

## AFTER A PHYSICIAN SUICIDE – EXECUTIVE SUMMARY

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### 1. Form a *Crisis Response Team (CRT)*. Membership should include:

- a. Chief Medical Officer
- b. Chief Wellness Officer/Physician Wellness Lead
- c. Communications/Public Affairs
- d. Peer support
- e. Representation from the following departments/roles should be enlisted at the time, dependent on circumstances:
  - i. Departmental Chief
  - ii. Division Head
  - iii. Human Resources
  - iv. EAP services
  - v. Legal services

### 2. Timeframe of events (responsible person in parentheses):

- a. **Within hours:**
  - i. Activate the CRT (*CMO/CWO/Chief of Service*)
  - ii. Enlist other members (see above) as the situation evolves
- b. **Within 24 hours:**
  - i. Reach out to family (*Division/Departmental Head*)
  - ii. Notify close colleagues (*Division Head, CRT & Peer Support*)
  - iii. Notify others in the organization via (*CRT, Communications & Peer Support*)
  - iv. Provide logistical support to the Division/work unit (*Division Head and CRT*)
- c. **Within several days/week:**
  - i. Memorialize the deceased individual (*Divisional leadership and colleagues*)
- d. **Over weeks/months**
  - i. Continue to provide support to the Division/work unit (*Divisional leadership & peer support*)
  - ii. Implement institutional change (*CMO/CWO*)

### 3. Helpful information in the attached whitepaper:

- a. Checklist for the first 24 hours (page 17) – **an essential document**
- b. Topics to cover when reaching out to the family (page 5)
- c. Sample scripts for in-person notification of colleagues after a suicide (pages 18-20)
  - i. Ways to talk about suicide (page 9-10)
- d. Sample media statement & information for PA/Communications (pages 21-22)
- e. Memorial service planning checklist (page 23)

# After a Physician Suicide

Respond Compassionately and Effectively as an Organization



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## How Will This Toolkit Help Me?

### Learning Objectives

- 1 Provide immediate assistance to family members and close colleagues following a suicide
- 2 Reduce the risk of suicide contagion and further distress among colleagues
- 3 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
- 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



## 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

Aim to have 4 to 5 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.



#### **Checklist: After a Physician Suicide**

Use this checklist as a starting point for your organization's Crisis Response Team and/or work unit leader.

## 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. 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 healthcare 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 1 to 2 days to discuss any other things that come up.

A detailed list of topics to cover is described in Table 1 below:

**Table 1. Topics to Cover When You Connect With the Emergency Contact Person or A Family Member**

First call   as soon as possible
<ul style="list-style-type: none"> <li>• Introduce yourself and explain your role in the organization.</li> <li>• Explain the reason for your call and offer condolences.</li> <li>• Ask what they have been informed of thus far, and gather any other knowledge or thoughts they may have.</li> <li>• Ask permission to speak with other clinicians or non-clinical team members about cause of death.</li> <li>• Offer to meet.</li> <li>• Explain the assistance the organization can provide (general, can hold details for next call).</li> <li>• Explain the potential for media attention. Make sure the contact knows that they are not obligated to take interviews and can refer media to the organization’s communications team if they prefer. If this is their preference, provide a name and number to direct all media inquiries to.</li> <li>• Provide your contact information.</li> <li>• Ask how best to make contact going forward (phone number, email, if evening or weekends are okay).</li> <li>• Make commitment to calling again in the next day or two.</li> </ul>
Second call   24 to 48 hours after the first call
<ul style="list-style-type: none"> <li>• Ask about willingness to share funeral or memorial plans, if flowers may be sent, and if colleagues may attend.</li> <li>• If appropriate, ask about desire for onsite memorial service and acceptable venue.</li> <li>• Offer more detailed assistance the organization can provide:               <ul style="list-style-type: none"> <li>• Collect the deceased physician’s belongings.</li> <li>• Assist with travel plans for any out-of-town family members.</li> <li>• Collect condolence notes and send to the family in one package.</li> <li>• Assist with administrative or human resource issues (insurance, final paycheck).</li> </ul> </li> <li>• Discuss the organization writing an obituary.</li> <li>• Provide resources for suicide loss survivors (<a href="https://afsp.org/loss">afsp.org/loss</a>).</li> </ul>
Subsequent call(s)   up to several weeks later
<ul style="list-style-type: none"> <li>• Follow up on any of the above items as needed.</li> <li>• Discuss the need to return any property of the organization (eg, electronics).</li> </ul>

*\*Adapted with permission from [After a Suicide: A Toolkit for Physician Residency/Fellowship Programs](#) developed by the American Foundation for Suicide Prevention and Mayo Clinic.*

## Q&amp;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.

## 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, 1 or 2 people from the Crisis Response Team or relevant site-specific resources (eg, 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 shares 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 nation-wide](#)).
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 (ie, 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 practitioners.
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

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.”*

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.<sup>1</sup> 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:

Table 2. Ways to Talk About Suicide

Give accurate information about suicide	By saying...
<p>Suicide is a complicated behavior. It is not caused by a single event.</p> <p>Research is very clear that in most cases, underlying mental health conditions like depression, substance abuse, bipolar disorder, PTSD, or psychosis (and often comorbid occurrence of more than one) were present and active leading up to a suicide. Mental health conditions affect brain functioning, impacting cognition, problem-solving, and the way people feel. Having a mental health problem is actually very common and is nothing to be ashamed of, and help is available.</p> <p>Talking about suicide in a calm, straightforward manner does not put ideas into other physicians’ minds.</p>	<p>“The cause of [Name]’s death was suicide. Suicide most often occurs when several life and health factors converge, leading to overwhelming mental and/or physical pain, anguish, and hopelessness.”</p> <p>“There are treatments to help people with mental health struggles who are at risk for suicide or having suicidal thoughts.”</p> <p>“Since 90% of people who die by suicide have a mental health condition at the time of their death, it is likely that [Name] suffered from a mental health problem that affected [Name]’s feelings, thoughts, and ability to think clearly and solve problems in a better way.”</p> <p>“Mental health problems are not something to be ashamed of—they are a type of health issue like any other kind, and there are very good treatments to help manage them and alleviate the distress.”</p>
Address blaming and scapegoating	By saying...
<p>It is common to try to answer the question “Why?” after a suicide death. Sometimes this turns into blaming others for the death.</p>	<p>“The reasons that someone dies by suicide are not simple and are related to mental anguish that gets in the way of the person thinking clearly. Blaming others—or blaming the person who died—does not acknowledge the reality that the person was battling a kind of intense suffering that is difficult for many of us to relate to during normal health.”</p>

<p><b>If asked about the method of death, be open but brief, without going into graphic detail</b></p>	<p><b>By saying...</b></p>
<p>Talking in graphic detail about the method can create images that are upsetting and can increase the risk of imitative behavior by vulnerable individuals.</p> <p>If asked, it is okay to give basic facts about the method, but don't give graphic details or talk at length about it. The focus should not be on how someone killed themselves but rather on how to cope with feelings of sadness, loss, anger, etc.</p>	<p>"It is tragic that [Name] died by suicide. Let's talk about how his death has affected you and ways for you to handle it."</p> <p>"How can we figure out the best ways to deal with our loss and grief?"</p>
<p><b>Address anger</b></p>	<p><b>By saying...</b></p>
<p>Accept expressions of anger at the deceased and explain that these feelings are normal.</p>	<p>"It is not uncommon to feel angry. These feelings are normal, and it doesn't mean that you didn't care about [Name]. You can be angry at someone's behavior and still care deeply about that person."</p>
<p><b>Address feelings of responsibility</b></p>	<p><b>By saying...</b></p>
<p>Reassure those who feel responsible or think they could have done something to save the deceased.</p> <p>Many physicians have exceedingly high expectations of themselves, and along with medical training, they may feel that they should have detected signs of suicide risk. The reality is that many cloak their internal distress (to their detriment) so that it can be challenging for even the closest people in their lives to observe the change in their mental state. This highlights the importance of asking and caring when you notice even subtle changes in others' usual way of behaving and approaching problems.</p>	<p>"[Name] was a colleague, a friend, and not your patient. No one has the ability to predict imminent suicide. We do know that talk saves lives. If your gut instinct tells you something is different about a colleague's behavior, engage in a conversation with them, and if you are concerned, encourage them to seek help and consider letting [Name of appropriate person] know."</p> <p>"This death is not your fault. This is an outcome we all would have wanted to prevent, and no one action, conversation, or interaction is what caused this."</p> <p>"We can't always predict someone else's behavior. Especially when many of us are able to hide distress."</p>
<p><b>Promote help-seeking</b></p>	<p><b>By saying...</b></p>
<p>Advise physicians to seek help from a trusted mentor or mental health professional if they or a friend are feeling depressed.</p> <p>Communicate that we don't need to wait for a crisis—early help-seeking is a sign of strength. If colleagues have thoughts of self-harm, encourage them to call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255), text HELLO to the Crisis Text Line at 741-741, go to the emergency room, or call 911.</p>	<p>"We are always here to help you through any problem, no matter what. Who are the people you would go to if you or a friend were feeling worried, or depressed, or had thoughts of suicide?"</p> <p>"There are effective treatments to help people who have mental health struggles or substance use problems."</p> <p>"Suicide is never an answer."</p> <p>"This is an important time for all in our community to support and look out for one another. If you are concerned about a friend or colleague, you need to be sure to tell someone."</p> <p>"Whether you get help from recommended resources or others, the important thing is to get help when you need it."</p>

\*Adapted with permission from [After a Suicide: A Toolkit for Physician Residency/Fellowship Programs](#) developed by the American Foundation for Suicide Prevention and Mayo Clinic.

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**

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**

Share this guide with the designated media spokesperson so they are prepared to field media inquiries regarding the death.

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.

## 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

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

- 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&amp;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.

## 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 (eg, mental health), health condition (eg, depression, suicide), target audience (eg, program administrators, clinicians), resource population (eg, primary care, adults), and resource type (eg, guide, fact sheet, screening tool).

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## 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.
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# Further Reading

## Journal Articles and Other Publications

- Stone DM, Holland KM, Bartholow BN, Crosby AE, Davis SP, Wilkins N. *Preventing suicide: a technical package of policies, programs, and practice*. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2017. Accessed September 8, 2021. doi:[10.15620/cdc.44275](https://doi.org/10.15620/cdc.44275)
- Dyrbye L, Konopasek L, Moutier C, for the American Foundation for Suicide Prevention. *After a suicide: a toolkit for physician residency/fellowship programs*. Accessed September 14, 2021. <https://www.datocms-assets.com/12810/1578318836-after-a-suicide-a-toolkit-for-physician-residency-fellowship-program.pdf>

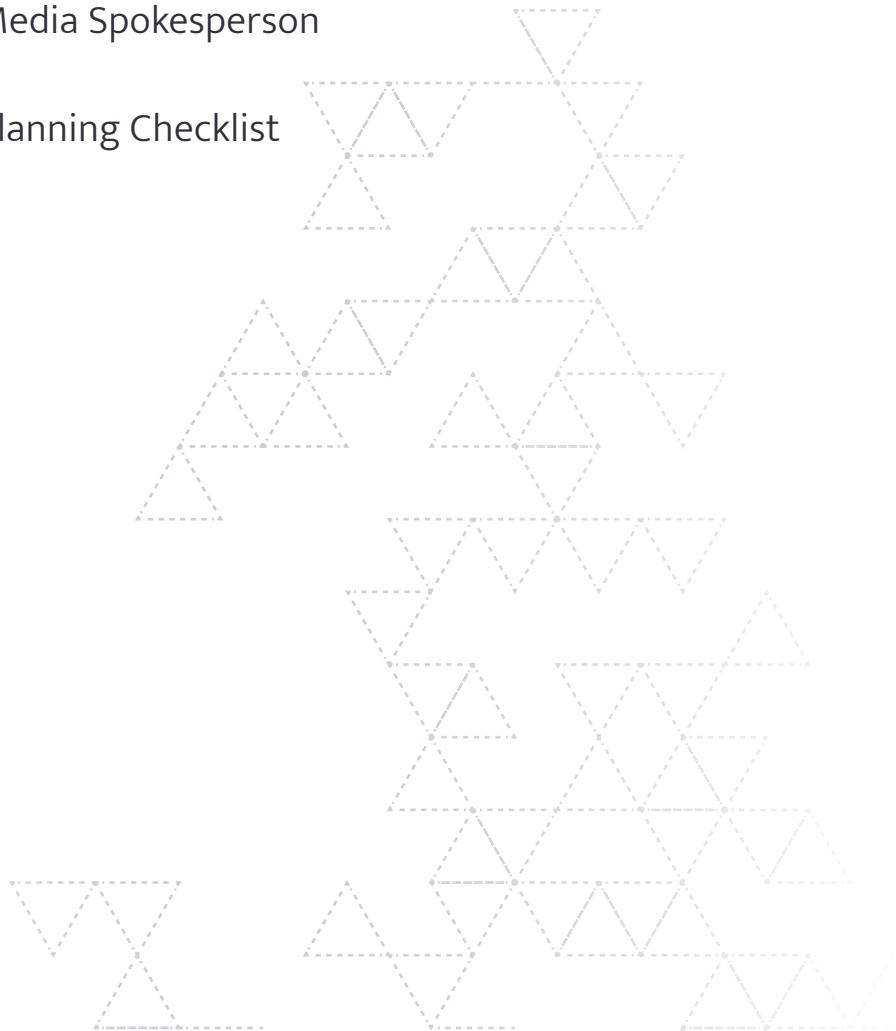
## Websites

- American Foundation for Suicide Prevention. <https://afsp.org/>
  - 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/>
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# Additional Tools

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# Checklist: After a Physician Suicide

Upon receiving the tragic news of the death of a colleague, clinical and non-clinical team members will experience a range of grief responses. This document provides tools and information about resources at leadership’s disposal that may be utilized as deemed appropriate and beneficial. These tasks can be split among the Crisis Response Team and work unit leader.

Day 1		
Action	Person Responsible	Completed [Date/Time]
Collect your thoughts. Take some initial time to reflect on the person and the event.		
Activate the Crisis Response Team.		
Notify local/work unit leadership as soon as possible.		
Contact the deceased’s family or emergency contact person.		
Notify close colleagues (in person, if possible; otherwise, virtually).		
Ensure continued coverage of the deceased’s workload, as needed.		
Task someone in the relevant work areas to manage support logistics for team members who may need additional support.		
Notify others within the organization.		
Day 2		
Action	Person Responsible	Completed [Date/Time]
Connect with site-specific resources (ie, Employee Assistance Program) for any employee issues that arise, as needed.		
Consider activating a <a href="#">peer support program</a> .		
Check in with individuals in the work unit or department.		
Check in with the deceased’s family or emergency contact regarding memorial service planning, additional questions, and their access to support services.		

*\*Adapted with permission from [After a Suicide: A Toolkit for Physician Residency/Fellowship Programs](#) developed by the American Foundation for Suicide Prevention and Mayo Clinic.*

# Sample Scripts for In-Person Notification

## Cause of death is confirmed as suicide

It is with great sadness that I have to tell you that [Name] has died by suicide. All of us want you to know that we are here to help you in any way we can.

A death of a colleague presents us with many questions that we may not be able to answer right away or at all due to patient confidentiality. Rumors may begin to circulate, and we ask that you not spread rumors you may hear. We'll do our best to give you accurate information as it becomes known to us.

**It is important to remember that death by suicide often is caused by a confluence of several stressors in an individual's life. There are risk factors, but those may not have fully been known to family, colleagues, and friends; further, it can be difficult to recognize that someone is getting overwhelmed by such internal turmoil.**

Each of us will react to [Name]'s death in our own way, and we need to be respectful of each other. Feeling sad is a normal response to any loss. Some of you may not have known [Name] very well and may not be as affected, while others may experience a great deal of sadness whether you knew [Name] or not. All types of emotions are common following the loss of someone you know—sadness, confusion, guilt, anger, numbness. Some of you may find you're having difficulty concentrating, and others may find that diving into such activities as your work or exercise are good distractions.

We have counselors available to help you deal with this sad loss and to enable us to understand more about how to stay healthy. If you'd like to talk to a counselor, these are the contacts: [Contacts].

Sometimes, as health care providers, we may feel responsible for the death of a colleague. We may wonder if there was something that we could have done differently. First, remember that [Name] was a colleague, a friend, and that [Name] was not your patient. Although we are not able to predict death, we do know that reaching out for help and talking saves lives. If you are worried about one of your colleagues, please reach out to them and have a caring conversation or let us know about your concern.

This is a time to take a moment to be together, to remember [Name] in our grief, and to support one another. Please remember that we are all here for you.

Cause of death is unconfirmed →

## Cause of death is unconfirmed

It is with great sadness that I have to tell you that [Name] has died. All of us want you to know that we are here to help you in any way we can.

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 [manner or cause of death, eg, COVID-19, 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. Please also be mindful of the use of social media in discussing this event. We'll do our best to give you accurate information as it becomes known to us.

Each of us will react to [Name]'s death in our own way, and we need to be respectful of each other. Feeling sad is a normal response to any loss. Some of you may not have known [Name] very well and may not be as affected, while others may experience a great deal of sadness whether you knew [Name] or not. All types of emotions are common following the loss of someone you know—sadness, confusion, guilt, anger, numbness. Some of you may find you're having difficulty concentrating, and others may find that diving into such activities as your work or exercise are good distractions.

We have counselors available to help you deal with this sad loss and to enable us to understand more about how to stay healthy. If you'd like to talk to a counselor, these are the contacts: [Contacts].

Sometimes, as health care providers, we may feel responsible for the death of a colleague. We may wonder if there was something that we could have done differently. First, remember that [Name] was a colleague, a friend, and that [Name] was not your patient. *[In case of death by suicide, consider adding information along these lines: Although we are not able to predict death, we do know that reaching out for help and talking saves lives. If you are worried about one of your colleagues, please reach out to them and have a caring conversation or let us know about your concern.]*

This is a time to take a moment to be together, to remember [Name] in our grief, and to support one another. Please remember that we are all here for you.

Cause of death may not be disclosed →

## Cause of death may not be disclosed

It is with great sadness that I have to tell you that [Name] has died. All of us want you to know that we are here to help you in any way we can.

The [family or emergency contact] has requested that information about the cause of death not be shared at this time.

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 from [manner or cause of death, eg, COVID-19, suicide]. Rumors may begin to circulate, and we ask that you only share information known to be factual since inaccurate information can be hurtful to those coping with this loss. We'll do our best to give you accurate information as it becomes known to us and as we are allowed to share.

Each of us will react to [Name]'s death in our own way, and we need to be respectful of each other. Feeling sad is a normal response to any loss. Some of you may not have known [Name] very well and may not be as affected, while others may experience a great deal of sadness whether you knew [Name] or not. All types of emotions are common following the loss of someone you know—sadness, confusion, guilt, anger, numbness. Some of you may find you're having difficulty concentrating, and others may find that diving into such activities as your work or exercise are good distractions.

We have counselors available to help you deal with this sad loss and to enable us to understand more about how to stay healthy. If you'd like to talk to a counselor, these are the contacts [Contacts].

Sometimes, as health care providers, we may feel responsible for the death of a colleague. We may wonder if there was something that we could have done differently. First, remember that [Name] was a colleague, a friend, and that [Name] was not your patient. *[In case of suspected death by suicide, consider adding information along these lines: Although we are not able to predict death, we do know that reaching out for help and talking saves lives. If you are worried about one of your colleagues, please reach out to them and have a caring conversation or let us know about your concern.]*

This is a time to take a moment to be together, to remember [Name] in our grief, and to support one another. Please remember that we are all here for you.

*\*Reprinted with permission from [After a Suicide: A Toolkit for Physician Residency/Fellowship Programs](#) developed by the American Foundation for Suicide Prevention and Mayo Clinic.*

# Sample Media Statement

It may be necessary to proactively or upon request provide a statement to local media outlets. Such statements will likely need to be reviewed by the organization's communication and legal team. In some states there may be a state law regarding discussing cause of death. A sample script is below:

We were informed by the coroner's office that [Name] has died. The cause of death was suicide.

OR

We were informed by the coroner's office that [Name] has died unexpectedly.

[Name] was a [position/title] at [Organization Name].

Our thoughts and support go out to [Name]'s family and friends at this difficult time.

Trained crisis counselors will be available to meet with colleagues, employees and staff starting tomorrow and continuing over the next few weeks as needed.

Research has shown that graphic, sensationalized, or romanticized descriptions of suicide deaths in the news media can increase the risk of suicide contagion ("copycat" suicides). Media coverage that details the location and manner of suicide with photos or video increases risk of contagion.

Media should avoid oversimplifying the cause of suicide; this gives people a simplistic understanding of a very complicated issue, and doesn't allow for learning about the many risk factors that can be points for intervention.

Media should include links to or information about helpful resources such as local mental health resources, the National Suicide Prevention Lifeline at 1-800-273-TALK (8255), and the Crisis Text Line at 741-741.

Media are strongly encouraged to refer to the document "Reporting on Suicide: Recommendations for the Media," which is available at [afsp.org/media](https://afsp.org/media).

*For further questions, please contact [Name of organization's media contact].*

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# Key Messages for Media Spokesperson

For use when fielding media inquiries:

## Suicide and Mental Illness

- Suicide is one of our nation's leading, yet preventable, causes of death.
- Among the top ten leading causes of death in our nation, suicide continues to be on the rise; we must invest in research and prevention at a level commensurate with suicide's toll on our nation.
- The risk of suicide increases when several health factors and life stressors converge at the same time in a person's life.
- Multiple risk factors and protective factors interact in a dynamic way over time, affecting a person's risk for suicide; this means there are ways to decrease a person's risk, once you learn which modifiable risk factors are pertinent in a particular person's life (eg, getting depression treated and well managed; limiting use of alcohol, particularly during times of crisis; developing healthy boundaries in relationships; limiting exposure to toxic people; developing healthy self-expectations and accepting imperfection as a part of life).
- We are learning how to connect the dots and notice warning signs, to detect when people are at increased risk. Suicide is preventable.
- Depression and other mental health problems are the leading risk factors for suicide. More than 90% of people who die by suicide have an underlying mental health condition such as depression.
- Mental health can be treated and optimized like any other aspect of health. Depression is among the most treatable of all mood disorders; more than three-fourths of people with depression respond positively to treatment.
- The best way to prevent suicide is through early detection, diagnosis, and vigorous treatment of depression and other mental health conditions, including substance use problems.
- Physicians are more likely to die from suicide than people of many other professions.

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# Memorial Service Planning Checklist

In consultation with the family, the following details may be considered:

Detail	Who	When	Notes/Completed
Name and date of remembrance			
Location			
Order flowers			
Obtain a sign-in book for the family to keep			
Framed picture of physician to place on easel			
Furniture needs			
How many chairs are needed			
Tables to display pictures and belongings			
Coat racks			
Tissues			
Basket to collect cards			
Catering and room reserved			
Organization: How will the program run?			
Will there be a master of ceremonies?			
Will any colleagues speak?			
Does the family feel comfortable speaking?			
Music and/or slideshow			
What music will be playing when guests arrive? Are residents or staff able to play piano at opening, during the service, and after?			
Will a slideshow be put together to run with pictures while people are arriving or as part of the memorial?			
Video—Does the family want it videotaped?			
What A/V is needed?			
Program: Who will design program for memorial?			
Support: Will counselors be on hand to support guests?			

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## Article Information

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## References

1. Sinyor M, Schaffer A, Nishikawa Y, et al. The association between suicide deaths and putatively harmful and protective factors in media reports. *CMAJ*. 2018;190(30):E900-E907. doi:[10.1503/cmaj.170698](https://doi.org/10.1503/cmaj.170698)

### 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 its 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 productivity, and reduce health care costs.