After a Physician Suicide: Responding as an organization toolkit

How will this toolkit help me?

Learning objectives

- Provide immediate assistance to family members and close colleagues following a suicide
- Reduce the risk of suicide contagion and further distress among colleagues
- Institute organizational change to reduce physician burnout, mental health conditions, and suicide

Introduction

The death of a physician colleague by suicide is devastating, shocking, and potentially traumatizing for all involved. It feels different than the death of a patient and may feel very personal.

While tragic and untimely, thankfully, physician suicide is a rare experience. Preventing physician suicide—by recognizing early signs of burnout, distress, and mental health deterioration and providing appropriate forms of support—is crucial. In recent years, many organizations have made considerable strides in tackling burnout and promoting physician wellness. However, organizations are often uncertain about how to respond in the unexpected event of a physician suicide and need expert guidance, practical tips and tools, and reliable information.

In the event of a physician suicide, it is extremely beneficial to have a plan of action already in place. This toolkit provides step-by-step guidance for organizational and work unit leaders on how to:

- Be prepared in advance for the untimely critical incident of losing a physician to suicide
- Prevent suicide contagion (an increase in suicide or suicidal behaviors following exposure to a suicide)
- Allow the community to grieve and feel supported
- Reduce stigma related to mental health needs
- Make vulnerable members of the community aware of mental health and supportive resources and facilitate access to support

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Engage in or advance the organization’s suicide prevention efforts at a later stage

For the suicide of a trainee (resident, fellow, or student), which is a particularly vulnerable and somewhat distinct population, please see dedicated resources from the American Foundation of Suicide Prevention.

Seven STEPS for organizations to respond compassionately and effectively to physician suicide

1. Form or activate a crisis response team
2. Reach out to an emergency contact person or family member
3. Notify close colleagues
4. Notify others in the organization
5. Provide logistical support for the practice or work unit
6. Memorialize the deceased individual
7. Implement necessary organizational change

STEP 1: Form or activate a crisis response team

A crisis response team serves an important role following any critical incident, including losing a physician to suicide. The team carries out the critical aspects of crisis management in the aftermath of suicide loss: communication, support of the community and prevention of suicide contagion. This team will essentially be responsible for carrying out all of the items detailed in the subsequent STEPS of this toolkit.

This team should include:

- A team leader
- Key hospital leaders such as the chief medical officer or chief wellness officer
- Key faculty and non-clinical team members (eg., from specific departments, human resources, public affairs, Employee Assistance Program [EAP])
- Mental health or spiritual care professionals

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Aim to have four to five people on the team. Ideally, an organization will form the team *before* a suicide occurs. Organizations with geographically distributed sites may need to coordinate between several crisis response teams located at each site.

Organizational processes should be put into place to ensure that the crisis response team is made aware of a physician's death by suicide. Initial notification can come from a wide variety of potential sources depending on the individual decedent, the area where they worked, and where the death occurred (in the community, out of the country, etc.). For example, a family member of the deceased physician may notify someone at the organization, or a colleague may learn about the death from social media. A family member, employee, or colleague should be able to inform and activate the crisis response team through a centralized operator, regardless of the time of day or day of the week.

Upon activation, the crisis response team notifies and supports the impacted work unit leadership team (eg., department chair or clinical unit leader), as well as organizational leadership and human resources. It may also be appropriate to notify the organization’s legal and public affairs teams (eg., in case of death by suicide on the organization’s property). An “After a physician suicide” checklist is a good starting and grounding point for the crisis response team.

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**STEP 2: Reach out to an emergency contact person or family member**

In the event of a physician suicide, it is imperative that department or work unit leadership, with the support of the crisis response team, reach out to the deceased’s emergency contact person or a close family member. Making contact is difficult but necessary.

The purposes of quickly reaching out are to:

- Share heartfelt condolences.
- Briefly provide further information regarding support and benefits, which will be coming as soon as the family is ready to engage in those topics.
- Learn what and how the organization can share information with the deceased’s colleagues and the broader organization:
  - Give them the option to take more time to let the information settle in. Family members are often in acute shock in the first several days following the death.

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Sometimes when family members are newly processing their loved one’s manner of death, they are not ready to share the information with others. If they are unwilling to share that the death was a suicide with the health care community, accept this and give them time.

Reassure the family that while research has found that it is helpful for the grieving community to know that the death is being acknowledged as a suicide, no further details about the method or circumstance need to be shared publicly.

Share that the organization’s leaders understand that suicide occurs as the result of suffering and that there is no stigma or shame to be associated with this tragic loss.

Answer questions:

- Clinical questions regarding the death and medical treatments before death should be directed to the physician(s) who cared for the deceased. If the treating physicians are part of the same organization as the deceased, you can offer to facilitate contact. Do not speculate on what might have happened.
- Questions and concerns related to health insurance, retirement plans, life insurance, etc., should be directed to human resources.
- Direct questions related to the death certificate process, autopsy services, tissue or organ donation, research, and other end-of-life and postmortem care inquiries to the appropriate personnel within the organization or medical examiner’s office.

Let them know that you will follow up in one to two days to discuss any other things that come up.

A detailed list of topics to cover is described in Table 1, "Topics to cover when you connect with the emergency contact person or a family member" (PDF).

**Q&A**

**Who should make the initial call?**

Work unit leadership is the natural point of contact for the deceased physician’s family/emergency contact even if, following this initial contact, further contact comes from human resources or other departments. If the work area leadership is uncomfortable with making the initial call, a member of the Critical Response Team can assist.

Regardless of who makes the initial call, members of the crisis response team should connect with the work unit leadership to support them as needed.
STEP 3: Notify close colleagues

Following discussions with the deceased’s emergency contact person or family member(s), and provided permission is obtained or the information is widely available to the public, the crisis response team should then work with departmental or organizational leadership to notify close colleagues in the workplace.

Goals for leaders during this process are to:

1. Be visible and proactive about communication
2. Provide credible information and dispel rumors
3. Acknowledge the grief of the community
4. Communicate about resources for support
5. Provide realistic hope while managing expectations
6. Promote cohesion and teamwork

Work unit leadership should arrange an initial notification meeting with close colleagues of the deceased physician. Share the news in person or virtually as soon as possible (within hours of finding out about death when feasible) with colleagues who worked directly with the deceased physician.

Prior to the meeting with the deceased’s colleagues, the work unit leadership team should connect with the crisis response team to discuss the tenor of the work unit and review available resources for the impacted colleagues. The crisis response team can help by describing how to conduct meetings, how to adjust staff roles as needed, and where to access available resources. Additionally, the crisis response team can provide guidance to work unit leadership on who should be at the initial notification meeting. Typically, peers need each other when in a state of normal shock, and peers can be the first point of contact to provide support during distressing times. Attention should be given to any individuals with identifiable vulnerabilities such as recent struggles, mental health history, family history of suicide, etc. In cases where specific vulnerabilities are identified, provide support and mental health resources through 1:1 outreach.
Many prefer that individuals outside the immediate work unit are not present at the initial notification meeting. At the work unit leadership’s discretion, however, one or two people from the crisis response team or relevant site-specific resources (e.g., EAP) may be invited in case any employee needs additional support. If such individuals are invited, they should remain the main point of contact during this process to allow for continuity of care. If any others are present at the notification meeting, such as spiritual care, it should be clear that they are there at the behest of work unit leadership. While helpful to have other individuals present for support, it is important that the work unit leader share the news and leads the discussion.

Vetted scripts will help unit leadership share information during the notification meeting. Key points to remember during the discussion include:

1. Encourage colleagues to support one another in grief and resiliency in the wake of the loss of their colleague and friend. It may be helpful to remember that experiencing the death of a colleague and friend is a significant event with emotional and relational impact. Death is also a spiritual matter because it affects our relationships and causes us to reflect on the meaning and purpose of our lives, as well as examine beliefs and values, including matters of existential impact.

2. Allow colleagues to express their grief. Explain that everyone’s grief response is different—some employees will need time off, while others may find solace in working. Some may notice grieving right away, and for some, it may be days, weeks, or even months from the loss. Some may not experience a “typical” grief reaction. Share information about suicide bereavement groups in the community (AFSP has a list of over 800 support groups nationwide).

3. Remind colleagues of the processes in place to access care if they need additional support and resources. Provide a list of individuals, ranging from supervisors and peer supporters to site-specific resources (e.g., EAP) to institutional and community-based mental health providers. Provide information about whom to reach out to if they are concerned about the emotional or mental health of a colleague.

4. Commit to providing coverage or changing schedules as needed (see STEP 5).

5. Remove stigma for those who have never sought mental health services before—tell them that speaking with a trained mental health professional at challenging times like these is very helpful and reassure them that seeking mental health services will not have negative ramifications on licensure. Unaddressed mental health problems are much more likely to negatively impact safe practice or medical licensure than appropriate help-seeking behaviors. At a subsequent meeting, consider having individuals in attendance share their own experiences in seeking mental health care.

6. Remind colleagues that if they have struggled with mental health issues in the past or are actively getting mental health care, they may want to check in with their mental health
7. Recognize that clinicians may feel guilty about not recognizing the signs of distress in a colleague and friend. In this situation, it is important to remind clinicians that individuals can be very adept at cloaking their emotions in order to carry out their work.

8. Provide colleagues with an easy mechanism to notify leadership if they know of others who may need to be connected with additional resources.

9. Ask colleagues to reflect on how they would like to remember the deceased. Ideas include writing a personal note to the family or doing something kind for another person. This can be discussed at follow-up meetings.

10. Let colleagues know that they will be informed of any official funeral or memorial service plans as they come into place (see STEP 6).

Sample scripts for in-person notification after a physician suicide (PDF) These sample scripts can serve as a starting point for work unit leaders to craft their own vetted scripts for in-person notifications.

Additional considerations include:

- Individuals in the same work unit as the deceased physician who were not able to attend the meeting should be informed as soon as possible, preferably by telephone and not email.
- A second meeting should be offered for individuals who want to discuss in more detail. For example, work unit leaders could offer to spend an additional 30 minutes with anyone who wants to talk further about the death.
- The work unit leader should send a follow-up email summarizing resources that were verbally shared during the meeting and any next steps.
- At the end of the initial notification meeting, work unit leadership should meet with the crisis response team to review the day’s challenges, support each other, and share experiences and concerns. Consider strategies for individuals who may need additional support, remind each other of the importance of self-care and plan for next steps and follow-up.

For a non-employed physician, many of the same principles apply as the ones delineated above. Who does the notification and to which group of clinicians depends on the situation.

Q&A

Does permission need to be obtained to share the cause of death?

Yes. The deceased physician’s family or emergency contact person provides permission to share information. However, in cases where the cause of death is undetermined, details related to the death may need to be withheld, regardless of family or emergency contact permission, until the cause of
death is confirmed and the information becomes public.

**What if the family or emergency contact does not wish for the cause of death to be disclosed?**

The cause of death should only be disclosed if approved by the family or emergency contact person. In situations where the family does not want the cause of death shared with others, it is still important to immediately acknowledge the death and follow with information about available mental health resources. Organizations have a responsibility to balance the need to be truthful with the community with the need to remain sensitive to the family’s preferences.

Work unit leaders and members of the crisis response team can take the opportunity to talk with colleagues about suicide in general terms and state:

“We know there has been a lot of talk about whether this was a suicide death. Since the subject of suicide has been raised, we want to take this opportunity to give you accurate information about suicide in general, ways to prevent it, and how to get help if you or someone you know is feeling depressed, struggling or may be suicidal.”

**What if there is uncertainty about the cause of death?**

There may also be cases in which there is disagreement between the authorities and the family regarding the cause of death. For example, the death may have been declared a probable suicide, but the family believes it to have been an accident or possible homicide.

If the cause of death has not been confirmed and there is an ongoing investigation, individuals on the crisis response team should state that the cause of death is still to be determined and additional information will be forthcoming. Work unit leaders and members of the crisis response team can take the opportunity to talk with colleagues about suicide in general terms and state:

“The cause of death has not yet been determined by the authorities. We recognize that uncertainty can fuel anxiety and stress. We are aware that there has been some talk about the possibility that this was a death due to suicide. Rumors may begin to circulate, and we ask you only to share information known to be factual since inaccurate information can be hurtful to those coping with this loss. We’ll do our best to provide accurate information as it becomes known to us.”

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STEP 4: Notify others in the organization

Organizational leadership should take the lead for communication with employees beyond the work unit. Details of the notification will vary by size and type of organization and the resources available, but the same 10 key components detailed in STEP 3 still apply. This is a great opportunity to educate individuals about the complexity of suicide—it has multiple “causes,” and we do not know all of the things that the person was contending with, physically, emotionally, or in terms of their life stressors and/or past experiences.

For this type of larger-scale communication, it is critically important to take steps to minimize that the risk of suicide contagion risk to every extent possible. Suicide contagion risk is heightened when vulnerable individuals are exposed to sensationalized communication about the suicide or when the deceased’s manner of death or life is portrayed in an idealized manner. The risk of suicide contagion is mitigated by including support and mental health resources in several communications and ensuring that every communication following the death is vetted with the following principles in mind from Table 2: "Ways to talk about suicide" (PDF).

Q&A

How should communication with media be handled?

A member of the crisis response team should be assigned to media relations. Prepare a media statement for a designated media spokesperson based on key messages about suicide and the organization’s response to physician suicide. Typically, only authorized staff or institutional communication personnel should speak with the media. It may be best to advise colleagues to avoid interviews with the media. The organization or crisis response team can provide guidance on reporting about suicide to media to minimize risk of suicide contagion.

Sample media statement (PDF)  Share this sample media statement with your crisis response team as a starting point to prepare a custom media statement for the organization
Key messages for media spokesperson (PDF)  Share this guide with the designated media spokesperson so they are prepared to field media inquiries regarding the death.

STEP 5: Provide logistical support for the practice or work unit

The crisis response team can work with a leader within the deceased's work unit or practice to help
with practical and logistical matters, including:

- **Arranging workload and inbox coverage** Consider asking colleagues from outside the immediate work unit to pitch in if possible.
- **Rescheduling patients**
- **Notifying patients of the death** This can be done in the same manner as non-suicide deaths; however, no mention of death should be made to patients until after the emergency contact or family representative has made a public announcement. Sometimes families choose not to grant permission, and in those situations, patients are not notified.

Provide a generic script to the front desk or scheduling team in the interim before a formal notification is sent, or if the emergency contact or family declines to make the information about the death public (“Dr. [Name] is currently unavailable, and we will need to reschedule your next appointment with one of the covering physicians”).

**Q&A**

**How should the work unit leaders or the crisis response team respond if law enforcement wants to speak with coworkers about a physician’s death?**

The crisis response team can work with local law enforcement to help determine whether there are certain coworkers who must be interviewed by the police. In situations where law enforcement needs to speak with coworkers to help determine the cause of death, a crisis response team member should consider notifying the organization’s legal counsel and having someone from the legal team present during any interviews.

**STEP 6: Memorialize the deceased individual**

The approach for responding to the death of a physician from suicide should be the same as from a car accident or cancer. This approach minimizes stigma and reduces the risk of suicide contagion.

If family members approve of a memorial service or remembrance event, ask them what religious beliefs they have and what would be most appropriate for them. The hope is to have a remembrance gathering or service that fits the values and beliefs of the physician who died and that also supports surviving team members in their grief. When announcing a family memorial service, include details regarding what to expect and policies for attending funerals, coverage for clinical assignments (as applicable), and other relevant details.
Memorial service planning checklist (PDF)  This checklist can help you as you consult with the deceased’s family to identify needs and assign responsibilities when planning a memorial service for colleagues.

Some important points to remember when holding a memorial service for the deceased’s colleagues include:

- In choosing a location, it is best that the memorial service not be held in regular meeting rooms; doing so could inextricably connect the space to the death.
- The location should not be the place of death.
- It is best if services are held outside of regular hours.
- If services are held during work hours, provide time off as needed.
- It is important to provide an opportunity for colleagues to be heard; it will be valuable to remind all who will be talking at the funeral the importance of emphasizing the connection between suicide and underlying mental health issues and not romanticizing the death in any way.
- Counselors and mental health professionals should attend the memorial and be available to provide support.
- Attendees should be requested, if at all possible, to turn off their phones and pagers as a sign of respect to their deceased colleague; being able to truly focus for this brief span of time means a great deal to those most intimately affected by the loss.
- Sometimes there is a desire to establish a permanent memorial (eg., planting a tree, installing a bench or plaque, establishing a scholarship). Although such memorials may not increase the risk of suicide contagion, they can be upsetting reminders to bereaved colleagues. Careful consideration should be given to whether a permanent memorial is warranted, and this should only be done if this is protocol for other types of deaths. If possible, permanent memorials should be located away from common areas of work and learning. It is also important to remember that once a permanent memorial is set up, it establishes a precedent that can be difficult to sustain over time.

Other approaches for memorialization include:

- Holding a day of community service or creating an institutional?based community service program in honor of the deceased
- Putting together a team to participate in an awareness or fundraising event sponsored by one of the national mental health or suicide prevention organizations (eg., walks in support of Out of the Darkness), or holding a local fundraising event to support a local crisis hotline or other suicide prevention program
- Sponsoring a mental health awareness day

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Purchasing books on mental health for the local library
Volunteering at a community crisis hotline
Raising funds to help the family defray their funeral expenses
Making a book available in a common space for several weeks in which colleagues can write messages to the family, share memories of the deceased, or offer condolences; the book can then be presented to the family on behalf of the community

Q&A

What about online or social media?based memorialization?

Online memorial pages and message boards have become common practice in the aftermath of a death. Organizations, with the permission and support of the deceased physician’s family, may choose to establish a memorial page on their website or on a social networking site. As with all memorialization following a suicide death, such pages should take care not to glamorize the death in ways that may lead other at?risk physicians to identify with the person who died and their suicide. It is therefore vital that memorial pages utilize safe messaging, include resources, be monitored, and be time?limited.

It is recommended that online memorial pages remain active for 30 to 60 days after the death, at which time they should be taken down and replaced with a statement acknowledging the caring and supportive messages that were posted.

If friends of the deceased physician create a memorial page of their own, it is important that the crisis response team communicate with the friends to ensure that the page includes safe messaging and accurate information. An example of recommended language for a friends?and?family memorial page could include: “The best way to honor your loved one is to seek help if you or someone you know is struggling.” When possible, memorial pages should also contain information about where a person in a suicidal crisis can get help (eg., National Suicide Prevention Lifeline at 1?800?273?TALK (8255), or the Crisis Text Line at 741?741). crisis response team members should also join any colleague?initiated memorial pages so that they can monitor and respond as appropriate.

Social media should be monitored for several weeks following the death. A member of the crisis response team who is adept at social media can watch for distressed posts by colleagues as well as for posts that get into graphic details about suicide, pictures of the location of death, or memes that make suicide seem like a positive outcome.
STEP 7: Implement necessary organizational change

There is rarely one reason a distressed physician dies by suicide. Rather, it is thought to be the culmination of multiple stressors that overwhelm an individual who then, often impulsively, acts. Work-related stressors associated with burnout can contribute.

All organizations should have programs in place to provide proactive peer support to physicians experiencing high levels of work stress, as well as a long-term commitment and sustained effort to improve physician well-being. In the weeks to months following the suicide, organizations should deeply investigate how physicians are supported in the aftermath of medical errors, during malpractice litigation suits, and in response to local drivers of burnout, implementing necessary system-level change from the top down.

Some resources to do this include:

- From the AMA: Additional AMA STEPS Forward™ toolkits on well-being and burnout along with organizational culture.
- From the Suicide Prevention Resource Center: A database of suicide prevention and awareness programs.
- From the CDC: *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*, a collection of strategies and approaches based on the best available evidence, including teaching coping and problem-solving skills and identifying and supporting people at risk.
- From the Substance Abuse and Mental Health Services Administration (SAMHSA) of the US Department of Health and Human Services: A national registry of evidence-based programs and practices. While most of these programs are not specific to suicide prevention, this database includes mental health interventions that have been scientifically tested. The registry can be filtered by topic (e.g., mental health), health condition (e.g., depression, suicide), target audience (e.g., program administrators, clinicians), resource population (e.g., primary care, adults), and resource type (e.g., guide, fact sheet, screening tool).

Conclusion
Though no one wants to prepare for a physician death by suicide, it is essential for organizations to have a concrete plan in place in case this unthinkable event occurs. This toolkit provides practical tools and resources for organizational and work unit leaders to use to support physicians and other team members within the organization in the aftermath of a physician suicide.

AMA Pearls

Form a crisis response team and a plan of action before a suicide occurs.
Communicate with colleagues in the right way at the right time using vetted scripts.
Provide maximal support from within the organization, such as through peer support.

Further reading

Journal articles and other publications


Websites

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. https://www.cdc.gov/suicide/
Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/suicide
Suicide Prevention Resource Center. https://sprc.org/
Additional tools

1. Checklist: After a physician suicide (PDF)
2. Sample scripts for in-person notification (PDF)
3. Sample media statement (PDF)
4. Key messages for media spokesperson (PDF)
5. Memorial service planning checklist (PDF)

Article information

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About the American Foundation for Suicide Prevention

The American Foundation for Suicide Prevention is dedicated to saving lives and bringing hope to those affected by suicide. AFSP creates a culture that’s smart about mental health through education.
and community programs, develops suicide prevention through research and advocacy, and provides support for those affected by suicide. Led by CEO Robert Gebbia and headquartered in New York, and with a public policy office in Washington, D.C., AFSP has local chapters in all 50 states with programs and events nationwide. Learn more about AFSP in our latest Annual Report, and join the conversation on suicide prevention by following AFSP on our social media channels.

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 and reduce health care costs.

References