President's message

A Line in the Sand

BY JENNIFER HagMAN, M.D.

Last summer, I crossed an invisible "line in the sand." A patient in whose care I was very involved committed suicide. Although it is well known that many of us will face this experience in the course of our careers, there is little preparation or education for what may be one of the most difficult experiences encountered in the professional life of a psychiatrist. The statistics say that 51% of psychiatrists have had a patient who committed suicide (Kaye 1991); other studies report that 33% of residents have experienced a patient suicide (Brown 1987). A 2005 article in the APA publication, Psychiatric News, quotes Robert Simon, M.D. stating, "There are three kinds of psychiatrists: those who have had a patient commit suicide, those who will have one commit suicide and those with both. If you practice long enough, someone will commit suicide. It's inevitable."

Little in my training or my career had prepared me for this experience. I began my psychiatry residency in 1986 and have been involved in the care of individuals with mental illness for 22 years. During my residency and child fellowship, I don't recall any seminars or small group discussions about the likely experience of a patient suicide in the course of one's career, nor do I recall any supervisor discussing this with me, or sharing their experience.

After the suicide, I felt as if I had crossed an invisible line, and found myself suddenly "on the other side," in an unfamiliar place, unsure of how to navigate my way forward, yet having to do so. Due to the severity and persistence of the patient's illness, many others had also been involved in interventions over several years. This fact broadened the depth and impact of the loss but also provided a circle of support as we worked through the experience. The range of reactions and responses from colleagues who were aware of the death was widely varied. I greatly appreciated those who shared their own experiences freely and offered support. Still, I found the experience to be a solitary one. There was the challenge of being mindful of my own emotional responses, and the impact of the experience on my interactions in my clinical practice and persona life. There was the challenge of related administrative reviews and legal consultations. There was also the need to be supportive and aware of the wide range of responses and needs of others who were impacted. Some of the most difficult challenges came in being available to and aware of the needs of the patient's family.

Many weeks after the event, I found myself in intellectualization – searching for information and articles. I called CPS to ask if we had any discussion groups or support groups for psychiatrists who had gone through this difficult experience. I was somewhat surprised to learn that we did not. However, Barbara Dygert was able to provide me with a very useful set of articles gathered up over the years on the issue of patient suicide. The articles she provided and my own subsequent literature search gave me helpful information for understanding my own experience. The APA also has a useful area on its website, under educational resources called "Helping residents cope with a patient suicide." In addition, the 2003 APA Practice Guideline, "For the Assessment and Treatment of Patients with Suicidal Behaviors" includes a section on "management of suicide in one's practice." My hope is that this column will stimulate discussion of what CPS can do to support our members and trainees to be better prepared in the tragic event of a patient committing suicide, and to help CPS members with awareness of currently available resources.

The emotional impact of a patient's suicide cannot be minimized, and includes a range of emotions: guilt, shame, denial, disbelief, anger, fear, and depersonalization. The responsibility...
to maintain confidentiality often limits the ability of the individual to discuss the loss with those in their usual support system. For those who decide to seek psychotherapy, the therapist/patient privilege will allow open discussion in treatment. Ness (1990) reports, “With striking unanimity therapists have said that formal and informal consultation with colleagues is one of the most important and helpful actions to take in coping with a patient’s suicide.” Kaye (1991) also suggests “the experience should be shared with younger clinicians, particularly those still in training. Only through personal contact with a caring mentor can the delicate issue of a patient’s suicide be addressed.” In one study, 57% of psychiatrists reported ongoing intrusive thoughts and avoidant behaviors persisting 6 months after a patient’s suicide (Chemtob 1988). There is also discussion of reactive changes one might make in clinical practice which might or might not be helpful.

Gitlin (1999) reports on an early career psychiatrist who had experienced a patient suicide in his first week of private practice. He noted that impact of a patient suicide on the psychiatrist is influenced by the relationship between the patient and the psychiatrist, and the individual psychiatrist’s psychological makeup, including personality features and the developmental stage of his or her career. Gitlin also provides some important recommendations for coping with a patient’s suicide: “Decreasing the sense of isolation, making efforts at reparative, constructive behavior and using specific cognitive defenses.” Examples of reparative efforts given included “helping others prepare for or cope with similar experiences.” In writing this column, I suppose I am still working on this myself. Kolodny (1979) reports on a support group for trainees who had experienced a patient suicide. The participants found that discussing their “shared experience helped them master the undesired challenge of working through the complex reactions which follow a death by suicide”.

A study completed by the Suicide Data Bank Project (Hendin 2000) contains the largest sample and a research approach to data collection. It finds that the intensity of the therapist’s response to a suicide is “independent of the therapist’s age, years of experience, or practice setting.” The study examines five areas: emotional reactions, changes therapists would make in treatment, support from colleagues and supervisors, interactions with relatives, and impact on practice.

The CPS packet also includes the outline of a lecture given by W. Walter Menninger, M.D. in March 1990 on “Patient Suicide and its Impact on the Therapist.” He notes that while a “fatal outcome occurs in many medical and surgical conditions, in the psychiatric arena, the most common “fatal disease” is one which ends in self-destruction.” The lecture includes advice for therapists and further discussion of the impact of this experience on growth and development in one’s career.

Another important issue is consideration of risk management and legal consultation after a patient suicide. Nearly every article I reviewed also included information about the psychiatrist’s concern about legal issues. CPS has an aritcle from a psychiatrists professional liability insurance program, which emphasizes the obligation to continue to protect confidentiality after a patient’s death. The CPS packet also includes an AMA Ethics opinion regarding “Confidentiality of Medical Information Post Mortem,” which states that “At their strongest, confidentiality protections after death would be equal to those in force during a patient’s life.” Family members often contact the psychiatrist seeking information. Despite the need to be compassionate and helpful, you must still follow state laws about who can legally give consent to release patient information, and ensure that the appropriate written documentation is obtained before any information is released or discussed. The same advice applies to requests from law enforcement for information. Maintaining confidentiality does not prevent the physician from expressing concern and caring, or offering support. The AMA article also

Continued on page 3
contains useful advice about contact with the family including a cautious approach, factors to consider, and the use of professional judgment. Appropriate documentation is also discussed.

The experience of a patient suicide has had sustained impact on my life and in my clinical practice. I still carry sadness and regret with me about this loss of life and continue to think about what could have changed the course. This patient gave me a deeper understanding of how painful and intolerable a severe, persistent mental illness can be and how inadequate many of the available interventions remain for those whose symptoms are intense and refractory. The experience also brought a harsh reality to the optimism I have always felt about recovery, and the limits of my ability to improve quality of life and outcome for those with severe and unrelenting mental illness. I have a heightened focus on suicide risk identification and suicide prevention efforts at The Children’s Hospital and in community and school based efforts. I am also focusing on ways that we can improve the information given to patients and families we interact with to heighten their own awareness and effectiveness in minimizing this risk, and responding when suicidal ideation is present. As I have now crossed this invisible line, I also see the importance of being willing to share my experience and offer support to others.

Every situation is unique and will bring its own challenges and opportunities for reflection, growth and change. I was in a setting where there were other impacted colleagues and staff. Although this created some challenges, it was largely helpful and allowed more opportunities for process and support. I would imagine that in private practice this experience might be even more difficult. If you would be interested in contributing to the discussion about how CPS can provide resources and support related to this area, please contact the office or myself via e-mail or phone.

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Program Committee Presents Fresh Idea

Please Save the Date:
November 11
for the CPS Fall Dinner Meeting

In an effort to respond to requests from members for more interaction at our meetings, the CPS Program Committee is pleased to announce that our Fall Dinner Meeting will feature tables set up as interest group discussions. Local psychiatrists with specific expertise will focus and facilitate each discussion. Attendees will have the opportunity to submit questions or case examples in advance to the facilitators to aid in tailoring the conversations to address the concerns and interests of the members.

In July, the Committee sent out an e-mail survey to members soliciting ideas for topics. The response was overwhelming with positive reactions to the concept and with many great suggestions. The topics that generated the most interest were: Countertransference; Treating Anger; CAM and Integrative Medicine; Neuroscience, Genetics, and Pharmacology; Psychiatry and General Medicine; and Confidentiality. These will be the options from which members will choose when they register for the meeting.

We will begin the evening at 6 p.m. with cocktails and time for socializing. At 7 p.m., members will join their tables for dinner and discussion.

We often hear psychiatrists lament that they feel isolated in their work and don’t have enough opportunity for collegial connection. This format has been used successfully by other organizations and the Program Committee hopes that members will give it a try. We will look carefully at evaluations after the meeting and, if it proves popular, we may add this as an annual event.

Another motivation for the novel approach is that CME meetings are becoming increasingly difficult to implement. The combination of the drop in pharmaceutical funding and the tightening of requirements for CME credits has made it financially and logistically impractical to continue to bring in expensive out-of-state speakers.

Please watch for registration information in the mail and feel free to call our office if you have any questions. With thanks to our hard working Program Committee members: Drs. Bob House, Chair, Robinette Bell, Rob Feinstein, Harley Lubin, and Sylvia Simpson.