WPHP Report

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What is the Washington Physicians Health Program Doing About Physician Suicide?

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As Washington's trusted resource for restoring the health of medical professionals, the Washington Physician Health Program (WPHP) considers physician suicide awareness and prevention an important priority – one in which we are leading efforts at state and national levels. Through our education and outreach mission, WPHP strives to provide accurate information about physician suicide as well as resources to support physicians and physician assistants (PAs) with health conditions that are associated with suicide.

Recent estimates suggest that approximately 120 physicians in the United States die by suicide each year.[1] Whether physicians in the U.S. experience elevated rates of suicide compared to the general population, however, remains unanswered. That said, studies consistently find a higher risk for female physicians vs. female non-physicians.[2]

Many medical practice variables have been suggested as potential contributors to physician suicide: burnout, moral injury, unhealthy medical education and training environments, toxic practice settings, malpractice claims, medical board complaints, and referrals to physician health programs. While these factors may relate to distress and dissatisfaction among physicians or PAs, causal links to suicide remain unclear. A review of 498 physician suicide decedents found that intimate partner problems and physical health problems were the most common circumstances associated with the deaths. About half of the physician suicides involved a firearm. Job problems were more common among physicians than non-physicians, but were found to be a contributing circumstance in less than 20% of the physician suicides.[2] While job-related stressors are prevalent in medical practice, the vast majority of physicians with these stressors will not die by suicide, and most physicians who died by suicide do not appear to have job problems. As such, examining practice stressors may inform prevention efforts, but they are poor predictors of physician suicide on an individual, case-by-case basis.

Suicide prediction, in general, is fraught. Multiple studies have shown that clinical judgement is no better than chance at predicting suicide. Current or recent psychiatric hospitalization dramatically elevates suicide risk. Yet, the positive predictive value of prior psychiatric hospitalization for future suicide – 2.5% for men and 1.5% for women – is too low to predict suicide even among these high-risk individuals. As such, universal and selective prevention strategies that seek to improve overall health and provide early intervention for distress are likely to have more impact on physician suicide than prevention efforts that rely on probabilistic suicide prediction models.[3]

Regardless of prevalence or predictability, suicide remains a tragic outcome. People in suicidal despair suffer deep emotional anguish, and suicide loss survivors often experience painful and complicated grief with persisting questions of "Why?" and "What if…?". From this perspective, even one suicide is too many. It is therefore critical to use accurate and balanced information when discussing suicide among physicians. Sensationalistic, overly simplistic reports about the "alarming epidemic" of physician suicide, relating to specific stressors or the collective problem, can misdirect resources toward ineffective advocacy and prevention efforts, add distress to surviving loved ones, cost people their jobs and careers, damage reputations, traumatize organizational cultures, discourage gifted individuals from taking leadership roles, undermine the public trust in our profession, and may increase suicide risk among vulnerable populations by discouraging help-seeking and promoting suicide contagion.

Discussions that attribute physician suicide to specific actions, events, organizations, institutions, circumstances, or conditions in the healthcare ecosystem can be interpreted as understandable efforts to grapple with meaning-making after tragic events. Complex problems in systems of healthcare delivery unquestionably contribute to burnout and distress among health care professionals. At the same time, we caution against narratives that justify the inevitability of suicide – i.e., that a "perfect storm" of events can or will lead to suicide. Instead, we maintain that dignity, hope and agency are possible regardless of circumstances. A compassionate approach should neither trivialize

nor demonize high-intensity stressors, including those related to medical practice. As recommended by people with lived experience of suicidality, we suggest an approach that focuses on a message of hope that affirms the existence of life-directed pathways: that suicide is not the inevitable consequence of any individual or set of circumstances, no matter how difficult.

As physicians and physician assistants, we have a professional responsibility to critically appraise health information and communicate accurately to the public and to ourselves. We must educate ourselves about mis- and disinformation so that we may guard against unintentionally propagating it and recognize that suicide and physician suicide are complex, nuanced phenomenon. We must be watchful for confirmation bias, recognizing how seductive it is to favor information, regardless of its accuracy, that confirms our pre-existing beliefs and values, including the understandable frustrations many of us share regarding the modern practice environment. The American Foundation for Suicide Prevention provides safe reporting guidelines for the media that can help health professionals recognize and avoid harmful communication about suicide.

WPHP has a long-standing commitment to addressing suicide among physicians. At the individual level, for program participants, WPHP's suicide risk assessment and management protocols are a model among physician health programs. While suicide risk assessment has limited utility in predicting suicide, it can help identify appropriate targets of therapeutic intervention. This represents a shift in focus from "risk assessment" to "needs assessment."[4] Every referral call to WPHP is screened for concerns of suicide and all intake assessments include the empirically validated Columbia Suicide Severity Rating Scale Screen Version. Positive screens undergo comprehensive suicide risk assessment by licensed mental health professionals and are staffed with one of our program psychiatrists. Program participants are asked about thoughts of hopelessness and suicide during any encounter where a clinically relevant increase in distress is observed. Acute distress or exacerbation of illness triggers communication with the participant's care team, identification of unmet needs, and linkages to additional resources and support as indicated.

Although not required by our DOH contract, WPHP provides 10-year suicide data to both the DOH and the Washington State Medical Association, underscoring our commitment to transparency and partnership on this important issue. WPHP is the only physician health program in the country that obtains external peer review, conducted by nationally recognized experts in physician suicide, for all program suicides. In the past 12 years, five program participants died from suicide and, while WPHP met the standard of care in each of these tragic cases, these reviews always help us improve our work.

Key findings of external reviews are provided to the WPHP Board of Directors which includes nationally recognized psychiatrists and other physician and non-physician experts who lend valuable insight to our internal and external prevention efforts.

At the local and state level, WPHP conducts educational presentations about physician suicide to Washington's medical community, including students and trainees, and recently collaborated with the Department of Health (DOH) to develop suicide training for veterinarians. In addition, we recently participated in a Washington Medical Commission webinar, Coffee with the Commission: Personal Data Questions, to report on regulatory reforms that demonstrate our shared commitment to removing barriers to seeking help for mental health conditions. WPHP is also involved in national educational events that promote physician suicide awareness and resources for physicians in distress. For example, we recently presented at the American Conference on Physician Health and participated in a national webinar on suicide prevention, Physician Suicide Prevention Listening to the Voices of Experience, sponsored by the Federation of State Physician Health Programs and the American Foundation for Suicide Prevention. Both presentations are available to the public at the links provided.

You can find more resources for suicide prevention and crisis intervention, request a speaking engagement on physician suicide, and learn more about physician health and well-being on our website. In addition, you may wish to sign up for our newsletter, where you can stay up to date on the issues in physician health and wellness of interest to you.

At the national level, WPHP is working in close partnership with the Federation of State Physician Health Programs, American Medical Association, Federation of State Medical Boards, American Foundation for Suicide Prevention, Accreditation Council for Graduate Medical Education, and the Lorna Breen Heroes Foundation on physician suicide prevention and advocacy efforts including educational sessions and webinars, communications strategies, licensure and credentialing application reform, financial support, and decreasing barriers to mental health care access across the physician and PA career spectrum. Collectively, we are aligned in the belief that these efforts will decrease stigma, increase help acceptance, and promote life - now and in the years to come.

We are sometimes asked whether a referral to WPHP might precipitate a physician or PA suicide. While we cannot know the constellation of factors that may contribute to a suicide at the point of referral, we do understand that it can be a precarious time. WPHP has the experience, expertise, and outcomes that demonstrate our ability to effectively address the health conditions that relate closely to suicide risk. We believe,

on balance, that a referral to WPHP decreases rather than increases suicide risk. Because numbers are too low to empirically validate this belief, we turn to the direct, lived experience of our program participants. 25% of program graduates report that WPHP saved their life. Experience suggests one of the most important ways we can protect our participants from suicide is by quickly establishing a collaborative connection based on mutual trust and support. In so doing, we provide a beacon of hope to help physicians and PAs navigate through despair. Over the years, countless physicians and PAs have shared with us how WPHP brought them back from the brink of suicide. These heartfelt reports deepen the meaning, purpose, and importance of our mission. You can find examples of these personal stories on our website.

We consider it a continuing privilege to serve the physicians and PAs of Washington and to be recognized nationally for our expertise and advocacy in addressing physician suicide. If you or someone you know is thinking about suicide, needs help, or has questions, do not hesitate to call us at 800-552-7236 or reach us via our website contact form at www.wphp.org.

1. Gold KJ, Schwenk TL, Sen A. Physician Suicide in the United States:Updated Estimates from the National Violent Death Reporting System. *Psychol Health Med. Aug 2022;27(7):1563-1575. doi:10.1080/13548506.2021.1903053*

2. Ye GY, Davidson JE, Kim K, Zisook S. Physician death by suicide in the United States: 2012-2016. J Psychiatr Res. Feb 2021;134:158-165. doi:10.1016/j.jpsychires.2020.12.064

3. Large MM. The role of prediction in suicide prevention. Dialogues Clin Neurosci. Sep 2018;20(3):197-205. doi:10.31887/DCNS.2018.20.3/mlarge

4. Kapur N. Management of self-harm in adults: which way now? Br J Psychiatry. Dec 2005;187:497-9. doi:10.1192/bjp.187.6.497

Medical Cannabis Update

The Medical Cannabis Program has been getting questions about whether authorization forms and recognition cards that contain the term "marijuana" are still valid. The short answer is yes. In 2022, a bill passed that replaced the term "marijuana" with "cannabis" in Washington State Law. As a part of this change, the DOH updated the patient authorization form and recognition cards to reflect the term "cannabis".

Key Information

- Recognition cards and authorization forms printed on tamper-resistant paper with the term "marijuana" are still valid.
- Healthcare providers should use the new authorization form when printing authorizations in-clinic.
- Vendors that provide forms to healthcare professionals should switch to the new authorization form as soon as practicable.
- Current recognition cards do not need to be replaced. At the next renewal cycle, patients will be issued an updated card with the term "cannabis."
- No other changes have occurred on the card or in the database.
- The term "marijuana" may still appear in the database or program resources as we go through this transition.

Related Regulations:

- Second Substitute House Bill 1210 (passed in 2022) replaces the term "marijuana" with "cannabis" in Washington state law.
- Expedited rulemaking in November of 2022 updated the term cannabis in Chapters 246-71 through 246-72 WAC.

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Need database support?
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Website: www.doh.wa.gov/MedicalCannabis

For additional training references and information, please visit the Medical Cannabis Retail Store Setup website.