AMA | STEPSforward™

Preventing Physician Distress and Suicide

Recognize and respond to physician distress and suicidal behavior

CME CREDITS: 0.5

Elizabeth Brooks, PhD
University of Colorado

The Colorado Physician Health Program Research Committee

How will this module help me successfully identify at-risk physicians and facilitate access to appropriate care?

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

Increasing administrative responsibilities—due to regulatory pressures and evolving payment and care delivery models—reduce the amount of time physicians spend delivering direct patient care. Physician suicide rates are much higher than the general public. 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.

Preventing Physician Suicide
Release Date: August 31, 2016
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Objectives
At the end of this activity, participants will be able to:
1. Identify risk factors and warning signs for suicide
2. Implement standardized methodology for physicians seeking care in your practice
3. Create an environment of support and physician wellness in your organization

Target Audience
This activity is designed to meet the educational needs of practicing physicians.

Statement of Need
Physicians die by their own hands at a rate much higher than that of the general public. Female physicians' suicide rate is about 130 percent higher than the general female population. For male physicians, the suicide rate is about 40 percent higher than that of the general male population. Even though doctors agree that they have an ethical obligation to intervene when they believe a colleague is actually impaired, only 67 percent will report appropriately. This module teaches physicians how to identify warning signs for physician suicide, how to approach colleagues that are displaying signs of distress and how to standardize care-seeking in health care organizations. This module also teaches the importance of physicians keeping themselves healthy in their professions and ensuring that wellness is a part of their lives to prevent distress.

Statement of Competency
This activity is designed to address the following ABMS/ACGME competencies: practice-based learning and improvement, interpersonal and communications skills, professionalism, systems-based practice and also address interdisciplinary teamwork and quality improvement.

Accreditation Statement
The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

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Planning Committee
Alejandro Aparicio, MD, Director, Medical Education Programs, AMA

Rita LePard, CME Program Committee, AMA

Bernadette Lim, Program Administrator, Professional Satisfaction and Practice Sustainability, AMA

Becca Moran, MPH, Program Administrator, Professional Satisfaction and Practice Sustainability, AMA

Sam Reynolds, MBA, Director, Professional Satisfaction and Practice Sustainability, AMA

Christine Sinsky, MD, Vice President, Professional Satisfaction, AMA

Allison Winkler, MPH, Senior Practice Development Specialist, Professional Satisfaction and Practice Sustainability, AMA

Author(s)
Elizabeth Brooks, PhD, Assistant Professor, Department of Community and Behavioral Health, Colorado School of Public Health, University of Colorado, Denver

Sarah R. Early, PsyD Executive Director Colorado Physician Health Program

Michael H. Gendel, MD Associate Clinical Professor Department of Psychiatry University of Colorado, Anschutz Medical Campus Medical Director Emeritus Colorado Physician Health Program

Doris C. Gundersen, MD Clinical Assistant Professor Department of Psychiatry University of Colorado, Anschutz Medical Campus Medical Director Colorado Physician Health Program

Scott Humphreys, MD Senior Medical Director Colorado Access Medical Director Colorado Physician Health Program

Mary Louwagie Compliance Coordinator Colorado Physician Health Program

Amanda Parry, MPA Director of Public Affairs Colorado Physician Health Program

Jay H. Shore MD, MPH Associate Professor Department of Psychiatry University of Colorado, Anschutz Medical Campus Associate Medical Director Colorado Physician Health Program

Faculty
Christopher C. Bundy, MD, MPH, Medical Director, Washington Physicians Health Program

Lisa J. Merlo, PhD, MPE, Assistant Professor of Psychiatry, University of Florida College of Medicine

Becca Moran, MPH, Program Administrator, Professional Satisfaction and Practice Sustainability, AMA

Warren Pendergast, MD, CEO, North Carolina Physicians Health Program

Christine Sinsky, MD, Vice President, Professional Satisfaction, AMA

Allison Winkler, MPH, Senior Practice Development Specialist, Professional Satisfaction and Practice Sustainability, AMA

About the Professional Satisfaction, 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.

Disclosure Statement
The content of this activity does not relate to any product of a commercial interest as defined by the ACCME; therefore, neither the planners nor the faculty have relevant financial relationships to disclose.

Media Types
This activity is available to learners through Internet and Print.

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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.[3] For male physicians, the suicide rate is approximately 40 percent higher than that of the general male population.

Even though doctors agree they have an ethical obligation to intervene when they believe a colleague is actually impaired, only 67 percent will report 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 unique 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,[8] such as long work hours, and consider it to include depression, substance abuse, relationship problems and suicidal behavior.

Four STEPS to identify at-risk physicians and refer them to appropriate care

1. Talk about the risk factors and warning signs for suicide
2. Take steps to standardize care-seeking in your organization
3. Make it easy to find help
4. Consider creating a support system for physicians in your organization

> “[The doctor] was amazing in helping me work through my depression and issues with residency…I cannot thank [the doctor] enough for her support and assistance during what was a very difficult decision and time of my life.”

> I strongly feel that [the PHP] saved my career [by helping me] deal with stressors.

1 Talk about the risk factors and warning signs for suicide

Suicidal behavior is a complex problem with no single cause or absolute predictors. Risk factors for physician suicide are similar to those in the general public and include[9-14]:

- Diagnoses of major depressive disorder, bipolar disorder, alcohol use disorder, anxiety disorder, borderline personality disorder
- Prior suicide attempt
- Difficult childhood/troubled family of origin
- Family history of mood disorders or suicide
- History of sexual abuse
- Relationship problems or domestic violence
- Multiple current stressors, including for physicians:
  - Being named as defendant in a lawsuit
  - General job problems (e.g., concerns about job security, increased work 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]

It is important for all physicians to be aware of the warning signs of suicide, which include[15, 16, 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 when these actions are unusual for the person

DOWNLOAD Sample scripting for approaching distressed physicians

Q&A

If I believe that a physician colleague is displaying signs of distress, how should I approach him or her? What should I say?

It is important to take action if you suspect a colleague is experiencing distress or is at risk 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, for example by saying: "I'm concerned about you. Have you had any thoughts of harming yourself?" (see Sample Scripting tool for additional suggestions on wording). 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 have all of the answers yourself in order to help. Often, a simple recommendation to talk with a mental health professional can be an important first step. To facilitate confidential referral to care, keep an updated list of local and national resources on hand that physicians can access discreetly (see a list of Other Helpful Resources in Step 3).

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 indicative of 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 its warning signs. In other cases, physicians recognize their distress but fail to seek care through a conscious choice, often influenced by a variety of 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 work or student records
- Concerns about subsequent professional advancement
- Lack of a primary care provider
- 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?

Some options you could suggest for implementation in your organization include:

- Including stress and distress as regular agenda items in staff meetings to encourage dialogue about these issues and help to normalize care-seeking by staff
- Incorporating information about distress and suicide in company newsletters to raise awareness of the issue and provide information for staff members to whom doctors may turn when in distress
- Talking with physicians one-on-one about issues related to distress and suicide

- Showing videos or offering presentations from colleagues who have sought treatment for suicidal ideation or attempts
- Encouraging fulfillment of CME through coursework about stress management and physician burnout
- Encouraging self-care and promotion of wellness as an indicator of professionalism and an important component of patient safety efforts

Encourage your team to talk with colleagues who appear to be distressed. These phrases may help when reaching out to others.

Additional information about physician suicide:

- PBS Special - Struggling in Silence, Physician Depression and Suicide (55 minutes)
- Confronting Depression and Suicide in Physicians: A Consensus Statement
- Physician suicide information website
- Grand rounds presentation on physician suicide by Elizabeth Bromley, MD, PhD, of UCLA

How is burnout related to distress?

Persistent stress can lead to exhaustion and psychological and physical distress.[21] Burnout refers to a long-term stress reaction characterized by depersonalization, including cynical or negative attitudes toward patients, emotional exhaustion, a feeling of decreased personal achievement and a lack of empathy for patients.[22] Burnout now affects more than half of physicians in this country.[23,24] Burnout and distress have been linked to decreased empathy, reduced cognitive functioning and lower quality of care.[7,25] Burnout is also associated with higher rates of alcohol use disorder and depression, increased risk for suicide and lower quality of life.

2 Take steps to standardize care-seeking in your organization

Recognize the importance of modeling self-care and encouraging others to do the same. Start by taking steps to maintain your health:

- Allow yourself to recharge. Take personal time off and make time for relaxation with friends and family members.
- Talk to your colleagues about your own stress. Opening up to co-workers about your own anxieties and stress shows others that they are not alone. The support of colleagues can be a great source of comfort during difficult circumstances.
- Learn to say “no.” 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 the signs of stress, depression and burnout in yourself. Most importantly, if you feel that you too would benefit from assistance, reach out to colleagues. You will find that you are not alone. Sharing your experiences with colleagues may help others in similar situations.
    - If you feel you need immediate assistance or support, you may use any of these resources found on this list.
- Follow basic health rules for staying healthy! Get enough sleep, eat nutritiously and exercise regularly.

Foster a positive culture within your organization.

- Encourage and model support for colleagues.
- Reinforce colleagues in their requests for time off for vacations or sick leave.
- Try appreciative practice to create a more positive work environment. Effective, healthy communication within organizations, with positive feedback and praise, can help curtail distress.[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.

Communicate to 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.

DOWNLOAD Suicide prevention resource list

DOWNLOAD Sample scripting for approaching distressed physicians

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

Make it easy to find help

The leadership should keep updated referral lists for resources inside and outside your organization and make them readily available to staff. Be sure to house these resources in a highly visible location that does not require a password and assure users that there is no tracing of page visits or downloads.

Many confidential resources are available to help physicians in distress or at risk for suicide. Almost every state in the country has a 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.

Identify policy barriers to care-seeking in your organization and take steps to minimize them. Work with 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 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?

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; 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 and conditions/situations that would result in disclosure.

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. Organization leadership should consider this factor when developing policies about confidentiality, as the risks of untreated physician distress often outweigh the potential benefits resulting from disclosure of the physician's condition.

For more information, see:

- Federation of State Physician Health Programs
- Federation of State Medical Boards

Other helpful resources include:

- *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* – 3-day course that provides help for distressed physicians in a confidential environment
- *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)
- *Medical Malpractice Stress self-survey*
- *SAMHSA Suicide Behaviors Questionnaire, Revised (SBQR)*
- *American Society for Suicide Prevention Interactive Screening Program*

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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 benefits both physician health and patient safety. Let the leaders of these organizations know 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 Consider creating a support system for physicians in your organization

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

Forms of support include:

- 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 approaches used by external suicide prevention programs to your organization

Q&A

Who in my organization should provide support to physicians in distress? How do I train this person so my colleagues get the care they need?

Enlist a point person that physicians in the organization would feel comfortable approaching to distribute resource materials, provide internal policy information and serve as a physician advocate, such as a human resources professional or a member of the hospital wellness committee. This individual must be trustworthy, discreet and knowledgeable about the benefits and potential ramifications of accessing care. He or she should be prepared to answer physicians' questions about the potential impact of receiving mental health care on job security, medical licenses, malpractice insurance and disability coverage.

The training of a point person is critical and should focus on explaining internal and external policies and policy implications regarding privacy, confidentiality and care-seeking. Once a point person is selected and trained, communicate widely with physicians about the availability of this physician advocate.

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 their social network 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. While the physician's care provider will determine the exact role that the individual can have in the treatment relationship, peer support can be a valuable asset to recovery.

"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."

"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"

Sample Scenarios

The following case studies 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 was a 28-year-old female resident in her second year of hospital rotations. She was doing well at work and rated highly on her performance evaluations; however, away from the office, she struggled with several personal issues. During an annual meeting with her resident advisor, Monique was not as cheerful as usual, her mood was down and she did not want to talk about her personal feelings. Concerned, the advisor encouraged Monique to contact the state physician health program (PHP). After contemplating this advice for several weeks, Monique called the program to schedule an appointment. Approximately two weeks after her call, Monique presented for her appointment at the PHP on time and appropriately dressed. She completed a detailed, computer-assisted intake tool in a private room. The tool included 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 spoke with a clinician in a thorough, in-person interview. During the assessment, Monique reported that she had experienced physical and mental abuse as a child, which she had never previously disclosed. Monique stated that the abuse caused her severe anxiety and affected her ability to connect with others and have stable relationships. She admitted to the clinician that she had thought about suicide in the past but did not have any immediate plans or access to lethal means. She expressed to the clinician that she would like help learning to cope with her abuse history.

Approximately two weeks after her call, Monique presented for her appointment at the PHP on time and appropriately dressed. She completed a detailed, computer-assisted intake tool in a private room. The tool included 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 spoke with a clinician in a thorough, in-person interview. During the assessment, Monique reported that she had experienced physical and mental abuse as a child, which she had never previously disclosed. Monique stated that the abuse caused her severe anxiety and affected her ability to connect with others and have stable relationships. She admitted to the clinician that she had thought about suicide in the past but did not have any immediate plans or access to lethal means. She expressed to the clinician that she would like help learning to cope with her abuse history.

The peer-assistance program connected Monique to a therapist who specialized in childhood trauma and a psychiatrist. Initially, Monique struggled in treatment and her mood worsened during the first few months. Early into therapy, her roommate found a suicide note and confronted Monique, who then reported it to her therapist. The therapist consulted with the PHP clinician, who recommended that she take a brief hiatus from work. Over time, Monique learned strategies that helped her cope with her abuse history. She began medications to regulate her depression and post-traumatic stress disorder (PTSD) symptoms. Monique successfully graduated from her program on time and moved back to her state of residence, where she continues to practice medicine.

Sample Scenario 2

A medical assistant contacted the state physician health program (PHP), concerned about the behavior of one of the physicians at the clinic where she worked. Carlos, a 52-year-old male internist, exhibited mood swings at the office and was absent from work frequently. The PHP asked the medical assistant about Carlos' ability to practice and about any concerns regarding patient safety, which she denied. In the absence of such concerns, the PHP explained to the caller the referral process and confidentiality information, and asked that the workplace encourage Carlos to present for a voluntary evaluation. The peer-assistance program followed up with the medical assistant two weeks later, but she had not yet spoken with the physician. The PHP inquired about the current status of the physician, which remained the same. After additional encouragement, the medical assistant spoke to Carlos to express her concern, urging him to contact the PHP.

Three months passed before Carlos called the peer-assistance organization. When he presented for the first appointment, Carlos brought his wife for support. With the permission of the PHP, his wife sat in on his evaluation and provided 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 was referred to a local, low-cost outpatient substance use treatment center for immediate intervention. Soon after, he enrolled in individual counselling and a 12-step program, which he attended regularly over the course of the next two years. During this time, he continued working at the clinic, where he successfully practices today.

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.

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.

STEPS in practice

1

How's it working in San Diego?

In 2009, officials 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: http://healthsciences.ucsd.edu/som/hear/pages/default.aspx. All UCSD medical students, residents, fellows and faculty members are encouraged to complete a brief online questionnaire to determine whether and how stress and depression may be affecting them. 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, as needed. The HEAR screening questionnaire is not a crisis intervention tool; rather, it is designed to provide individuals with rapid feedback about their current mental health status, and, if appropriate, encourage them to seek further evaluation and access external support.

In the seven years since the inception of the HEAR program, staff have delivered almost 120 presentations, reaching medical and pharmacy students, residency training directors, chief residents, faculty chairs, Health Sciences Center executives and attendees of multiple local, regional and national professional meetings. More than 2,600 individuals have completed the anonymous HEAR Program online questionnaire. The most recent published report detailing the use of the screening tool with medical students showed that it was able to identify a high proportion of currently untreated, at-risk and potentially suicidal individuals. Almost 8 percent of medical student respondents met the criteria for high-to-significant suicide risk. The study also reported that the number of medical students completing the online questionnaire increased over time and provided preliminary evidence suggesting that suicide risk in this population is decreasing.

For further reading see:

Downs N, Feng W, Kirby B, McGuire T, Moutier C, Norcross W, et al. Listening to depression and suicide risk in medical students: the Healer Education Assessment and Referral (HEAR) Program. *Acad Psychiatry*. 2014;38(5):547-553.

Moutier C, Norcross W, Jong P, Norman M, Kirby B, McGuire T, et al. The suicide prevention and depression awareness program at the University of California, San Diego School of Medicine. *Acad Med*. 2012;87(3):320-326.

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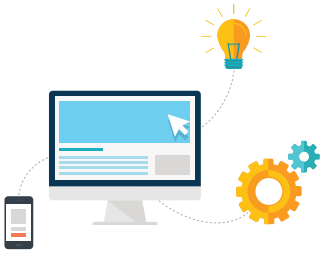

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