



The Case of the Resident-at-Risk

Case by Drs. Mary Haas & Loice Swisher

Kristin, a second year resident, walked into the emergency department ready for another night shift. She saw her senior resident Patrick and headed over to receive handover from him.

"Hi Patrick, how was your shift today?" she casually asked, noting that he appeared exhausted.

Patrick sighed and looked over with bloodshot eyes, "Terrible..... I had the worst day and I've about had it with residency. I might as well just shoot myself.. I want to crawl into bed and just die."

"Oh no, what happened?" Kristin asked, wide-eyed.

"Everything that could go wrong, did go wrong... which seems to be the theme lately. For instance, we had an 80-year old with a CHF exacerbation who failed BiPAP. I screwed up the intubation and looked like an idiot in front of everyone in the resuscitation bay. The patient then decompensated and the attending had to take over, nearly had to perform a surgical airway. When I went to tell the wife he had died, she screamed at me and told me it was my fault," With tears beginning to appear in his eyes Patrick stammered, shaking his head in defeat, "I ... I just don't think I fit in here."

After a moment of awkward silence, Kristin responded, "Patrick, everyone has tough days, we all have been there. I bet if you get some sleep it will make a world of difference. Let's sign out so you can get out of here."

The remainder of the providers began to congregate around Patrick's computer and both residents quickly turn their attention to sign out. After handover, Patrick slipped out before Kristin had a chance to ensure he was doing ok. She shrugged it off, thinking that he would probably be fine, shifting her focus to managing her patients.

Kristin's shift went by smoothly, and was largely uneventful. At the end of her shift, she headed over to the resident lounge to finish her notes. A fellow resident, Jennifer, was also hanging out in the lounge working on some notes. Despite having 15 more

notes to dictate, Kristin couldn't stop replaying her interaction with Patrick the night before. While sitting at a computer, she thought to herself, "Something just wasn't right about how he was acting...come to think of it, this isn't the first time I've seen him that down". As she sat and thought i over, she grew increasingly worried.

"Hey Jen, have you seen Patrick lately?"

"I saw him at grand rounds last week, why?"

"He said something really weird to me last night before sign out," Kristin whispered, looking around to make sure no one would overhear.

"Yeah, like what?" Jennifer asks.

"He was telling me about a difficult case and tough encounter with a patient's wife that sounded pretty traumatizing, and then made a comment along the lines of 'Maybe I should just shoot myself.' I'm sure he was just kidding but it just wasn't right, the way he said it. It caught me off guard and I wasn't quite sure how to respond."

"Hmm, I don't know. I've never known Patrick to have any issues with depression or anything like that but I know his mom's pretty sick right now and I did hear he had several rough cases in the last few weeks. And he's also in fourth year, working a heavy shift load, doing some administrative work and I think he still has some research on the go. That's a lot to deal with... Still, we are a pretty resilient group and I wouldn't want to open up a can of worms. We all have bad runs and we push through it. Were you planning on telling someone about it? Maybe you should give our Program Director a call?"

"I don't know. I don't want to invade his privacy and make things worse. Maybe he just had a bad day... like you said we all have bad runs"

The shrill sound of a pager interrupts the conversation. Jennifer looked down, looking slightly relieved: "Look, I gotta run. I have a new consult I need to go see. I'll leave you to do your notes. See you around."

Case

Dr. Mary Haas
Dr. Loice Swisher

Objectives / Questions:

Dr. Teresa Chan

Expert Commentaries

Dr. Ramin Tabatabai
Dr. Dimitri Papnagnou
Dr. Gretchen Diemer
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Curated Community Commentary

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Questions for Discussion

1. What red flags does Patrick display that suggest he is at increased risk of suicide?
2. What do you think of both Kristin's and Jennifer's responses to the situation? What are other options for how both of them could have responded, and which approach is best?
3. What is the best way for Patrick's co-residents to respect his privacy while still ensuring his safety? What resources are available to residents at risk, and what are the barriers to utilizing them?
4. If you as the Program Director or mentor are told about this incident, how do you respond?

Competencies

ACGME	CanMEDS
Professional Values (PROF1) Team Management (ICS2)	Professional Communicator Collaborator Medical Expert

Intended Objectives of Case

1. Discuss and identify red flags for mental health issues including increased suicidality.
2. Describe an approach to handling concerns about a colleague's mental health.
3. Identify local processes and resources available to residents, mentors, and program directors.

Suicide Prevention - Identification, Engagement and Referral

by Ramin Tabatabai MD, FACEP

I can't think of a more uncomfortable scenario than openly discussing the possibility of suicide in a colleague. As emergency physicians (EPs), we are equipped to deal with nearly every critical scenario and we pride ourselves in rising up in these situations. We are rarely taught, however, how to identify the red flags of a colleague in a potential suicidal crisis. Having now spoken to several EPs who have been touched by suicide, many of us continue to feel underprepared in identifying and intervening when our presence is most needed. Is it possible to identify the red flags or "tells" of a colleague contemplating suicide? If so, what actions can we take?

The answer to whether we can identify a physician in crisis is tricky but many suicidal victims will communicate their intent sometime during the week preceding the event (QPR). In this case, Patrick expresses several concerning sentiments, though not all physicians will "disclose" their emotions so explicitly. Suicide experts may describe Patrick's comments as **indirect verbal cues**: "I might as well just shoot myself" or "I want to crawl into bed and just die." These indirect statements can be even more veiled such as "this is nothing that 20 sleeping pills couldn't cure." Other times, the statement can be a **direct verbal cue**: "I'm going to kill myself" or "I'm going to end everything." All of these statements should be taken with equal gravity. In the absence of any direct or indirect verbal cues, the only sign may be a behavioral cue (drug or alcohol abuse especially if in relapse, relinquishing of prized possessions, a sudden interest or disinterest in religion, any signs of hopelessness, irritability, anger or depression) (QPR). Other major risk factors for suicidality are a sense of social isolation or a perceived burdensomeness toward those around them (1). Therefore, any resident lacking social support can be at particular risk especially considering many residents move across the country for training.

Triggers from a life crisis such as a loss of a relationship, death of a loved one, or loss of financial security can be major contributors. Unfortunately, a work crisis can also play a significant role as in Patrick's case. As a result of his 80-year-old patient's death, he is experiencing what is known as a **"second victim" phenomenon**. A second victim can be defined as a "health care provider who is involved in an unanticipated adverse patient event... a medical error, ... or a patient related injury and becomes victimized in the sense that the provider is traumatized by the event (2)." The death of his patient and feeling of embarrassment toward the family and his attending are particularly concerning and may be the cause for his high-risk comments to Kristin. Appropriate peer support immediately following such an adverse event can significantly decrease the

chance of negative outcomes in Patrick including subsequent burnout, depression and suicide.

In this scenario, Patrick has demonstrated a clear risk for suicide and Kristin is appropriately perturbed by their interaction. If Kristin were to identify Patrick as potentially suicidal, how should she ideally respond? The most appropriate first response is that she should engage Patrick directly. Ideally, there should be no delays and the discussion would occur in a private setting. Avoiding the conversation altogether to not "invade his privacy" is likely to only further isolate Patrick and leave him without any social support. If someone in crisis does obtain the necessary help, he or she will be less likely to commit suicide in the future. Therefore simple questions such as, "How are you doing, have you been unhappy lately?" and "I'm really worried about you, are you considering suicide?" can actually be life-saving. It is equally important to not judge the person by asking a question such as, "You're not thinking of killing yourself, are you?" or "Do you know how upset people would be if you did this?"

With regard to Patrick's privacy, confidentiality and trust are integral. As a trusted confidant, Kristin can make all the difference in the world by just expressing her concern and letting him know she is on his side! The next important step is professional referral. Barriers for physicians to obtain mental health counselling include a fear of professional stigma, confidentiality breaches and professional repercussions and every effort should be made to mitigate these concerns (3). Resources will vary at the state and residency program level, but most institutions will likely offer at least one of the following: confidential counselling, an employee assistance program (EAP), or a spiritual advisor. Whether or not these services are available, at minimum, a crisis line phone number should be provided. Mobile phone apps targeted at suicide prevention also exist and can assist someone in developing a "personal safety plan". These resources are all listed below.

As an Assistant Program Director and as someone who knows the feeling of having failed to identify a colleague in a suicidal crisis, I know the pervasive negative impact that suicide can leave behind. I often speak with residents about their troubles and I often think about the possibility of suicide during each of these conversations. I strongly believe that residents should have multiple confidential pathways to discuss their challenges and we must work together as a profession to ensure these pathways are readily available at our respective programs and institutions. **Identification, engagement and referral** are all critical in suicide prevention but the very first step toward preventing suicide is to acknowledge its existence.

Expert Response

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3. Schwenk, et al. A survey on the impact of being depressed on the professional status and mental health care of physicians. J Clin Psychiatry. 2008. 69(4):617-20

Additional Resources

- **National Suicide Prevention Lifeline** 1-800-273-8255
- **American Foundation for Suicide Prevention**
<https://afsp.org/our-work/education/physician-medical-student-depression-suicide-prevention/>
- **QPR Gatekeeper Training**
<https://www.qprinstitute.com/individual-training>

Apps

- Suicide Safe App
- Virtual Hope Box
- Safety Net Personal Safety Plan

Acknowledgements

Special thanks to Drs. Loice Swisher, Christopher Doty and Paul Quinnett for their wisdom on this topic and who have empowered me to gain a deeper understanding of suicide when before I had none.



About the Expert

Dr. Ramin Tabatabai (@tabair25) is an Assistant Professor of Clinical Emergency Medicine Keck School of Medicine of University of Southern California. He locally serves as the Assistant Residency Program Director at the Los Angeles County & University of Southern California Medical Centre. Nationally, he is the current Vice Chair, Council of Residency Directors (CORD) of Emergency Medicine Resilience Committee.

A Very Delicate Situation

by Dimitrios Papanagnou MD, EdD, & Gretchen Diemer MD

The Case of the Resident at Risk highlights several challenges that residency leadership may encounter when addressing issues threatening resident wellness and mental health. It is essential that program directors (PDs) and assistant/associate program directors (APDs) are equipped with tools and resources to prepare themselves to appropriately respond to vulnerable, at-risk learners with timely and effective interventions. While each institution will be equipped with policies, procedures, and personnel to address resident mental health, several organizations provide resources (i.e., toolkits) to help PDs and APDs create a culture of physician well-being, as well as provide support in cases of resident burnout, depression, and/or suicide.

The case touches upon several issues that merit discussion; these include red flags from the protagonist (i.e., Patrick); specific behaviors from his peers (i.e., Kristin and Jennifer); responsibilities of supervising faculty members in the clinical learning environment (CLE); and expectations of residency leadership.

Focus on Patrick

Throughout the case narrative, several red flags are raised that question Patrick's well-being. His description paints the picture of a sad resident, who makes several passive comments on suicidal ideation (i.e., *"I might as well just shoot myself"* and *"I want to crawl into bed and just die"*). He also makes comments that suggest he is not connecting socially (i.e., *"I just don't fit in here"*). Significant concern is raised that his issues may have been escalating unaddressed over time (i.e., *"Patty has been fairly withdrawn and didn't seem like himself the last few months"*). These concerns are further compounded when the reader later learns that he is experiencing significant personal psychosocial stressors (i.e., *"his mom's pretty sick"*). In aggregate, the aforementioned red flags should raise significant suspicion that Patrick is at high risk for attempting suicide.

Physicians have higher rates of burnout, depression, and suicide when compared to the general population. Because of time constraints, hesitancy to draw attention to self-perceived weakness, and concern about confidentiality and reputation, physicians are less likely to seek mental care.(1,2) Given these statistics, residency leadership and colleagues have an obligation to be cognizant of red flags and appropriately act upon them.

Focus on Patrick's Peers, Kristen and Jennifer

While Patrick's red flags demand a proactive response, any reactions must be handled delicately, with sensitivity and confidentiality. Kristin was appropriate to have addressed her concern with Patrick. However, instead of discussing her concerns in the CLE where others could easily overhear, she should have pulled him aside and discussed this with him privately. Furthermore, to engage in a discussion about his suicidal comment with Jennifer, one of her peers, is inappropriate. Sharing her opinion that she was sure he was *"just kidding"* is also inappropriate and dismissive. Any joke about suicidality needs to be critically evaluated and escalated.

Kristen should have immediately escalated her concerns to the PD and/or APD. Jennifer's comment regarding resident resiliency (i.e., *"we're a pretty resilient group and I wouldn't want to open up a can of worms"*) is inappropriate and only propagates the stigma about physician burn-out and suicidality. If more physicians came forward to openly discuss their struggles, these issues would be normalized, and an environment would be created to both identify and support struggling colleagues.

Focus on Supervising Faculty in the CLE

Real-time debriefing is a strategy that is well suited to the emergency department where the teaching environment is complicated and patient outcomes can be unpredictable. This debriefing strategy encapsulates key tenets of feedback delivery including that it be *timely, specific, tailored, and learner-centered*. (3) The clinical case Patrick participated in was marked by several significant events that would have benefited from a debriefing (i.e., the failed attempt at endotracheal intubation; the patient's death; delivering bad news to the family). Discussing these events in the form of a debriefing would afford all participants involved to unload their concerns and/or questions surrounding the case. While any member of the clinical team can call for a debriefing, residents frequently struggle to initiate this dialogue, especially in the setting of an unfavorable outcome. Supervising faculty should be cognizant of the need to debrief these events, either with the entire team or, when appropriate, with the involved residents(s). It might have been helpful if Patrick's supervising attending took the initiative to debrief the event with him before the end of his shift.

Expert Response

Focus on Leadership

Once provided with this information, residency leadership should thank Kristen and assure her that escalating her concern for her at-risk colleague was the correct course of action. Another crucial step is to convey to Kristen that her confidentiality in disclosing this information will be preserved. The Program Director (PD) or Assistant Program Director (APD) should subsequently reach out to Patrick and assess if he is in any immediate danger. The PD and/or APD cannot be Patrick's treating physician. The PD/APD should escort Patrick to Employee Health Services at their respective institution to assess his fitness for duty. Specific questions or concerns can also be directed to the institution's Designated Institutional Officer (DIO) or the Office of the Dean for Graduate Medical Education (if available).

A growing compendium of information is available for residency leadership on physician wellness, burn-out, and suicidality. As examples, the Accreditation Council for Graduate Medical Education (ACGME)(4) and the American Foundation for Suicide Prevention(5) both offer toolkits that can help leadership navigate several of the issues identified in this case.

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About the Experts

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About the Experts

Dr. Gretchen Diemer (@gretchendiemer) is an Associate Professor and Vice Chair of Education for the Department of Medicine at SKMC/TJU. She served previously as a program director for a 126 resident program but gave that up to serve in her current position of Associate Dean for GME and Affiliations at SKMC/TJU. She graduated from University of Virginia Medical School and completed IM residency at Hospital of the University of Pennsylvania. Her academic interests include medical education, particularly around communication skills and professionalism as well as teaching clinical reasoning. She is married to an American History professor and has three children and is pre-contemplative for the addition of a dog to her daily chaos. She also tweets under @gmejefferson.

More Common than You May Think: Let's Talk About Suicide

by Margaret Chisolm MD

This case illustrates several key points regarding the identification and approach to addressing mental health illness in healthcare providers. First, and foremost, talk of suicide must always be taken seriously. Although Patrick's appearance of being exhausted and having bloodshot eyes could conceivably be chalked up to usual resident fatigue, his statement to Kristin "I might as well just shoot myself... I want to crawl into bed and just die" is unequivocal. Suicidal statements like this must not be ignored. This statement alone is sufficient to warrant a mental health evaluation. Almost as concerning, though, is Patrick's additional statement "I just don't think I fit in here," as this suggests an element of the cognitive distortion - negative thoughts about oneself and the world - that so often accompanies depression. Tearfulness is not necessary in order to suspect depression although it does support a decision to refer for evaluation. In this case, however, Kristin "shrugs it off, thinking he'll probably be fine and focuses on managing her patients." Thankfully, upon further reflection, she realizes that "something just wasn't right about how he was acting... come to think of it, this isn't the first time I've seen him that down" and - worried - she follows her gut and does the right thing.

It is imperative that medical students, residents, fellows, and faculty understand the clear link between depression and suicide. Since depression is the primary cause of suicide, depression education can be effective suicide prevention. The key message of any educational intervention is that depression is a common, treatable, medical illness.

Research focusing on mental illness in health care providers has facilitated raising awareness on this important topic. A 2015 systematic review and meta-analysis - which included 54 studies and 17,560 resident physicians - found a 21% to 43% prevalence of depression or depressive symptoms, depending on the instrument used. Depression prevalence was also found to be steadily increasing, with every calendar year (1).

Furthermore, depression is associated with greater long-term morbidity and mortality and, in physicians, can also adversely affect the quality of patient care (2). Suicide is the most serious risk of depression and - despite better access to health care than other populations - physicians are at higher risk of suicide than the general population (3). In fact, suicide ranks as the leading cause of premature death among physicians and female physicians seem to be at particular risk (4).

In reflecting on whether or not she should reach out to the program director, Kristin demonstrates the key decision point of this case. Kristin must weigh the potential risks of talking with

the program director, as well as the risks of not talking with the director. It is natural that Kristin would not want to jeopardize her relationship with Patrick by violating his confidence and causing him further distress. However, these understandable concerns must be weighed against the risks of not seeking counsel regarding her observations and concerns. Suicidal talk represents a potentially life-threatening situation and must be treated like any other medical emergency. If Patrick had exhibited severe dyspnea, Kristin would have had no hesitation in reaching out for help, even against Patrick's wishes. Ultimately, it is the multi-factorial explanations for suicidal talk and depression - and the stigma surrounding mental illness - that make Kristin unsure of the next step. Kristin may wonder if she is over-reacting and making a mountain out of a mole hill. She may be worried that Patrick will become angry or resentful if she reaches out for help (which he may be but he is more likely to be thankful). Suicide is a radical cure for a treatable illness and, once well, most patients are extremely grateful that someone prevented them from taking their own life. Because Kristin and Patrick are colleagues, Kristin is not in a position to make a neutral assessment of the severity of the situation. She cannot be expected to differentiate between the feeling of sadness and the illness of depression in a peer. Also, the risks are high and this case could have a deadly outcome, for which Kristin alone cannot be expected to shoulder responsibility. Reaching out to Jennifer - in this case a peer at hand - with her concerns about Patrick is a smart next step. Although Jennifer's response is not ideal - at first rationalizing and normalizing Patrick's suicidal talk - luckily she does recommend that Kristin call their program director. Another alternative would be to call another faculty member to ask them to call the program director. This is the most important lesson from this case: whether you are a peer or a faculty member - and really, regardless of what a colleague might suggest otherwise - the training program director must always be notified of suicidal talk by a resident.

The program director can then arrange a meeting with the resident to talk about the matter privately and directly. Typically, individuals with severe depression and suicidal thoughts have some ambivalence about ending their life and are actually greatly relieved - often displayed by crying - to finally be able to share their feelings with someone and to be offered a more hopeful alternative. To that end, the program director can couch the referring individual's report as one of concern and normalize this action, while being supportive and empathic and - most importantly - instilling hope. With this approach, one will only rarely encounter resistance to further evaluation. Although the program director needs to assess for immediate risk of suicide

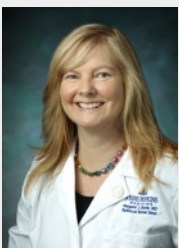
Expert Response

(which would indicate the need for an emergency psychiatric evaluation, whether the resident is willing or not), he/she should avoid making a diagnosis or treatment recommendation. Instead, the program director can introduce the idea of an outside evaluation, help address any barriers to access, and follow up with the resident to confirm that the evaluation is scheduled and, later, has taken place. Of course, maintaining confidentiality at this point will be very important.

Unfortunately, many residency training programs do not have a formal curriculum to address depression. With at least 1 in 5 residents affected by depression, this is one of the most common illnesses our physicians-in-training face. The high rate of suicide in depressed physicians underscores the importance of all trainees learning that depression is a treatable medical illness and what to do if they have concerns about themselves or a colleague.

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About the Expert

Dr. Margaret Chisolm (@Whole_Patients) is Associate Professor and Vice Chair for Education in the Johns Hopkins Department of Psychiatry and Behavioral Sciences. She is co-author of a textbook on psychiatric evaluation and editor of a book on social media in medicine. She has written more than 70 scientific and clinical articles about substance use and other psychiatric disorders, humanistic practice, and medical education. Dr. Chisolm is a member of the Miller-Coulson Academy of Clinical Excellence and recipient of the 2014 Johns Hopkins University Alumni Association Excellence in Teaching Award, and has twice been recognized as an Arnold P. Gold Foundation Humanism Scholar.

Curated Community Commentary

By Eve Purdy MD, FRCPC (candidate), MA(candidate)

This week's case, purposefully launched during Emergency Medicine Wellness week, looks at the complicated situation of concern for the safety of a resident. While opening up about the stressful time he has had in the program, Patrick a senior resident, makes comments that are concerning to the junior resident he is speaking with, Kristin. "I might as well shoot myself, I want to crawl into bed and just die" he said at one point in their discussion. In the moment Kristin struggles to know how to respond, and offers platitudes, but as the day goes on she realizes that she is quite concerned about Patrick's wellbeing. Kristin is left trying to sort out the best way to navigate her concern for his safety. She turns to her fellow resident Jennifer for counsel. Jennifer suggests that Kristin could contact their program director with the concerns but only if willing to "open up a can of worms". The readers were left to discussing multiple issues. What are the signs of increased risk of suicide? How should concerned residents navigate such interactions? How might the program director respond if she was made aware of this situation? What resources are available to residents and what are the barriers to using them?

The online community responded to the case with very thoughtful discussion. We were fortunate to have a number of experts in suicide prevention elevate the conversation. We have highlighted some themes that emerged from the discussion in the curated community commentary below. Thank you to all those who participated.

Recognizing

Contributors agreed that Patrick was in trouble. They were concerned about his physical appearance, the stresses at home, his feelings of incompetence, and his failed sense of belongingness. Multiple contributors raised the issue of second victim syndrome and suggested that Patrick may be struggling with this given his recent stretch of difficult cases. Michael Myers pointed out that Kristin's persistent concern and gut feeling that something is wrong was something that cannot be ignored. The combination of physical, psychological, social stressors for Patrick was concerning to readers.

Most worrisome, however, were what Paul Quinnett described as "Suicide Warning Signs". Twice in the same conversation Patrick very directly vocalized his desire to kill himself. Paul pointed out that suicide warning signs almost always precede an attempt. He suggests that we should be trained to detect these and must respond appropriately or risk the worst possible outcome.

Contributors

Thanks to the participants (in alphabetical order) for all of their input:

MJ Brown	Michael Myers
Lauren Falvo	Alicia Pilarski
Andy G	Sameed Shaikh
Robert Lam	Loice Swisher
Tamara McColl	Paul Quinnett

Responding

Contributors recognized that in his interaction with Kristin, Patrick was exceptionally vulnerable. They believed that responding appropriately in the moment both as an individual but also as an institution was best.

At the individual level readers felt that Kristin was nice but not necessarily supportive or direct enough in addressing suicide warning signals. Kristin minimized Patrick's feelings by saying "everyone has tough days" and "get out of here and get some rest". These responses may have Patrick believe that he was not listened to or worse he was heard but no one cares. Paul Quinnett pointed out that denial and avoidance are the most common responses when we faced with suicide warning signals. Directly addressing them can feel uncomfortable but is likely the best way to show to Patrick that he has been heard and that Kristin is concerned and available for support. Paul suggests that she could have said, "Patrick, what you just said frightens me. I know things have been rough. So, I need to know if you've been having thoughts of ending your life. Have you?" Such frank dialogue validates Patrick's feelings and offers an opening for him. Multiple contributors pointed out that this is a conversation that we feel comfortable having with our patients when they display depressive affect and suicidal intent and that these signs should be taken just as seriously when we happen upon them in our colleagues. Contributors were less concerned about Patrick's privacy and more concerned about Patrick's safety.

Sameed Shaikh eloquently stated that "concern for self-harm should be treated like a sepsis workup in a newborn- you do everything until you know there is nothing serious going on." Most readers felt that Kristin should escalate her concern to someone trusted, most likely the program director.

Curated Community Commentary

The program then has a duty to respond. Contributors suggested a number of ways that it might do so including reaching out to Patrick, mobilizing confidential mental health resources, and creating for him the time he needs. Alicia suggested that a protocol be in place, similar to our protocols for chest pain, that residents and faculty can follow when they come in to contact with a colleague who is displaying the worrisome signs described above. She suggests that such a protocol be distributed widely, and often, then put into action when needed.

Culture of Support

Culture is a learned set of values, beliefs, and practices that are shared amongst a group of people. Our contributors identified many medical cultural factors that make it more likely that residents like Patrick will face barriers to seeking help.

Robert Lam described the “warrior mentality”. Medicine is a culture in which we value competition, autonomy, invulnerability and power. Sameed further identified the “chin-up and move-on” tendencies of our profession. Contributors identified that these, and other, traits make it difficult to seek help because one will fear losing her job but perhaps more importantly her sense of self. These values are taught systematically and in the hidden curriculum throughout medical training and are reinforced in our day-to-day interactions with colleagues.

However, our contributors feel that there are ways to change the culture. While reading the comments I could sense an optimism towards the way we might treat each other better, for as MJ Brown and Michael Myers eloquently said “we are our brother’s and sister’s keepers in medicine”. Contributors

discussed a number of mentorship and peer support programs designed as prophylaxis and treatment. They highlighted the necessity of a culture of support, of truly wanting what is best for our colleagues and trainees as humans. Readers felt that discussing mental health openly and normalizing conversation about the challenges we face is a first step towards “leaving no colleague behind.”

To that end we ask you to please share this case widely. Teach with it, tweet it, send it to your departmental leadership and to your residents. Discuss and watch for suicide warning signs. Work towards building a culture of support. We are our brother’s and sister’s keepers.

There were a number of resources and articles shared this week:

- This video released by the American Foundation for Suicide Prevention is specifically related to suicide in medical trainees. There are a number of resources for program directors and trainees at this page also. <https://afsp.org/our-work/education/physician-medical-student-depression-suicide-prevention/>
- This article highlights the psychological challenges physicians face when involved in poor outcomes: <https://www.babble.com/parenting/humans-of-new-york-dr-la-quaglia-pediatric-surgeon-lose-child-in-his-care/>
- [Onsuicide.com](#) is Paul Quinnett’s, a suicide prevention professional’s, blog whose expertise was greatly appreciated in our discussion this week.

About

The Medical Education In Cases (MEdIC) series puts difficult medical education cases under a microscope. We pose a challenging hypothetical dilemma, moderate a discussion on potential approaches, and recruit medical education experts to provide their insights. The community comments are also similarly curated into a document for reference.

Did you use this MEdIC resource?

We would love to hear how you did. Please email MEdIC@aliem.com or tweet us @Brent_Thoma and @TChanMD to let us know.

Purpose

The purpose of the MEdIC series is to create resources that allow you to engage in “guerrilla” faculty development – enticing and engaging individuals who might not have time to attend faculty development workshops to think about challenging cases in medical education.

Usage

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