

Physician Suicide and Support

Identify At-Risk Physicians and Facilitate Access to Appropriate Care



CME
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How Will This Module Help Me?

- 1 Presents 4 STEPS for identifying at-risk physicians and facilitating access to appropriate care.
- 2 Answers common questions about physician distress and suicidal behavior.
- 3 Provides downloadable tools to help you and your organization prevent physician distress and reduce the risk of suicide.



Introduction

Physicians die by their own hands at a rate much higher than that of the general public.¹⁻⁴ The suicide rate among female physicians is approximately 130 percent higher than that of the general female population. For male physicians, the suicide rate is approximately 40 percent higher than that of the general male population.³

Even though doctors agree they have an ethical obligation to intervene when they believe a colleague is impaired, many will fail to report it appropriately.⁵ 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.^{6,7}

Although the information in this module may be applicable to other clinical staff, the focus is on the vulnerability and treatment needs of physicians. In this module, we consider suicidal behavior to include suicide attempts and completed suicides. We define distress as a harmful response to a stressor, such as long work hours, and consider distress to include depression, substance abuse, relationship problems, and suicidal behavior.⁸

For additional information on physician suicide, please refer to the following resources:

- [PBS Special—Struggling in Silence: Physician Depression and Suicide \(55 minutes\)](#)
- [Confronting Depression and Suicide in Physicians: A Consensus Statement](#)
- [Healthcare Professional Burnout, Depression, and Suicide Prevention](#)
- [UCLA Department of Pediatrics Grand Rounds: Physician Burnout, Depression, and Demoralization](#)

Four STEPS to Identify At-Risk Physicians and Facilitate Access to Appropriate Care

1. Discuss Suicide Risk Factors and Warning Signs.
2. Promote Care-Seeking Behaviors.
3. Make it Easy to Find Help.
4. Create a Support System.

1

Discuss 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 the following⁹⁻¹⁴:

- Diagnoses of major depressive disorder, bipolar disorder, alcohol use disorder, anxiety disorder, or borderline personality disorder.
- Prior suicide attempt.
- Adverse childhood events (ACEs).
- 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.
- Multiple stressors, including:
 - Being named as defendant in a lawsuit.
 - General career concerns (e.g., job security, increased demands).
 - License restriction.
 - Financial problems.
 - Professional isolation.

The identities of many physicians are closely tied to their professional image, making them more vulnerable to distress when problems arise at work.¹⁵

“

Because of [the PHP'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

It is important for all physicians to be aware of the warning signs of suicide, which can include¹⁵⁻¹⁷:

- Increased substance (alcohol or drug) use.
- Feeling or expressing that there is no reason for living; no sense of purpose in life.
- Anxiety, agitation, difficulty sleeping, or sleeping all the time.
- Feeling trapped, like there's no way out.
- 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 important to take action if you suspect a colleague is demonstrating warning signs for suicide. While not every suicide may be preventable, suicide is not inevitable—people with suicidal feelings can be helped. Speaking with the physician directly is a good first step. You can say, “I’m concerned about you. Have you had any thoughts of harming yourself?”

Sample Script for Approaching Distressed Physicians

This document can help you prepare to approach a colleague that seems distressed.

(MS WORD, 939 KB)

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.

It is also important to recognize that you do not need to be an expert 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.

Suicide Prevention Resources

These Resources Provide Free and Confidential Support for Those in Distress

(MS WORD, 933 KB)

Q&A

What barriers prevent physicians from seeking mental health care?

Although physicians should recognize the value of obtaining treatment, they often are the most reluctant to access medical care and frequently receive poorer care than other patients (e.g., fewer laboratory tests, less rigorous medical evaluations).^{18,19}

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 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^{10,20}:

- 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.

How can I teach my team to recognize and respond to physicians in distress or at risk for suicide? What actions can they take to support these physicians?

- Include stress and distress as regular agenda items in staff 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.
- Show videos and allow colleagues, who have sought treatment for suicide ideation or attempt, to discuss their journey through a presentation.
- Encourage fulfillment of CME through coursework on stress management and physician burnout.
- Encourage self-care.

How is burnout related to distress?

Persistent distress can lead to physiological and physical exhaustion, otherwise known as burnout.²¹ Burnout now affects almost **half** of physicians in this country.^{23,24} It 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.²² **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.^{7,25}

2

Promote Care-Seeking Behaviors.

Recognize the importance self-care, model wellness behaviors, and encourage others to do the same.

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 doctor.
- 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.

“

The support I received from my psychiatrist and social worker was much appreciated. They had my back in a miserable residency experience. Thank you!

”

—Anonymous

These self-care tips may decrease distress, but it is important to recognize when it is time to seek help from outside resources.

Foster a positive culture within your organization, you can try some of these strategies:

- Encourage and model support for colleagues.
- Reinforce colleagues in their requests for time off for vacations or sick leave.
- Practice [appreciative inquiry](#) to create a more positive work environment.
- Promote effective and healthy communications with positive feedback and praise.²⁷

Remind colleagues that they have a responsibility to maintain their own health and wellness by addressing mental health issues including distress, according to the [AMA's Code of Medical Ethics' Opinion 9.0305](#).

Suicide Prevention Resources

These Resources Provide Free and Confidential Support for Those in Distress

(MS WORD, 933 KB)

Communicate with your staff widely and often about the need to intervene if they suspect a colleague needs help. Physicians can refer colleagues to physician health programs (PHPs) if they suspect their colleague is distressed. In most cases, programs can provide confidential services for voluntary referrals. You may also refer your colleagues to [AMA's Code of Medical Ethics' Opinion 9.031](#) for more information.

3

Make it Easy to Find Help.

Your organization should keep updated referral lists for resources inside and outside your organization and make them readily available to staff and physicians. There are a variety of confidential resources available to help physicians in distress or at risk for suicide. Almost every state in the country has a physician health program (PHP). Although programs vary, PHPs provide or facilitate in-depth evaluations, appropriate treatment referrals, and if necessary, monitoring for residents, physicians, and sometimes medical students. Because PHPs 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 [listing](#) of state PHPs with a description of the services provided by each. Display these resources in a highly visible location that does not require a password and assures users that there is no tracing of page visits or downloads.

“

I strongly feel that [the physician health program] saved my career [by helping me] deal with stressors.

”

—Anonymous

Helpful resources for physician distress and suicide include:

- *National Suicide Prevention Lifeline*: Provides free and confidential support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week: 800-273-TALK (8255)
- *Depression and Bipolar Support Alliance*: An advocacy group that provides support, resources and information for people living with depression and bipolar diagnoses
- *The American Foundation for Suicide Prevention*: Physician-specific suicide information, including the documentary *Struggling in Silence*
- *Acumen Institute*: Specializes in acute distress assessments and education for medical professionals
- *Vanderbilt University Program for Distressed Physicians*: Offers a 3-day course that provides help for distressed physicians in a confidential environment
- *Medical Malpractice Stress self-survey*
- *SAMHSA Suicide Behaviors Questionnaire, Revised (SBQR)*
- *American Society for Suicide Prevention Interactive Screening Program*

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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, 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?
- Do physicians have the flexibility and time in their schedules to seek care if they need it?
- Is personal time off encouraged in the 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 of mental health treatment when applying for renewal of their medical licenses?
- 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, it may lead to worsening of their condition. 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 policies about

confidentiality, as the risks of untreated physician distress often outweigh the potential benefits of mental health disclosures.

For more information, see:

- [Federation of State Physician Health Programs](#)
- [Federation of State Medical Boards](#)

Q&A

[What policies do we need to have in place to ensure confidentiality for physicians seeking care?](#)

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, they should be upfront about the limitations.

Confidentiality policies should be informed by a nuanced understanding of the causes of impairment in the medical workplace. While suicidal ideation can correlate with potentially impairing conditions, these types of thoughts should not be considered impairment when creating relevant policies.

[What do physicians need to know about referral and confidentiality policies and state laws relevant to seeking care?](#)

One of the principal reasons that physicians do not seek care is confidentiality concerns. The licensing applications for each state differ in the information collected and what an applicant must disclose about a condition. 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, it is important for individuals 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. Confidentiality policies vary among PHPs as well. If physicians present to a PHP for care, it is appropriate to ask about their limits to confidentiality as well as any conditions or situations that would result in disclosure.

[If I want to take additional steps outside my organization to advocate on behalf of physicians in distress and at risk for suicide, what should I do?](#)

Offer to give presentations or lectures on this topic or assist organizations 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.¹⁰

4

Create a Support System.

Creating a supportive atmosphere in the workplace can be instrumental to addressing physician distress.

You may consider having a person within your organization serve as a physician advocate. Enlist an individual within the organization, such as a human resource professional or a member of the hospital wellness committee, who 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 as well as 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 would be 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:

- Enlisting a physician advocate to provide support to physicians in distress.
- 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.
- Offering regular screenings for depression, distress, and burnout.
- Identifying and adapting external suicide prevention programs.

Q&A

What difficulties do physicians face when caring for other doctors 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, the treating physician may be anxious about his or her own ability to treat a colleague and may worry about how issues of confidentiality, privacy, or empathy may affect the care they provide.¹⁹ However, these concerns should not discourage a physician from seeking care or from encouraging a colleague to seek care. When needed,

the state PHP may be able to assist the physician in identifying another physician with experience and expertise in treating distressed physicians.

What role do family and friends play in identifying and addressing physician distress and suicidality?

Enlisting support from social networks is often critical for distressed physicians. If the physician seeks mental health care, he or she may ask to bring a friend or family member for support. The physician's mental health care practitioner will determine the exact role the support person has in the treatment relationship.

Sample Scenarios

The following scenarios illustrate 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.

Sample Scenario 1

Monique is a 28-year-old female resident in her second year of rotations. 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 and appropriately dressed. 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.

Sample Scenario 2

A medical assistant contacts the state physician health program (PHP), concerned about the behavior of one of the physicians at the clinic where she works. Carlos, a 52-year-old male internist, exhibits mood swings at the office and is frequently absent from work. The PHP asks the medical assistant about Carlos's ability to practice and about any concerns regarding patient safety, which she denies. In the absence of such concerns, the PHP explains the referral process and confidentiality information to the caller, and asks that the workplace encourage Carlos to present for a voluntary evaluation. The peer-assistance program follows up with the medical assistant two weeks later, but she has not yet spoken with the physician. The PHP inquires about the current status of the physician, which has remained the same. After additional encouragement, the medical assistant speaks to Carlos to express her concern, urging him to contact the PHP.

Three months pass before Carlos calls the peer-assistance organization. When he presents for the first appointment, Carlos brings his wife for support. With the permission of the PHP, his wife sits in on his evaluation and provides the intake clinician with supplemental information, including evidence of increased alcohol use and her fear that recent financial difficulties would “push [Carlos] over the edge” towards suicide. Carlos is referred to a local, low-cost outpatient substance use treatment center for immediate intervention. Soon after, he enrolls in individual counselling and a 12-step program, which he attends regularly over the course of the next two years. During this time, he continues working at the clinic, where he successfully practices today.

Conclusion

Physicians have a higher risk of suicide than the general population, yet are often reluctant to access care. Approaching and speaking with a physician experiencing distress or at risk for suicide is a good first step. These steps will help you standardize care-seeking in your organization, teach your staff to identify at-risk physicians, and facilitate access to appropriate care.



AMA Pearls

Not every suicide is preventable but people at risk can be helped. Talk about the risk factors and warning signs for suicide to help your team identify at-risk physicians.

Standardizing care-seeking can encourage self-care. Encourage and model self-care by allowing yourself time to recharge, talking about your own stress, saying “no,” and learning to recognize the signs of distress in yourself. Foster a positive work environment by supporting colleagues in their self-care efforts.

At-risk physicians face a number of barriers to obtaining treatment. Review your organization's policies and revise, if needed, to minimize barriers to care-seeking.

Creating a support system for physicians is important in addressing physician distress. Take steps to provide support to physicians who currently have distress, such as reducing his or her caseload in the short term.

STEPS in practice

1 Physician Suicide and Support Case Report: The University of California San Diego

Leaders at the University of California San Diego (UCSD) School of Medicine launched The Healer Education Assessment and Referral (HEAR) program in an effort to increase the use of mental health services and decrease the risk of suicide among faculty members, residents, fellows, and medical students. The program includes two components: education and assessment.

For the educational component, a multidisciplinary committee consisting of school faculty, program counselors, and medical students deliver one-hour presentations about physician suicide. These live presentations generally consist of an informational lecture, a 15-minute screening of the American Foundation of Suicide Prevention's film about physician suicide, *Struggling in Silence*, and a question-and-answer period. The lecture reviews the scope of the problem, discusses the relationships between burnout, depression and suicide, and highlights factors that affect physicians' care-seeking behavior. Presentations are modified for different educational forums, such as professional workshops, brief meetings, and departmental grand rounds. By providing tailored presentations, the HEAR program has the flexibility to reach a variety of audiences.

The second component of the program is a web-based screening tool that is housed on [HEAR's website](#). The medical students, residents, fellows, and faculty members are encouraged to complete a brief online questionnaire to determine how stress and depression may be affecting their personal and professional lives. The screening tool, developed by the American Foundation for Suicide Prevention, includes items from the Patient Health Questionnaire (PHQ-9) and gathers information about prior suicide attempts, affective states (e.g., anxiety, panic, rage, desperation, and loss of control), alcohol and drug use, eating behaviors, and current mental health treatment. Responses to the questionnaire are completely anonymous. If an individual chooses to provide his or her email address, a counselor will contact the individual to provide an interpretation of the assessment, recommendations for further evaluation, and referrals to local resources. The HEAR screening questionnaire is not a crisis intervention tool; however, it is designed to provide individuals with rapid feedback about their current mental health status and encouragement to seek further evaluation and access external support.

Since the inception of the HEAR program, staff has delivered almost 120 presentations that reached medical students, pharmacy students, residency training directors, chief residents, faculty chairs, leadership, and attendees of multiple local, regional, and national conferences. More than 2,600 individuals have completed the anonymous HEAR Program online questionnaire. The most recent published report describes how the HEAR tool found that 8 percent of medical students were at high-to-significant risk of suicide. The study also reported that the number of medical students completing the online questionnaire steadily increased over time. This provided preliminary evidence suggesting that suicide risk in this population is decreasing.

For a deeper dive into these topics, check out these resources:

[Listening to depression and suicide risk in medical students](#)

[The suicide prevention and depression awareness program at UC San Diego School of Medicine](#)

Learning Objectives

1. Identify risk factors and warning signs for suicide
2. Describe steps to implement standardized processes for physicians seeking care in your practice
3. List ways to create an environment of support and physician wellness in your organization

Article Information

AMA CME Accreditation Information

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Additional Information: About the AMA Professional Satisfaction and Practice Sustainability Group: 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.

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