Welcome to ASA's Central Line, the official podcast series of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

DR. ADAM STRIKER:
Welcome back. This is Central Line. And I'm Dr. Adam Striker, your host and editor. Today, we're going to discuss a pretty weighty topic, but a truly vital one, an issue that's touched the lives of far too many of us, and that is physician suicide. And to help us understand and process this subject, I want to welcome to the show three fellow physicians, drs. Michael Fitzsimons, Ronald Harter and Catherine Kuhn. And to all of you, thank you very much for joining me for this important conversation.

DR. RONALD HARTER:
My pleasure.

DR. MICHAEL FITZSIMONS: Well, thank you very much.

DR. STRIKER:
Well, let's get started talking broadly about this topic. Physicians and specifically members of the anesthesia community are at high risk for death by suicide compared to other occupations or the population in general. Let's just start out giving our listeners a little bit of background on this by what is contributing to this and is there something unique about the specialty of anesthesiology that puts us at higher risk? And to start off, Doctor Fitzsimons, do you mind giving us a little bit of background?

DR. FITZSIMONS:
I really appreciate the opportunity to speak on this topic. You know, and this is not just an issue of anesthesiologists. 300 to 400 physicians die by suicide every year. This is 3 to 4 medical school classes. And male physicians have a rate that's around 1.4 times
higher than the general population. Female physicians around 2.2, 2.4 times that of the general population. And then, you know, when we add in the incidence of attempts of death by suicide and then suicidal ideation, you know, there is no doubt that this is a significant problem among very promising individuals. Among medical students, the incidence of suicidal ideation is up to 11% and of medical students up to 6.4 actually attempt to take their lives. So the problem starts early on and continues throughout our medical career.

DR. STRIKER:

I think the general conception or understanding, I should say, is that there's one key piece that leads to potentially depression and physician suicide and burnout is amongst them. But additionally, we know that substance abuse is also a risk for physicians, but particularly for anesthesiologists. And Dr. Harter, do you mind talking a little bit about those two aspects and both individually and then both how they potentially relate to anesthesiologists specifically? And then what we should be looking at as fellow physicians when it comes to these two aspects of practicing medicine?

DR. HARTER:

Yes. And I want to also express my thanks for having the opportunity to put on this presentation. Certainly, if there's one thing that I think we all agree on is that if we're going to have an impact in reducing the number of deaths by suicide, a part of that is to have it be something that we shine a light on and that we talk about openly. So hopefully to that end, this discussion will help somewhat in that regard.

So you brought up a couple of key factors -- burnout and substance use disorder. Burnout is something that prior to the pandemic, was already raging at a fairly high level within our specialty and really across all facets of health care providers. And the early days of the pandemic, it appears that there might have been a slight reduction in that because there was recognition by the public of really the heroic efforts that physicians, especially those of us in the front lines, were really putting on. But very soon into the pandemic as it wound on for weeks and months and years, burnout became a more prevalent issue than it had been previously. There's a recent survey that showed as much as 60% of health care workers now are at high risk for burnout. So this is clearly a significant problem. There are clear linkages between burnout and depression. They're not exactly the same thing, but it's clear that they both relate to each other and one certainly can contribute to the other. And then depression obviously can be a significant risk factor for death by suicide. So that is something that there's increasing awareness of that there are increasing efforts to identify opportunities at the system level as well as
at the individual provider level to reduce barriers to receiving mental health care. But I will say there's a long way that we still have to go in that respect.

Substance use disorder similarly is and it's rampant throughout our society. Unfortunately, we have had our colleagues die from fentanyl overdose for decades, unfortunately, and that is now found its way into the general public. And we're seeing the effect of that. So the substance use disorder muddies this issue, if you will, somewhat for our specialty. You know, an anesthesiologist who is found dead. It's not always clear whether that was intentional or whether it was an accidental overdose from opioid use disorder. But in any event, the end result is the same and it's tragic. But as a result of that issue, that is also a significant concern in our specialty. It tends to make the numbers of anesthesiologists' deaths by suicide be among the more frequently cited specialties within health care.

I will also add that if you think there's issues with a colleague, don't brush it off and, you know, work within your system to determine the best and safest way to proceed on that. Although having said that, oftentimes those with depression, burnout, and substance use disorder have a commonality that they may be putting their best face on their disorders when they're at work to try and evade being detected because they don't want to face whatever consequence might come from that in their employment. And so it's often that at home with either family or friends outside of the hospital system, that may be the warning signs may be evident a little sooner. That's a challenge for us, is to educate and inform the family members and the loved ones of those of us in the specialty of anesthesiology.

DR. STRIKER:

The most important thing we can talk about during this episode is what are things that we can do to help prevent a colleague from going down this pathway. Let me open this up to the rest of the panel here. Do any of you have any specific insights you can offer our listeners into what you might be able to observe or glean from behavior that might key you in on a time to intervene? I know this is not an easy question. It's easy to talk about, and it's quite another thing to actually approach a colleague with something this serious. Again, what specific insights can you potentially offer our listeners that they can utilize when they're trying to tackle this issue with another colleague? Dr. Harter, let's start with you and then I'll broaden it out to the rest of the panel.

DR. HARTER:

So that's that's hugely important point. And I think that there are various things and the warning signs are somewhat different for a colleague with substance use disorder
versus one who's burnout, depressed and maybe at risk for death by suicide. The
substance use disorder physician might be someone that they're the first one to get to
the hospital, the last one to leave. They're frequently providing breaks for colleagues.
They may show up on a weekend when they're not even on call and have some excuse
of why they're in the OR. Because the driving force there is that they need access to
their drug of abuse, usually opioids, but it may be other anesthesia related controlled
drugs. And so they really can't be away from their source of their drug or drugs of choice
for too long and in general for both substance use disorder and for burnout, depression,
suicidal ideation. You know, there may be clues that are somewhat subtle, but if they
don't want to engage in conversation, they don't want to do things outside of the
hospital. They just seem that they are not themselves, which is somewhat vague. But if
you know someone well and they just seem like they are different and more withdrawn
than what they have been previously, you know, those can be warning signs.

And I think that it's important that if you have a suspicion about a colleague having
either a substance use disorder or that they might be having plans to harm themselves,
this is something that requires a planned approach to address it. Simply pulling the
person aside and saying, hey, you know, I think you need help. That can potentially if
you don't really have things in place for them to get, if necessary, inpatient treatment for
either depression or substance use disorder, that can run the risk of having that
colleague now perhaps do something out of desperation because they are concerned
now that they're going to lose their job, they'll lose their license. Et cetera. So not to say
that you can't express some concern, legitimate concern for a colleague, but if they
really appear to be on a path where they need professional in-patient or extended
intensive services, that's something that needs to be coordinated with your leadership
and your department within your medical staff. Et cetera. And to really have a plan in
place before that person is really approached with specific concerns.

DR. STRIKER:

And Dr. Kuhn, let me get your take on that as well. Any specific insights you can offer?

DR. CATHERINE KUHN:

Yeah, Thank you. And like my colleagues, I'm really happy to be here for this important
topic today. I think in terms of warning signs and how to approach them, there is some
overlap between people who may have substance use disorder or just be profoundly
depressed and suicidal. I'm going to focus more on the suicidal end of this, realizing that
it might not be obvious right away, but I think with substance use disorder, the concern
is that the individual may feel so desperate once they are potentially discovered that
they may harm themselves, which obviously is tragic. But if someone is really just
withdrawn, depressed, seems depressed, I think we all worry that if we say something, we could make it worse and that if we raise the question about have you thought of harming yourself, that it may put an idea in their head or may cause them to take action on that. And I think that is generally not the case. People who are suicidal have been thinking about it a lot longer than than we have. Obviously, hindsight is 2020, but expressing concern as you would for anybody you care about, expressing some concern. You haven't seemed like yourself. Is there anything I can do? Showing that kind of compassion, I think is an important piece. If we're talking more here around mental illness and behavioral health issues. I think if we think about a different disease model, if you knew you had a colleague who was diabetic, not well controlled and they passed out in the O.R. one day, presumably from hypoglycemia, we would never leave them alone until they were able to get help and to get care. So if in the course of a conversation with a colleague, we learn that they are feeling suicidal, they have considered thoughts of suicide or hopelessness, I think we owe them the same consideration that we would in a situation that may not feel as stigmatizing, which is to stay with them. And I think we'll talk later about resources and things that are available. But I think one of the biggest problems with physician suicide is the stigma that's associated with admitting that you might need help. And so somebody that can be thoughtful, compassionate and be there for somebody, I think is a really important and important role that we should offer each other.

DR. STRIKER:

And Dr. Fitzsimons.

DR. FITZSIMONS:

So just want to a little bit just mention some things that are associated with death by suicide or risk factors for death by suicide or kind of what are called the vulnerabilities or profile of an individual that might be at higher risk than others, you know, status other than married, divorced or going through a marital disruption or marital breakdown, alcoholism, substance use disorders. If you notice risk taking behaviors among an individual, changes in work status or financial status or threats to that particular status or threats to your income, individuals that are have higher debt or individuals certainly that are subject to litigation. And I think also we need to remember our colleagues that have other risk factors for death by suicide, which includes our veterans that suffer from post traumatic stress disorders or individuals that are transgender or members of the LGBTQ plus community can have higher rates. So we need to also recognize that there are those factors that we see among physicians, but then factors we see among other individuals.
You know, we talk a little bit about what to do. Well, studies have shown there's three components of successful programs that address death by suicide and suicidal ideation. And they all seem to include the same three things: education, the ability to self screen and access to mental health care. And that's making sure that people actually get out and that care is available and readily available well, not only available through time, but also available logistically in a close aspect that people can get to. You know, one study showed that when they moved mental health care off campus, the utilization by individuals that were members of the care family actually decreased. The United States Air Force did a wonderful job reducing its incidence of death by suicide. But it really was an effort that involved everybody, the highest level of leadership, the battalion commanders, the company commanders, or if it's the Air Force, the wing commander, I guess, which you would say, but it also involved the family members and the mental health care professionals.

And then I do want to kind of address what has been said by our colleagues earlier is the willingness to sit down and address issues that we're concerned among our work colleagues and having a well-established system ahead. At a time breaks down those barriers. We're not reinventing the wheel every single time. We know what we're going to do, when we're going to do it, where we're going to do it, how we're going to do it. And we know the people that are involved that are actually comfortable doing this. One of the things that we do at our institution is whenever we have to sit down, whether it's related to substance use disorders or something else, we really try and have a mental health professional there, you know, so that they can kind of read the situation and provide emotional support to our colleague that may be at risk or may be suffering.

DR. STRIKER:

And this might be a good time to delineate between the terms committing suicide and death by suicide. And then also substance abuse and substance use disorder for our listeners. Doctor Fitzsimons, do you want to just follow up a little bit and maybe explain the difference with the terminology?

DR. FITZSIMONS:

I use the term substance use disorders as more of a broad term because, you know, there's substance abuse, misuse and dependence. There's a whole wide spectrum of the results of actually using substances. So I think substance use disorders is a more encompassing term. And then the term committing suicide or death by suicide. And my feeling is at the end, they're kind of the same thing. But, you know, committing suicide in a way, really, it almost kind of comes across as a little bit accusatory on the the unfortunate individual. And I feel it doesn't really address the whole spectrum of issues
that can really go into, you know, unfortunately, an individual taking their own life, regardless of who it is or how it occurs. It is always a tragic event.

DR. STRIKER:

You all have touched on already the issue that getting treatment might present particular physician when it comes to credentialing or licensing. And Dr. Kuhn, I want to ask you this question by starting with this comment that I found ... this was from a few years ago in response to a Medpage article when the data about physician suicide was presented at, I believe, the American Psychiatric Association. And I'm just going to read the comment and then use this as a means to ask you about this issue. And the comment came from from a physician. It says, “say what you will about available options for depression. The minute a physician assumes that diagnosis, he or she carries that baggage for the rest of their professional days. When a carpenter or auto mechanic is seen for depression, it's a laudable act. For a physician, that diagnosis is a potential target for perceived impairment, forced treatment and leave, and a potential for professional and financial ruin. I dare say that no other professional is so adversely affected with such a diagnosis. I often wonder how or if I would pursue help for depression in light of the cost.” And I didn't put quotes. That's the end of the quote. So I think that maybe underscores a lot of the true resistance to potentially seeking appropriate treatment. Do you mind talking about what issues are present and really how much of a true effect that might have on the prevention of a physician seeking appropriate treatment?

DR. KUHN:

I'm happy to do that. I think I certainly understand the fear that the author expresses, and I understand that that practice that we've had in both our state medical boards, our board organizations like the ABA as well as hospital credentialing committees, has been punitive in the sense of asking intrusive questions that really don't impact, don't don't have anything to do with the ability of a physician or any other provider to provide safe care. So there's a difference between having a diagnosis and being impaired by the diagnosis and whether that's depression or other. I do think that there's been a lot of progress in the last 10 or 15 years to move away from asking those intrusive questions, although it's not uniform. And I think I'll just speak from my own experience. I basically serve as part of the credentials committee here at our hospital for 400 trainees coming in every summer. And we certainly know that a lot of our more junior colleagues are much more comfortable acknowledging their struggles with mental health in the past. And I'll just say that I have not seen a single one in 10 years not be able to be credentialied. And if the workplace has a positive and supportive approach to this, it actually can facilitate having people come into an organization and have a better
chance of having the care that they will require over the time of their training and potentially their employment. So I definitely hear the concerns the writer mentioned. But I think that the ability for organizations to be able to ask a non-intrusive question like, Are you currently impaired by a medical diabetes, to use the example that I mentioned earlier, or depression? And to have the knowledge that people can answer that question know honestly and will also usually those messages are paired with knowledge of the resources that are available and messages that encourage people to take care of these diagnoses. There's you know, physicians for many years have felt that they were special or different than, you know, than the other types of people. And bottom line, we're all human beings. And and I think that physicians are just as vulnerable, if not more potentially, to some of these problems, that we're not taking care of ourselves if we don't have a process that allows people to get the help they need. At the same time, making sure that our patients, the patients that we serve, are not harmed through the practice of someone who's not well cared for. And I would argue that keeping this under wraps and not being more forthright and open about it actually is a risk to both patient safety and the well being of our physicians that we work with.

DR. STRIKER:

I'm going to pivot just a little bit. Do you mind, Dr. Kuhn, talking a little bit about how death by suicide impacts the community?

DR. KUHN:

Well, it's a huge impact. And, you know, Mike mentioned earlier 300 to 400 of these a year. But no matter how many times I think an organization goes through this, it's devastating. And I think there's a lot of communities around any individual. So obviously, the person who died by suicide's immediate family and friends, some of which could be at the workplace, are going to be the most profoundly impacted. But then the work community really struggles because the there's always a sense of I think most people react to this sort of an event with what could I have done to prevent this or and sometimes some guilt. We also know that in any organization, people may have varied experience in the past with suicide and people who have had a family member who struggled with suicidal ideation or who died by suicide will have a very different outlook on the event compared to people for whom this is the first time they've encountered this. So it's very important to realize that there's multiple rings around that individual that are all important but sometimes have competing interests.

I think the key is that all of the communities, the smaller communities, need opportunities to work through what they're feeling, need opportunities to have conversations that in a safe place to talk about how they're feeling. As I said, a lot of
guilt often bubbles up. Like I told so-and-so that I was going to call them this weekend and get together and I got busy and I forgot. And the natural inclination, I think, is everybody wonders, could I have prevented this? Or am I responsible in some way for the action that they did? So I think that that's important thing to consider in an organization. And it is difficult sometimes to make sure that each of the circles around the person who died have their needs met, especially if the needs are conflicting. For example, many institutions or departments might have a memorial service potentially in partnership with the with the individual's family to commemorate them and to honor them. But if the family doesn't want that to happen, then it's obviously not the you know, I think most people would not want to go against the wishes of a family member of a family that is struggling with the death of their immediate relative. At the same time, there needs to be acknowledgment that the coworkers and the work family is important as well. And maybe the solution there isn't one event, but separate events to help each part of the of the family of the community accomplish what they need.

DR. STRIKER:

And Dr. Harter, what should the goal ultimately be for all of us when we look at what we should be accomplishing in trying to prevent death by suicide. Are the numbers in our profession, being physicians should be similar to the population at large, or is that the wrong framing of the issue or should we be looking at this differently to achieve a different metric perhaps? How do you see that what we should be looking to accomplish? I mean, it goes without saying, prevention of this horrible outcome for anybody is certainly what we'd like. But in terms of looking at this from a bird's eye view and a physician health perspective.

DR. HARTER:

Certainly it's laudable to have an aspirational goal that no physician, no anesthesiologist die by suicide, that we get to that point. But I think the reality is, is that deaths by suicide occur in all parts of our society and all occupations, all demographic groups. And so what we can hopefully impact is to get to where none of our colleagues die by suicide because they weren't comfortable seeking mental health. They didn't have access to the resources and the treatments that could have helped them to get on a path where they were no longer seeing the death by suicide was the only option available to them. So I think that's where we can make an impact, is to reduce some of the barriers, reduce the stigma to the extent that we can, so that we can all, as dr. Kuhn pointed out, look at this the same as as a colleague that gets diagnosed with diabetes. And, you know, we help them as colleagues to deal with their very real medical issues, whether it's with diabetes or with depression, and that everyone's open and honest about the issues that are faced. And I think if we could get to that point, that would reduce the number of
physician deaths by suicide. And I think that would be an important step in the right direction.

DR. STRIKER:

Well, I want to talk a little bit more about how to prepare and cope with this issue for all of us. So please stay with us through a short patient safety break. We'll be right back.

(SOUNDBITE OF MUSIC)

DR. ALEX ARRIAGA:

Hi, this is Dr. Alex Arriaga with the ASA Patient Safety Editorial Board. Medication errors are not uncommon in health care systems. In the field of anesthesiology, medications are often prescribed, prepared, and administered by a single individual, all while working in a complex and dynamic environment. Pediatric anesthesia has additional intricacies surrounding weight based dosing, physiology, and pharmacal dynamics. There are several measures to reduce the risk of medication errors in pediatric anesthesia. Ensure accurate patient weight prior to procedures. Label all syringes and use standardized color-coded labels when possible. When administering medications, particularly very small volumes, ensure the IV line is flushed and that the medication does not stay in line. Provide a well lit work space and standardized organization of medication jars. By promoting medication safety within individual systems, as well as nationally and internationally, providers can work toward providing even safer pediatric care to the

VOICE OVER:

For more information on patient safety, visit asahq.org/patientsafet22.

DR. STRIKER:

Well, we're back. And Dr. Fitzsimons, for people who have suffered a loss, do you mind talking a little bit about some of the strategies that can help families and friends and also the communities and the organizations cope and begin to heal?

DR. FITZSIMONS:

First of all, what I would do is direct individuals, especially those within the medical community, to the American Foundation for Suicide Prevention website. There's a lot of good material that's on the website that's specifically devoted towards medical schools
and residencies and fellowship and how to deal with the aftermath of a death by suicide. And there's really several key goals. One is to prevent a contagion. There have been reports of one death by suicide in an institution quickly followed by other deaths by suicide in that particular geographic area. The second is to allow the community to grieve and make sure that they feel supported. And this is one of the things that Catherine already mentioned. And then raising awareness of the mental health needs of the community.

Now, some important components, you know, after one of these events occur is to proactively, you know, today before one of these events even occurs, is develop a response plan, establish a checklist of what you need to do emotionally. Institutions are overwhelmed when one of these actually occurs, and it's important to be prepared. Identify and train a crisis response team, you know, a group of individuals that's going to get together to help deal with this. And it may be that, you know, members of the peer support team, it may be a separate team, but it should be multidisciplinary and really should include mental health professionals.

And in fact, things that need to be thought about is how we communicate. If one of these occurs, how we share the news. How do we help residents cope, understanding that there's going to be a variety of different emotions that actually occur? There's obviously going to be a tremendous amount of sadness, but there's also going to be anger. There's probably going to be some blame. Both faculty and staff need support. How do we work with the community, the community of the hospital, but also the local civilian community? As Catherine mentioned earlier, we need to consider memorialization and nowadays we have to talk about social media and how we communicate with the press. And then finally, how do we move forward and how do we improve our processes afterwards to make it easier for individuals to obtain the mental health they need and to continue to break down the barriers and the stigma associated with mental health care? You know, in long term, we need to address things at both the personal, the institutional and the scientific level if we're really going to make good progress in reducing this problem.

DR. STRIKER:

Drs. Harter and Kuhn, Dr. Fitzsimons brought up a couple topics just now that I do want to follow up with both of you on. Number one, the suicide contagion issue and the number two, institutional responsibility. And so let's start. Dr. Harter, do you mind talking a little bit about suicide contagion? It's an interesting phenomenon, and I'd just like to delve a little bit into it a little more. What causes it? How do we explain it? And is there a specifically a way to prevent it?
DR. HARTER:

Dr. Fitzsimon did a really nice summary of the issue, but I don't know that you can paint it with a single brush, but I think in many cases it's because of people who were in contact with the individual who dies by suicide and afterwards that accelerates their own mental health issues. They may be feeling guilt that they didn't prevent it. They feel like they should have and could have done something, but they didn't. And then they're carrying that guilt with them. And then that can be, unfortunately, like kind of ripples in a pond that that then impacts people that were close to if there's someone else who dies by suicide within a department or within a medical staff. And so I think the best thing that can be done is, as Dr. Fitzsimons pointed out, is to have resources available, mental health resources, make them readily accessible, really provide as much access and as much of that type of resource to really everyone in the department who might want it and even have some department level just open discussions about it. As Dr. Kuhn pointed out, you may not be able to do a memorial service, but you certainly can as a department, go through and talk through some of the challenges that people are facing in processing and dealing with the tragedy.

DR. STRIKER:

Dr. Kuhn, what do our institutions or organizations maybe as opposed to our departments or colleagues need to be doing to help prevent this, but also help the staff deal with an event of a death by suicide?

DR. KUHN:

So I would say that, again, the institutional level Mike mentioned preparation, and I think that's really important. You don't want to wait until this happens to figure out what your process should be. So preparing for this is really important and it can be simple things like what do you do if somebody doesn't show up for work? If you have a colleague who is scheduled to work and they're not there and they're not answering their page, they're not answering their cell phone, hardly anybody has landlines in their houses anymore. Is it just that their batteries are all dead or is something really going on? And so working with your institutional security or local police, whatever, for where the trigger would be to actually escalate not coming to work, to send police or security people to someone's home to do a well-being check is something that an institution should have a process for. And if the institution has a process for it, then I think that really makes it less personally stigmatizing to say they were so worried about me that they sent the police. Well, no, it's we do that for anybody that doesn't come to work. So that is an example, I think, of an institutional approach. I think knowing who the resources are and Mike mentioned many of them, but your media people, your behavioral health people, risk
management, all of this to help control the buzz that's going to happen and make sure it
doesn't go out of control, I think is important. Another element of preparation that I think
is pertinent both for behavioral health concerns as well as for substance use disorders
is to think about that, we mentioned earlier that sometimes this manifests itself at home
long before it manifests itself at work. So do departments. In this case, I think
departments have a plan or a process to educate spouses and significant others about
signs that their anesthesiologist family member might show at home before it becomes
obvious at work so that they know and that they know what resources exist for their
trainees, for themselves and for the trainees, and to try to realize that sometimes the
story they're hearing may not be the truth. Or I'll give it a personal example. I had a
resident one time who was using fentanyl and his wife believed that I was the most
obnoxious, horrible program director in the world and I was keeping him there late every
single night to do cases when that was actually not the case at all. And, you know, later
on when we spoke, she realized that this was not intentional between me and this
resident, but just his way of dealing with the denial that his diagnosis prevailed. And that
was with a substance use disorder situation. But the same thing could be true for
somebody who's just showing more withdrawal and not engagement with their families
or their friends. I think making sure that the families know what resources exist in the
institution and know some early warning signs is an important process. It helps
destigmatize this and normalizes the fact that people are going to struggle and that they
don't have to completely be overwhelmed by it.

DR. STRIKER:

I'd like to get each of you to to maybe weigh in here, if you could each choose a myth or
myth. Perception or misperception about this topic or both topics, death by suicide and
substance use disorder. What would you most like to dispel? What myth, if you will, or
what would you like our listeners to know that you wish people would understand just a
little bit better? So, Dr. Kuhn, let's start with you this time.

DR. KUHN:

Some really wise advice I got from one of our psychiatrists, a psychiatrist that I work
with, is that we can't be inside somebody else's head. And I think since we are all
generally responsible people and we do care about each other when something like this
happens, whether it's a suicide attempt or a substance use disorder diagnosis, that
becomes obvious. We all tend to look to ourselves and say, what could we have done
deeper and how could we prevent this from happening again? And I will just share a
conversation I had with the brother of someone that died by suicide who, when I said
something like that about how I'm really committed to trying to keep this from ever
happening again, he said, Well, this is the person's brother, right? This is that inner
family. He said, Well, you might, that’s nice of you to say, and I appreciate it, but you may have been able to stop at this time, but you may not, it wouldn’t have changed the outcome. And because obviously this brother had lived much longer with his sibling than any of the rest of us and knew how much trouble he’d had and how much he struggled with his mental health condition. So I think it’s important that we take those feelings where we feel some responsibility for what happened to somebody, not to ignore what happened at all, but to really focus our efforts towards making things better the next time and making the system better for the rest of the people who are left, rather than blaming ourselves for what happened for somebody else.

DR. STRIKER:

And Dr. Harter.

DR. HARTER:

I think the myth and Dr. Kuhn touched on this earlier, but that, you know, even though there’s a lot of us working to reduce the questions on both medical licensing applications and renewals and medical staff applications that refer to, have you ever sought any mental health treatment that even though those questions may still be there, either with your state medical licensing board or with your credentialing at your institution, those realities shouldn’t prevent you from seeking mental health care if you need it. And to Dr. Kuhn’s point, and I’m also not aware of an instance where someone who, you know, in response to that question would say, yes, I am being treated for depression, or I was when I was in medical school or residency or or whatever the case may be, that doesn’t lead to someone being either not getting their medical license or not getting medical staff privileges or being limited somehow in their ability to practice in the way that they previously were. So it adds an additional impediment, I would say, for people being willing to seek mental health treatment. But people just need to recognize that it’s there. But seeking mental health will not bar them from continuing to practice as they are, and if anything, it will allow them to have a longer and more fulfilling and successful career. If they do seek the whatever medical needs they have, including mental health care.

DR. STRIKER:

And Dr. Fitzsimons.

DR. FITZSIMONS:
I have two very short ones. So people often come to me and when we're talking about performing an intervention or sitting down with a colleague, one of the common questions they say is, what if I am wrong? I assure them you are never wrong to be concerned about a colleague. And I'll say it again - you are never wrong to be concerned about a colleague. If you're worried about them, sitting down in a coordinated response with the right people--and again, I always prefer a mental health professional there--is absolutely the right thing to do. The other thing is that I hope my colleagues understand that people do not talk as much about this as you think you do. We're always concerned about the stigma. We're concerned about what people are going to think of me, what my patients are going to think of me. You know what's going to be said? How am I going to be looked upon? I'll tell you the truth is in medicine, we're busy people. And the truth is we tend to move on. We tend not to dwell on things, and we don't talk about things as much as everyone thinks. So that shouldn't be a barrier. Being concerned about what's going to be the chatter in the hallway because people are very quickly going to move on. So I encourage everyone to get the help that they need. We're going to move forward after that.

DR. STRIKER:

And Dr. Fitzsimmons, do you mind just talking a little bit before you go about the resources that are available to someone in trouble or where someone could turn to, whether they're in trouble or whether colleague is?

DR. FITZSIMONS:

Absolutely. So, again, I want to emphasize again, the American Foundation for Suicide Prevention and their website is absolutely wonderful. They have some very good material that address multiple aspects of death by suicide. So we also encourage people to consider contacting the National Suicide Prevention Lifeline, 988. Also, the American Society of Anesthesiologists has a lot of material online that's available, including self-screening material that you can go to that can tell you if you're an individual that's at risk. Also, we're fortunate in Massachusetts to have a relationship with the Samaritans, and I encourage people to consider contacting the Samaritans. And you can always talk to your leadership or colleague or anyone, but just get the help that you need and get the ball rolling.

DR. STRIKER:

Thank you to all of you for joining us. To say this is an important topic is an understatement. It's incredibly important. And we here at Central Line certainly appreciate the three of you joining us to help our listeners not only understand it better,
but hopefully provide them with some resources to navigate the problem if need be. So thanks very much. Thank you. Thank you.

DR. FITZSIMONS:

Thank you. Thank you very much for the opportunity.

DR. STRIKER:

And to our listeners, if you or someone you know needs to talk, the 988 Suicide and Crisis Lifeline is available 24 seven with free and confidential support for people in distress for resources and support, visit 988 lifeline.org. Also, if you or a colleague are suicidal and need emergency help, call 911 or the National Suicide Prevention Lifeline at 988. You can contact the crisis text line by texting “home,” that’s h.o.m.e., to 741741 and visit ASA’s Suicide Prevention resources on the Web site that’s under the advocating for you tab. And that has a lot more information and resources. And thanks to all of you for joining us. And please tune in again next time.

(SOUNDBITE OF MUSIC)

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