members who have also had experience with suicide and want to help residents through the process.

The packet includes the following information:

- Typical responses to patient suicide
- Suggestions for ways to cope
- Peer/faculty support available to you
- Suggested questions for supervisors
- Nuts and Bolts of what happens after a patient suicide
- Organizations and Terms that you're likely to encounter
- Some legal information
- Useful references in the literature

I hope that this is helpful to you.

Sincerely,

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# TYPICAL REACTIONS TO PATIENT SUICIDE

## Initial Reactions

- Shock
- Disbelief
- Denial
- Depersonalization

## Second-phase Reactions

- Grief
- Shame
- Guilt
- Fear of blame
- Anger
- Relief
- Finding of omens and subsequent behavioral changes
- Conflicting feelings of specialness

[Adapted from Table 24-1 from Chapter 24: Psychiatrist Reactions to Patient Suicide by Dr. Michael Gitlin in Simon, RI and Hales, RE. Textbook of Suicide Assessment and Management. 2006. American Psychiatric Publishing, Inc. Washington, DC.]

## WAYS TO COPE

Below is a list of suggestions that have been helpful to prior residents after having a patient commit suicide.

- Talk to people
  - Co-residents (process group)
  - Chief residents
  - Training directors
  - Attending Supervisors involved in case
  - Attending Supervisors NOT involved in case
  - Prior Attending Supervisors NOT involved in case
  - Therapist
  - Family
  - Friends
- Consider taking a day off of work at some point after the event to reflect
- Read literature on suicide risk assessment
- Read literature on dealing with the death of a patient (see attached article by Gitlin).
- Consider giving a case conference on the topic
- Consider giving an APA workshop on the topic
- Consider writing a paper about your experience

Also, for other ideas, please refer to Table 24-3 (pg. 487) in Chapter 24: Psychiatrist Reactions to Patient Suicide by Dr. Michael Gitlin in Simon, RI and Hales, RE. *Textbook of Suicide Assessment and Management*. American Psychiatric Publishing, Inc. Washington, DC. 2006

## **SUGGESTED QUESTIONS FOR YOUR SUPERVISORS**

### General Questions

1. Should I talk with my colleagues?
2. How much should I reveal to them?
3. Should I worry in my revelations to them or even the experience of losing future referrals, or their perception of me?
4. How should I begin to address the suicide for myself?
5. How is this going to effect my treatment with other patients?
6. Is it best to try not to think about it and pretend it didn't happen? Or should I engage in an activity that would help me to learn from the experience? Or would that be too painful in reliving it again?
7. Is it unrealistic to think that this will affect my career?

### Questions about interacting w/ the family

1. Should I contact family?
2. If so what method should I use (phone, letters, even visit?).
3. What should I say to the family (should I be supportive, explanatory?).
4. What should I do if they accuse or blame me?
5. How much should I reveal to them about my thoughts on what went wrong?
6. What do I do if the family member needs urgent crisis management after I break the news?
7. How much of what I say and how I say it impacts the chances for litigation?

# ORGANIZATIONS AND TERMS THAT YOU WILL LIKELY ENCOUNTER AFTER A PATIENT SUICIDE

By Amy Bennett-Staub, R.N., M.P.A.

**The New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (CQCAPD, formally CQC)** is an independent, New York State government agency charged with improving the quality of life for New Yorkers with disabilities and protecting their rights by:

- o promoting the inclusion of people with disabilities in all aspects of community life;
- o ensuring programmatic and fiscal accountability in the State's mental hygiene system;
- o providing individual and systemic investigative and advocacy services;
- o advancing the availability and use of assistive technology for persons with disabilities; and
- o offering impartial and informed advice, training and recommendations on disability issues.

As the successor agency to the former Commission on Quality of Care for the Mentally Disabled and the Office of Advocate for Persons with Disabilities, CQCAPD serves as an advocate and a resource for individuals of all ages with all types of disabilities. All OMH facilities are required to report all deaths to the CQCAPD who has the independent authority to investigate these deaths on their own.

**New York State Office of Mental Health (OMH)** - New York State has a large, multi-faceted mental health system that serves more than 500,000 individuals each year. OMH operates 25 child and adult psychiatric centers across the State, 2 research facilities (NYSPI and Nathan Kline), and also **regulates, licenses, certifies** and oversees more than 2,500 mental health programs, which are operated by local governments and nonprofit agencies. These programs include various inpatient and outpatient programs, emergency, community support, residential and family care programs.

NYSPI and all other mental health programs certified by OMH are required to report incidents of all types to the Bureau of Quality Management at OMH. The Bureau also has the authority to independently review all investigations.

Each incident is reviewed by the Risk Manager. The intensity of review will depend on the seriousness of the incident and the extent of injury to the patient. Serious incidents are reviewed following the OMH format for special investigation and include at a minimum an interview by the Risk Manager, a thorough chart review, a literature review, and a review by a professional peer. **Peer Review** is a method to study the appropriateness of how clinicians provide services and make treatment related decisions in individual cases. It is conducted by individuals with comparable license, training and clinical expertise. A root cause analysis (RCA) is mandated if the incident also meets the definition of a Sentinel Event. An incident is considered a **Sentinel Event** when:

*The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient=s illness or underlying condition; or*

*The event involves a failure in one or more hospital system(s) to carry out policies and procedures which ensure the safety of our patients and staff and have a clear impact on the event; or*

*The event is one of the following:*

- a. Suicide of a patient in a setting where the patient receives around the clock care (e.g., hospital, residential treatment facility for children and youth, crisis stabilization center) or on the premises of an outpatient program; or suicide of any individual discharged within 72 hours from an around- the- clock setting
- b. Rape or sodomy (even if the outcome was not death or major loss of function) or non-consensual\* skin to skin sexual contact substantiated by investigatory evidence.
- c. Death related to a nosocomial infection
- d. Abduction of any individual receiving care, treatment, or services in a staffed round-the-clock setting

A **Root Cause Analysis (RCA)** is a class of [problem solving](#) methods aimed at identifying the [root causes](#) of problems or events. The practice of RCA is predicated on the belief that problems are best solved by attempting to correct or eliminate root causes, as opposed to merely addressing the immediately obvious symptoms. By directing corrective measures at root causes, it is hoped that the likelihood of problem recurrence will be minimized. However, it is recognized that complete prevention of recurrence by a single intervention is not always possible. Thus, RCA is often considered to be an iterative process, and is frequently viewed as a tool of [continuous improvement](#).

A **fishbone diagram** is a problem solving tool invented by Dr. Kaoru Ishikawa, a Japanese quality control statistician. Therefore, it may be referred to as the Ishikawa diagram. The fishbone diagram is an analysis tool that provides a systematic way of looking at effects and the causes that create or contribute to those effects. Because of the function of the fishbone diagram, it may be referred to as a cause-and-effect diagram. The design of the diagram looks much like the skeleton of a fish. Therefore, it is often referred to as the fishbone diagram

**Risk management** is the process of [measuring](#), or [assessing](#), [risk](#) and developing [strategies](#) to manage it. Strategies include transferring the risk to another party, avoiding the risk, reducing the negative effect of the risk, and accepting some or all of the consequences of a particular risk. Traditional risk management focuses on risks stemming from physical or legal causes (e.g. natural disasters or fires, accidents, death, and lawsuits).

Most regulatory agencies [(OMH, J.C.A.H.O., CMS (Centers for Medicaid and Medicare Services)] require institutions that provide patient care to develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. Poor patient outcomes generally get reviewed under

the rubric of this program. The Governing Body (or institution) assumes responsibility for the quality of care and services provided. The Governing Body delegates the oversight of the quality program to the medical staff. At NYSPI the Medical staff has several ongoing committees that provide oversight in the following areas:

Medical Staff Executive Committee  
Quality Improvement Committee  
Patient Safety (Risk Management) Committee  
Pharmacy and Therapeutics Committee  
Environment of Care Committee  
Information Management Committee  
Infection Control Committee  
Ethics Committee

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\* Denotes highly recommended resources