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THE LEARNER'S VOICE

Patient Suicide—All for One

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"I should tell you something… My patient just committed suicide." I finally sent this message to my supervisor, after struggling for half an hour to make myself sound as calm as possible. Did I sound like I was admitting a mistake? Did I actually need to inform my supervisor, or should I have acted more responsibly by keeping the burden to myself? After all, he was my patient. He hadn't been seen by any other psychiatrist. Minutes felt like hours as I awaited my supervisor's reply.

"Are you free to meet?" We decided to meet the next morning because of conflicting schedules. Throughout the rest of the day, I couldn't focus. I scrutinised my own documentation, reconsidered my diagnosis and management plans, and looked for potential mistakes. The last clinic visit replayed in my mind repeatedly. How could I have allowed this? Why did his family call me; should I call them back? I couldn't tell anyone else, I didn't want to be judged. Why couldn't this news have waited until the suicide was confirmed, maybe it was just an accident? Back home, I struggled to sleep. More questions and doubts flooded my mind. Is this the end of my career? Will they file a lawsuit? Am I selfish to think about myself rather than the patient's family?

Amidst my anxieties, I recalled that once-off suicide sharing session that I had attended just a few weeks ago. I was the only trainee; at least ten other psychiatrists attended. They had convened to share their experiences about patient suicide—an intentional deviation from the traditional journal club or case presentation. I attended out of curiosity, to prepare for my first patient suicide, which I expected to happen after qualifying as a psychiatrist a few years later, when I would have to treat someone who would be clearly that suicidal. They shared their patients' stories, how they managed the grief of the patients' families, how they wrestled with their emotions, and their emotional recovery, even if only partial. They deliberated legal, ethical, and moral dilemmas. Inevitably, the topics of religion and spirituality arose. Some approached it philosophically. Why are psychiatrists so unprepared for suicide, they discussed; how might it be different from a palliative care doctor expecting his patients' death? After all, suicide is the most tragic outcome in psychiatry, and a matter of "when" rather than "if".

The next day, I met my supervisor, filled with apprehension. I was ready to defend myself. My anxieties were quickly quelled. Rather than an inquiry, my supervisor reassured me simply that everything I had done was reasonable, and proceeded to talk about patient suicide being a real emotional "occupational hazard," an inevitable setback in every psychiatrist's career. I was given the space to share my anxieties; we talked for an hour. A few days, a week, and a month later, my supervisor checked in on me.

As the days went by, I realized that I was fortunate not only to have a supportive supervisor, but also to have attended the suicide sharing session. Whereas my supervisor helped me to process my own experience, the collective reflections of multiple psychiatrists informed a different perspective—the eerie universality of the multi-faceted emotional journey of a patient's suicide. Regardless of their seniority or experiences with patient suicide, the guilt, sadness, anger, doubt, and other emotions were strikingly similar. At the same time, it was somewhat comforting to observe the seemingly cathartic experience of acknowledging and validating each others' difficulties, some of which may have been left partially unprocessed for years. It was a side of my senior colleagues that I had hardly seen on a day-to-day basis in a busy clinical service—a delicate, vulnerable, and very human side, one that I had the privilege of witnessing first-hand.

Patient suicide is possibly the great equaliser amongst psychiatrists, psychiatry trainees, and perhaps any other clinician who has experienced a patient's suicide. My own experience came suddenly and unexpectedly, and it will likely leave a psychological scar as a grim reminder of one of the lowest points of my career. And so the suicide sharing

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session reminded me that I did not have to feel inferior or inadequate because of the confusing myriad of emotions, or that conquering these emotions was a competency that should be signed off in my psychiatric training, or that they had to be eliminated by the time I became a psychiatrist.

Psychiatry trainees need help in dealing with patient suicide. Almost half of psychiatry trainees in one review had encountered at least one patient suicide, and the trauma that they experienced was more intense compared to senior physicians [1]. This has to be taken seriously, as there is unfortunately increased suicide risk in those who have experienced suicide, which can described as an interpersonal crisis rather than a personal tragedy [2]. Trainees may be especially vulnerable because of their limited clinical experience with suicidal patients, erroneously perceiving the clinical failure of a suicide to be a personal failure [2]. Their early experiences with suicide may therefore shape their future behaviours and coping skills, and it would be undesirable to leave them to cope in uncertainty and isolation instead of fostering their growth [2, 3]. Additionally, the structure of residency, for example, frequent rotations and inconsistent supervisory figures, may lead to trainees not feeling safe enough to discuss patient suicide with their supervisors. Prabhakar et al.'s trial of a preventive suicide educational programme, and Henry et al.'s postvention guidelines to curb stress of patient suicide are welcome suggestions, although more work is needed to investigate their effectiveness in actual patient suicides [3, 4].

I gained invaluable insights from attending a suicide sharing session before my experience of a patient suicide, and I hope that both psychiatrists and trainees will consider initiating similar sharing sessions. Perhaps much more than we realize, our pooled experiences will invariably be a vital source of support for every trainee's first encounter of patient suicide.

Declarations

Conflict of Interest The author states that there is no conflict of interest.

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