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All physicians must learn to live in an irreducible tension regarding patient mortality. The tension is that we must do all we can to implement evidence-based interventions that prevent death while also accepting that some deaths will nonetheless occur. Christine Moutier's incisive commentary [1] deepens the reader's understanding of this tension, by making the distinction between the notion of "preventable," from the view of population health, and "predictable," from the view of the staggeringly complex set of variables at play in an individual instance of suicidality. Holding the two perspectives side by side, we can see how suicide—like myocardial infarction—is simultaneously "preventable" and yet "not predictable." Moutier meets a critical need by providing a guide to the current best practices of integrating suicide prevention into education. As educators, we are responsible for training students and residents in how to prevent suicide and then supporting them when we are unable to predict the outcome of suicide in a specific case.

Several papers collected in this issue are aimed at improving performance in suicide prevention. Walukevich-Dienst and colleagues [2] describe the introduction and implementation of the Collaborative Assessment and Management of Suicidality (CAMS) program in the outpatient clinic and inpatient services that train their residents. They describe the barriers navigated and lessons learned. Chuop et al. [3] address the need to train future primary care providers in suicide assessment. They report encouraging results of a brief intervention comprising a lecture on best practice in suicide assessment followed by a clinical skills assessment with standardized patients. Some people who die by suicide may not have recently seen a mental health clinician but have seen a primary care provider. Accordingly, it is important to train all physicians in building rapport, interview skills for suicide

assessment, use of suicide-risk screens, and basic safety interventions.

We must pay careful attention to suicide prevention within our own ranks. Eldridge et al. [4] describe a valuable pilot project to educate medical students about how to listen for, inquire about, and respond to suicidality among their peers. Nobleza and colleagues [5] remind us that such efforts are needed, as they conclude that it is likely that only a small minority of residents who needed help actually took advantage of mental health resources on their campus.

In "The Suicide Prevention, Depression Awareness, and Clinical Engagement Program for Faculty and Residents at the University of California, Davis Health" [6], Sciolla and colleagues report on a state-of-the-art program that sought to proactively identify depression and suicidality in residents and faculty and then engage them in treatment. The authors found a disturbingly high percentage of residents (41.3%) that met their criteria for "high risk," although interpreting this finding is limited by the low response rate (11%). The authors also note a significant difficulty with engagement and drop out, perhaps due to concerns about confidentiality or licensure reporting. More hopefully, they identified a small group of physicians who reported that the screening resulted in mental health treatment which would not otherwise have occurred.

It is important to remember that while suicide prevention efforts share many strategies with the larger field of public health, losing a patient to suicide is also different from other medical deaths, as Yeh's beautiful reflection reminds us [7]. The question of the patient's agency and choice is more complicated, because the brain (and its multiple states of self and conflicting motives) is more complex than any other organ. We ask a great deal of psychiatry residents. They must appreciate the powerful neurobiologic forces at work in the brain of a patient with serious mental illness while holding on to the hope that a therapeutic relationship can still alter the course and modify the risk of death. This is an inescapable challenge, and it is hard for even experienced clinicians when our interventions are not enough. In the face of the individual patient's suicide, we live with uncertainty and powerful feelings of guilt, anger, and heartbreaking sadness.

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Foster et al. [8] direct our attention to this dimension of suicide prevention by focusing on how the therapeutic relationship can have the most optimal impact on the patient's choices. Starting from the appreciation that suicidality is a dynamic and sometimes volatile phenomena, they ask, "How can we increase the odds that a patient will make use of the safety plans and opportunities for support and reassessment that we offer?". They argue that careful attention to the therapeutic alliance may help. To that end, they suggest curricula that (1) carefully examine opportunities for empathy; (2) reflect on the risks of negative countertransference; and (3) draw guidance from people who have survived dangerous suicidality and can share their perspective on our clinical interventions.

Part of the task of suicide assessment is listening to and understanding the patient's internal state—and often ambivalence—of wanting to die. Duggan's beautiful poem "The Way Day Breaks" [9] follows in the tradition of poetry that helps us understand the lived experience of psychic pain and suffering. It is a compelling demonstration of the value added to psychiatric training—and to our *Journal*—by the inclusion of poetry. Faletsky's essay [10], by contrast, provides a window into the internal worlds of trainees faced with completed suicide—the trauma, the self-doubt, and ultimately the determination to keep growing and offering oneself to patients. He puts us in touch with our own past trainee selves.

Qayyum et al. [11] did qualitative analysis of transcribed structured interviews with residents who had lost a patient by suicide and their supervisors. Although their sample is small, their data are rich and deep with insight. They allow us to see both the shock, guilt, shame, and fear of the residents and the supervisory response, which includes sharing painful experience, providing greater perspective, and sustaining professional growth. The authors go a step further by placing the pair's experience in the larger context of a healthcare system that can demonstrate very different degrees of preparation and alignment with the task of supporting trainees and faculty.

Several papers focus on how to best support trainees through the painful and confusing reactions that follow a patient's suicide. McCutcheon and Hyman's brief report [12] describes the implementation and evaluation of a curriculum about the consequences to providers of a death by suicide, which covered both the emotional and the medico-legal implications. Agrawal et al. [13] report their evaluation of a postvention protocol for residents who experience a patient's suicide. Their study indicates that support provided by the program director and attendings (especially those who have themselves experienced a loss by suicide) is deeply valuable to residents. The authors also note, however, "our results indicate that residents may need more prompting to seek self-care such as mental health services and work modifications." There may be reluctance for residents to opt into mental health services, perhaps due to our profession's general tendency for

self-treatment and perhaps due to ongoing stigma around mental health issues. The authors suggest considering whether such services be set up as opt out instead, to decrease the barriers to utilization.

In the "down to earth" academic skills column, "Recommendations for Effectively Supporting Psychiatry Trainees Following a Patient Suicide" [14], Qayyum and colleagues pivot from description to prescription. Readers will find a great deal of wisdom and practical guidance in this paper. Developing further the idea of "preparation," the authors spell out precisely what this should look like and then similarly provide thoughtful and clear descriptions of optimal processes and supervisory interventions. The table "Helpful Tips for Program Directors" is an excellent summary that can be used as a checklist to review our past responses and current readiness to take care of residents.

Collectively, the papers in this issue can help us clarify our thinking about suicide prevention and postvention, both within our own departments and as a larger academic community. They should inspire us to further research and support us in our efforts to care for our students and trainees.

Declarations

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