

RECOGNIZING NATIONAL SUICIDE PREVENTION MONTH



A LinkedIn Series by PRMS Risk Managers

Donna Vanderpool, MBA, JD
[LinkedIn.com/in/DonnaVanderpool](https://www.linkedin.com/in/DonnaVanderpool)

David Cash, JD, LLM, ARM
[LinkedIn.com/in/CharlesCash](https://www.linkedin.com/in/CharlesCash)

Ann McNary, JD
[LinkedIn.com/in/AnnMcNary](https://www.linkedin.com/in/AnnMcNary)

Justin Pope, JD
[LinkedIn.com/in/JustinAPope](https://www.linkedin.com/in/JustinAPope)



Recognizing National Suicide Prevention Month

3

Physician Suicide

Donna Vanderpool, MBA, JD, Vice President, Risk Management

[LinkedIn.com/pulse/Physician-Suicide-Donna-Vanderpool-MBA-JD](https://www.linkedin.com/pulse/Physician-Suicide-Donna-Vanderpool-MBA-JD)

5

Five Things to Remember When Treating Patients at Risk of Suicide

David Cash, JD, LLM, ARM, Assistant Vice President, Risk Management

[LinkedIn.com/pulse/Five-Things-Remember-When-Treating-Patients-Risk-Suicide-Cash/](https://www.linkedin.com/pulse/Five-Things-Remember-When-Treating-Patients-Risk-Suicide-Cash/)

6

Lessons to Be Learned: A Review of Post-Suicide Malpractice Lawsuits

Ann McNary, JD, Senior Risk Manager

[LinkedIn.com/pulse/Lessons-Learned-Review-Post-Suicide-Malpractice-Ann-McNary-JD/](https://www.linkedin.com/pulse/Lessons-Learned-Review-Post-Suicide-Malpractice-Ann-McNary-JD/)

7

Suicide Trends

Justin Pope, JD, Associate Risk Manager

[LinkedIn.com/pulse/Suicide-Trends-Justin-A-Pope/](https://www.linkedin.com/pulse/Suicide-Trends-Justin-A-Pope/)



LinkedIn Post

Physician Suicide

Donna Vanderpool, MBA, JD
Vice President, Risk Management
Professional Risk Management Services (PRMS)

Here are some very worrisome facts about physicians taking their own lives:

- One physician completes suicide every day in the US
 - › Physicians have the highest suicide rate of any profession
 - › The number of physician suicides is 28-40 per 100,000 - more than twice that of the general population
- The suicide rate for male physicians is about 50% higher than for female physicians
- Female physicians attempt suicide far less often than females in the general population; however,
 - › Their completion rate exceeds that of the general population by 2.5 to 4 times, and equals that of male physicians
- The most common psychiatric diagnoses of those physicians who complete suicide are depression, bipolar disorder, alcoholism, and drug abuse.
- Poisoning/medication overdoses, firearms, and hanging are the most prevalent means of physician suicide.

Factors that can contribute to physician suicide include:

- Untreated psychiatric diagnosis, particularly depression
- Self-medication, which can then lead to substance abuse
- Stress
 - › As a physician
 - Emergency medicine and psychiatry are reportedly near the top of specialty suicide rates
 - › As a result of litigation

A special note about stress during residency:

- One study reviewed the deaths of residents from 2000 to 2014 and found the following:
 - › Unlike physicians post-training, physicians in training have a lower death rate than the age- and gender-matched general population
 - › However, suicide was found to be the second-leading cause of resident death overall (second to cancer), and the leading cause of death among male residents
 - › In terms of the timing of resident suicides,
 - The majority of suicides occurred during PGY-1 and PGY-2
 - The months of July-September and January-March had the majority of resident suicides

- In terms of prevention, there are several resources addressing resident suicide:
 - From the ACGME – “10 Facts”ⁱ and other resourcesⁱⁱ
 - From the Association of American Medical Collegesⁱⁱⁱ
- The suicide of a resident can be devastating to the entire training program. The ACGME has a resource that may be useful, After a Suicide: A Toolkit for Physician Residency/Fellowship Programs^{iv}.

Barriers to physicians seeking treatment include:

- Stigma / loss of respect among colleagues, family, employers, employees, etc.
- Having to withdraw temporarily from practice
- Lack of treatment confidentiality
- Impact of diagnosis and treatment on their livelihood, in terms of:
 - › License
 - › Employment
 - › Hospital privileges
 - › Participation on insurance panels
 - › Disability insurance
 - › Professional liability insurance

What can be done?

- Address physician wellness and burnout – at all stages of a physician’s career, including residency. See my prior post^v.
- For physicians experiencing significant stress from litigation, contact your professional liability insurer for assistance, such as a litigation “survival guide”.

References / for more information:

- Physician Suicide^{vi}, Medscape, Aug. 1, 2018
- Doctors’ Suicide Rate Highest of Any Profession^{vii}, WebMD, May 8, 2019
- Causes of Death of Residents in ACGME-Accredited Programs 2000 Through 2014^{viii}, Academic Medicine, July 2017
- American Foundation for Suicide Prevention^{ix}

- The National Suicide Prevention Lifeline:
 - › 1-800-273-8255
 - › En Español: 1-888-628-9454
 - › For hearing impaired persons: 1-800-799-4889
 - › Chat and more information: <https://suicidepreventionlifeline.org/>

Note:

This post is one in a series of posts on suicide awareness during National Suicide Prevention Month. The other posts in the series by my colleagues include:

- “Five Things to Remember When Treating Patients at Risk of Suicide” by David Cash, JD, LL.M, Assistant Vice President^x
- “Lessons to Be Learned: A Review of Post-Suicide Malpractice Lawsuit” by Ann McNary, JD, Senior Risk Manager^{xi}
- “Suicide Trends by Justin Pope, JD, Associate Risk Manager^{xii}

Originally posted on September 4, 2018

- i <https://www.acgme.org/Portals/0/PDFs/ten facts about physician suicide.pdf>
- ii <https://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being/Resources>
- iii <https://www.mededportal.org/publication/10508/>
- iv http://www.acgme.org/Portals/0/PDFs/13287_AFSP_After_Suicide_Clinician_Toolkit_Final_2.pdf
- v <https://www.linkedin.com/pulse/physician-burnout-donna-vanderpool-mba-jd/>
- vi <https://emedicine.medscape.com/article/806779-overview>
- vii <https://www.webmd.com/mental-health/news/20180508/doctors-suicide-rate-highest-of-any-profession?print=true>
- viii https://journals.lww.com/academicmedicine/Fulltext/2017/07000/Causes_of_Death_of_Residents_in_ACGME_Accredited.41.aspx
- ix <https://afsp.org/our-work/education/healthcare-professional-burnout-depression-suicide-prevention/>
- x <https://www.linkedin.com/in/charlescash/>
- xi <https://www.linkedin.com/in/annmcnary/>
- xii <https://www.linkedin.com/in/justinapope/>

[LinkedIn.com/company/PRMSPrograms](https://www.linkedin.com/company/PRMSPrograms)
[LinkedIn.com/in/DonnaVanderpool](https://www.linkedin.com/in/DonnaVanderpool)



LinkedIn Post

Five Things to Remember When Treating Patients at Risk of Suicide

David Cash, JD, LLM, ARM
Assistant Vice President, Risk Management
Professional Risk Management Services (PRMS)

1. Assessment is key. Consider using a formal suicide risk assessment tool for consistency and thoroughness. SAMSHA recommends two such risk assessment tools – the SAFE-T Suicide Assessment Five-step Evaluation and Triage tool, and the Columbia Suicide Severity Rating Scale.
2. Do not hesitate to obtain consultation with a colleague. Medicine is a collegial profession, both in theory and in practice, and physicians consult with one another regularly.
3. Consider attempting to obtain and review past treatment records. If you are unable to obtain records, document your efforts to do so. Past treatment records can offer a nuanced view of prior treatment efforts and may provide information you would not otherwise learn.
4. Communication with other providers in a split treatment arrangement may be beneficial, especially in the event of emerging suicidal ideation or behaviors.
5. Educate the patient, perhaps family members or significant others as well, on who to call if a patient feels like hurting himself or herself. The National Suicide Prevention Lifeline is one resource:
 - 1-800-273-8255
 - En Español: 1-888-628-9454
 - For hearing impaired persons: 1-800-799-4889
 - Chat and more information: <https://suicidepreventionlifeline.org/>

Managerⁱⁱ

- “Suicide Trends” by Justin Pope, JD, Associate Risk Managerⁱⁱⁱ

Originally posted on September 4, 2018

i <http://www.linkedin.com/in/donnavanderpool/>

ii <https://www.linkedin.com/in/annmcnary>

iii <http://www.linkedin.com/in/justinapope/>

Note:

This post is one in a series of posts on suicide awareness during National Suicide Prevention Month. The other posts in the series by my colleagues include:

- “Physician Suicide” by Donna Vanderpool, MBA, JD, Vice Presidentⁱ
- “Lessons to Be Learned: A Review of Post-Suicide Malpractice Lawsuit” by Ann McNary, JD, Senior Risk

[LinkedIn.com/company/PRMSPrograms](https://www.linkedin.com/company/PRMSPrograms)
[LinkedIn.com/in/CharlesCash](https://www.linkedin.com/in/CharlesCash)



LinkedIn Post

Lessons to Be Learned: A Review of Post-Suicide Malpractice Lawsuits

Ann McNary, JD
Senior Risk Manager
Professional Risk Management Services (PRMS)

Over the past 30+ years, PRMS has handled hundreds (thousands?) of claims involving patient suicides and attempted suicides. While it is not always possible to prevent a patient's suicide, in reviewing past claims and the allegations made by attorneys in those cases, it is possible to identify areas in which small changes in treatment may increase patient safety and lessen the likelihood of a tragic outcome.

Allegations related to evaluation of the patient

These allegations relate to a clinician's failure to take an adequate patient history, adequately assess the patient, and make an accurate diagnosis. Typical allegations include:

- Failure to obtain collateral information from family regarding past suicidal behaviors
- Failure to determine what treatments had previously failed
- Failure to review prior medical records
- Failure to properly evaluate and record patient's risk for suicide
- Failure to diagnose suicidality

Allegations related to treatment of the patient

Generally, these allegations concern decisions about appropriate treatment modalities and settings and the correct development and implementation of the treatment plan. Typical allegations include:

- Failure to take protective measures (such as placing the patient on constant observation)
- Failure to hospitalize for suicidality
- Failure to communicate with other clinicians involved in the patient's care (e.g., therapist in a split-treatment relationship)
- Failure to communicate with the patient's family or significant others (for example, the family alleged that the clinician failed to alert them to the patient's suicidal ideation) or to receive information from them.
- Improper medication prescribing/management

Allegations related to a physician's lack of knowledge of current treatment methods of assessing and treating

patients with suicidal behaviors

These allegations assert that a clinician was not professionally current about assessing and prescribing treatment for patients with suicidal behaviors. Typical allegations include:

- Failure to appreciate suicide risk associated with specific psychiatric disorders
- Failure to stay current on the effectiveness of certain medications in decreasing potential suicide risk

Allegations related to a physician's liability for acts of others

These allegations assert liability on the part of the psychiatrist even though he/she was not directly involved in the care of the patient. Typical allegations include:

- Failure to adequately supervise a nurse practitioner
- Failure of a psychiatrist acting as a medical director to develop and/or enforce patient safety protocols

Note:

This post is one in a series of posts on suicide awareness during National Suicide Prevention Month. The other posts in the series by my colleagues include:

"Physician Suicide" by Donna Vanderpool, MBA, JD, Vice Presidentⁱ

"Five Things to Remember When Treating Patients at Risk of Suicide" by David Cash, JD, LLM, Assistant Vice Presidentⁱⁱ

"Suicide Trends by Justin Pope, JDⁱⁱⁱ, Associate Risk Manager

Originally posted on September 4, 2018

i <http://www.linkedin.com/in/donnavanderpool/>

ii <https://www.linkedin.com/in/annmcnary/>

iii <http://www.linkedin.com/in/justinapope/>

[LinkedIn.com/company/PRMSPrograms](https://www.linkedin.com/company/PRMSPrograms)
[LinkedIn.com/in/AnnMcNary](https://www.linkedin.com/in/AnnMcNary)



LinkedIn Post

Suicide Trends

Justin Pope, JD
Associate Risk Manager
Professional Risk Management Services (PRMS)

Since September is recognized as Suicide Prevention Awareness Month, I thought it might be of interest if I shared a few findings from a review of The Psychiatrists' Program's suicide claims and lawsuits over the past decade:

- The most common method of suicide or suicide attempt:
 - › Hanging
 - › Firearm
- The top two diagnoses (for both men and women):
 - › Major Depressive Disorder – by far the most prevalent diagnosis
 - › Bipolar Disorder
- Gender: Males were twice as likely as females to attempt or complete suicide.
- Practice setting: By far and away, suicides or suicide attempts have occurred most frequently in outpatient settings.

Note:

This post is one in a series of posts on suicide awareness during National Suicide Prevention Month. The other posts in the series by my colleagues include:

- “Physician Suicide” by Donna Vanderpool, MBA, JD, Vice Presidentⁱ
- “Five Things to Remember When Treating Patients at Risk of Suicide” by David Cash, JD, LLM, Assistant Vice Presidentⁱⁱ
- “Lessons to Be Learned: A Review of Post-Suicide Malpractice Lawsuit” by Ann McNary, JD, Senior Risk Managerⁱⁱⁱ

Originally posted on September 4, 2018

i <http://www.linkedin.com/in/donnavanderpool/>

ii <https://www.linkedin.com/in/annmcnary/>

iii <http://www.linkedin.com/in/charlescash/>

[LinkedIn.com/company/PRMSPrograms](https://www.linkedin.com/company/PRMSPrograms)
[LinkedIn.com/in/JustinAPope](https://www.linkedin.com/in/JustinAPope)
