

# Supporting general practitioners and practice staff after a patient suicide

## *A proposal for the development of a guideline for general practice*

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### Background

Managing the completed suicide of a patient in general practice has long been a taboo and neglected subject. Doctors and staff are too frequently unprepared for the crisis and its sequelae. The wellbeing of the doctor, practice staff and bereaved family are often neglected, with detrimental consequences.

### Objective

The aim of this article is to develop a guideline for a whole-of-practice strategy to support general practitioners and practices through the immediate aftermath of a patient suicide, with a view to improving outcomes for the doctor, practice staff and bereaved family; and to offer this guideline for further research and development, with a view to it leading to a national guideline.

### Discussion

In this article, the authors outline the background of the guideline and the difficulties and limitations in its development. Suggestions for future research are offered, along with its potential contribution to patient care and suicide prevention in the future.

**THE SUICIDE OF A PATIENT** may be one of the most stressful work-related events in a general practitioner's (GP's) lifetime. Grief, a sense of failure, shame and inadequacy, and fear of litigation may result in emotional turmoil, depression, burnout and even abandonment of a medical career and suicide.<sup>1-3</sup> Some studies have found GPs to be emotionally unavailable, ill-equipped to support the bereaved family and in need of support.<sup>4-6</sup>

A grieving family tends to be more severely affected after suicide than after other modes of death because of associated risk factors. Possible complications include post-traumatic stress disorder, depression, physical ill-health and imitative suicide.<sup>7-9</sup> Providing immediate outreach to the bereaved is well within the GP's terrain.<sup>10</sup> GPs have been found to be the professional of choice for support, and the most appropriate provider for the diverse needs of the bereaved in the long term.<sup>11-13</sup> It is therefore vital for the wellbeing of the bereaved that the doctor is emotionally and practically prepared to provide immediate support – an important area of secondary suicide prevention (postvention).<sup>14</sup> The quality of support given by GPs is often related to how supported the GP feels by the profession, particularly from colleagues.<sup>2,4</sup> Support also protects the GP against severe psychological reactions and enables motivation to improve suicide prevention practices.<sup>2</sup> In turn, compassionate and honest communication with the bereaved reduces the litigation risk.<sup>15</sup>

Currently, support for GPs by the profession is marginal. Although there exist some excellent Australian general practice resources about bereavement care after a suicide, little research exists worldwide into GPs' management of the immediate aftermath.<sup>16,17</sup> This silence is stigmatic and extraordinary: with more than 3000 suicides a year in Australia, the uncomfortable reality is that the suicide of a patient is a professional hazard.<sup>18</sup> Further, more than 50% of people who die by suicide consult their GPs in the month prior to suicide.<sup>19</sup> Most GPs experience at least one patient suicide in a working lifetime, and

more if they work among populations with high rates of mental illness.<sup>2,19</sup> The causes of suicide are now understood to be multifactorial, usually the result of complex problems in medical, social and family systems and beyond the sole responsibility of the individual GP. Establishing a no-blame approach not only enables the doctor in their support of the bereaved, but also better facilitates their reflection and learning on past events to identify improvements in preventing patient suicide.<sup>20,21</sup>

### Objective

The objective was to develop a document, in an easy-to-follow format, to guide GPs through the complex legal, emotional and practical issues of supporting the bereaved family in the immediate aftermath of a patient suicide. The purpose was to improve the outcomes for the GP, practice staff and the bereaved, and to offer this document for further research and development with a view to it leading to a national guideline.

### Methods

The guideline proposal was developed by a collaborative process in a busy eight-doctor practice in a high socioeconomic suburb of Adelaide. Following a cluster of two patient suicides and one suicide attempt, a practice meeting recommended that a team of staff develop guidelines on how best to manage a suicide event. One of the patients who died was well known to the practice, and several staff were considerably distressed. A team of two GPs, one of whom had considerable experience in postvention (SC), a practice nurse, practice manager and receptionist developed the first draft in conjunction other practice staff.

The guideline was designed in an easy-to-follow step-wise format. Clinical experience and a literature review defined four areas of action:

1. Managing the Australian national legal requirements for reporting and documenting a patient suicide
2. Creating an action group to establish a supportive, no-blame

practice culture fundamental to ongoing management

3. Personal support for the doctor and staff (cf. aircraft emergency paradigm of fitting the oxygen mask first)
4. Immediate outreach and follow-up of the bereaved.

The areas of action were supplemented by a fifth section of resources.

The section on managing practice records was compiled by a medico-legal expert. Action group and personal support strategies for the doctor and staff were based on work into no-blame approaches to a suicide event in UK general practice, research into Slovenian GPs' preferences for support from colleagues, and the practical experience of the authors.<sup>2,20,21</sup> Strategies for outreach to the bereaved were based on postvention research into bereaved persons' needs and preferences for support, particularly relating to GPs, and from the clinical experience of the authors.<sup>11-13,16</sup>

Two years later, the same practice experienced two further completed suicides, following which the practice trialled the guidelines. A second draft, incorporating amendments from the trial and advice from a psychiatrist, was repeatedly workshopped in-house and sent out for review to 45 doctors in five other suburban and rural practices around Adelaide. Only four responses (return rate 9%) were received; all approved the content without further contributions.

### Discussion

Gathering information about a rare and stigmatised event is always difficult. There is little research on this topic to draw on. The present method is limited by its single-practice setting and low return rate (possibly because of the length of the guidelines and GPs' lack of experience with suicide). Further research and development are necessary from varied GP populations, practice structures, geographical settings and patient populations, demographics and cultures. Possible evaluation processes include feedback from GPs through an education module structured around the guidelines, and research targeting

GPs following a recent experience of patient suicide. Further, periodic review would be necessary to accommodate new understandings of postvention and legal changes.

This guideline fills a gap in the existing general practice literature relating to suicide. It offers several benefits: GPs may have greater confidence in managing the aftermath of a patient suicide, resulting in better emotional and mental health outcomes themselves. In turn, earlier and more comprehensive care from the GP may result in improved physical and mental health outcomes for the bereaved, and reduce the doctor's risk of litigation. Further, the supportive, no-blame practice culture may better facilitate the GP's learning from the experience, leading to improved prevention strategies.

### Conclusion

This article presents a guideline for the management of the immediate aftermath of completed suicide in general practice. It offers practical support for the GP, practice staff and bereaved family, with subsequent potential long-term benefits for all concerned. This can be used for further research and development towards a national guideline and as a contribution to GP education. Inclusion within the canon of general practice would legitimise this as an important area of suicide prevention.

*The guideline proposal is presented on the following pages.*

## Guideline proposal

Managing practice records requires priority. The remaining three action areas are intended to run concurrently and interactively and in a step-by-step fashion.

### 1. Managing practice records

- On receipt of notification of a patient's suicide, the practice to inform the deceased patient's treating GP.
- The doctor to document details of the suicide in the patient's notes, together with any recent relevant notifications such as hospital discharge letters and notifications from other treating professionals, along with the dates these were received.
- Respond to any lawful requests for information, including copies of the patient's medical records. For example, in South Australia, the coroner can direct an investigator (usually a police officer) to examine, copy or take extracts from any records or documents for the purposes of determining whether or not it is necessary or desirable to hold an inquest (Section 22 of the Coroners Act 2003 [SA]). In Queensland, the coroner can issue a request for information pursuant to s16 of the Coroners Act 2003 (Qld). In New South Wales, the coroner can direct a person to provide information including medical records pursuant to s53 of the Coroners Act 2009 (NSW). Refer to ss40 and 42 of the Coroners Act 2008 (Vic), s59 Coroners Act 1995 (Tas), s19B Coroners Act 1997 (ACT), s19 Coroners Act 1993 (NT) and s33 Coroners Act 1996 (WA). This is a legislative requirement, and all patient notes must be produced. The police or the coroner's office should produce written authorisation pursuant to the relevant legislation at the time of the request for information is made and a copy of such documentation should be retained by the practice.
- Should the patient notes contain confidential information that the deceased patient had requested not to be disclosed, or that the doctor feels may be harmful to the bereaved, the relevant documents to be placed in a separate envelope and the concerns to be set out in a covering letter to the coroner accompanying the notes. This may forestall the family from having access to that information unless an inquest is held.
- The names of the bereaved family members to be recorded on the practice patient alert system, and in the deceased patient's notes, in the event of them needing urgent appointments.
- The police, on behalf of the coroner, may wish to obtain a statement from the patient's treating doctor, or a request for information may come directly from the coroner's office. It is recommended that advice is sought from the doctor's medical indemnity insurer prior to submitting a statement in order to seek expertise in meeting the obligations.
- In the event the GP is required to make a statement to the police, it is advisable to ask the police to set out a list of questions and to provide a written statement in response to their questions. The statement to be discussed with the doctor's medical indemnity lawyer before being submitted to the police. At times the coronial investigator will insist on conducting an interview. If any difficulties are encountered, the medical indemnity insurer to be contacted for clarification.
- In the event of an inquest, the medical indemnity lawyer to be consulted.
- The de-identified information from the action group forum (2.4) debrief to be retained in a legal file.

### 2. Action group

Within 24 hours of notification of the death, an appropriate staff member who is independent of the suicide (eg practice manager, doctor, nurse) to act as team manager to establish a safe, compassionate, no-blame, no-shame supportive culture through which to:

- Communicate personally to all staff about the suicide. Various staff such as doctors, nurses, receptionists and practice managers may have known the patient and/or their family and may be emotionally affected and even be in crisis.
- Set up a process of ongoing support for all staff concerned. This may take the form of individual support and debriefing meetings led by an appropriate staff member. These are intended to assist staff with their emotional reactions in a de-blaming and non-shaming environment: to identify those who are most affected and needing support (eg the patient's GP and junior staff), to mobilise ongoing interpersonal support and to prepare staff for supporting the bereaved family.
- Plan and monitor the immediate and ongoing support of the bereaved family (Action area 4).
- Convene a forum for open, supportive, respectful, compassionate and no-blame discussion of the context, difficulties and events surrounding the suicide. The objective perspectives of other staff may be helpful to the doctor concerned. Information gathered may contribute to future patient care as well as help the bereaved family understand why the suicide occurred, which may be discussed with family at a later meeting (Action area 4.6). For legal reasons, relevant documents should be retained and filed with a record of the recommendations and actions taken in response to the appraisal. Any such documentation of the review, including recommendations, should be de-identified in relation to the patient, any healthcare provider and other staff, and should not be stored in the patient's medical record.
- Review which processes of the guideline worked and the learnings from them.

6. Provide an ongoing, non-threatening context for any sequelae of the suicide (eg coronial investigation, litigation).
7. Review the wellbeing of staff at later intervals.

### 3. Support for the doctor and staff

The following are addressed to the doctors and staff affected by the suicide:

1. Acknowledge your emotions. Feelings of grief, guilt and failure, shame, anger and fear of facing the bereaved family are normal. Their intensity is often related to the closeness of the professional relationship. Stress and trauma reactions may occur and affect one's coping ability and decision-making, and even lead to doubt about one's ability to continue working, especially if there is fear of litigation. The perceived risk of being sued is usually much greater than it actually is. It takes courage to work with suicidal patients and suicide is always multifactorial. It is important to gain the support you need and to care for your own wellbeing.
2. Seek support from other practice staff, particularly the action group.
3. Seek legal support from your medical indemnity lawyer.
4. Consider consulting with other service providers who cared for the deceased person: searching for why the person took their life can be mutually supportive and provide some answers.
5. Attend to your own self-care by:
  - considering brief leave when appropriate
  - seeking the support of family, friends, peers, own GP
  - considering professional counselling (refer to Resources)
  - implementing lifestyle changes, such as exercise, sleep, activities, diet, socialisation and coping strategies.

### 4. Immediate outreach to the bereaved

1. The family should be contacted by telephone within 24 hours with expressions of condolences and offers of support.
2. The treating GP along with other practice staff should plan:
  - Who needs support: consider the immediate next of kin as well as the wider relationship network of the deceased.

- To whom and by whom is outreach appropriate. There may be multiple responses based on whether the deceased person and family were practice patients (Table 1).
- Responses to variations in cultural backgrounds and experiences, and with appropriate advice sought where needed (<https://grieflink.org.au/grief-reactions-in-different-cultures>).
- Confidentiality: be aware that the family may not want it known that the cause of death is suicide. While this needs to be respected, it is important that the practice does not buy into the stigma of suicide by not offering upfront support.
- The form of the outreach: assess suitability of a home visit versus a family meeting in the practice rooms. Offer a prompt family meeting inviting all who wish to attend; otherwise, send a sensitive note of condolence.
- Where to hold the immediate outreach. Suicide is a traumatic death. The grieving family are often left traumatised, guilt-ridden and stigmatised; as a result, they may be reluctant to seek help. Consequently, the family home is the place of choice for immediate outreach, as it is a location in which they feel safe and where multiple members of the family can comfortably gather. For some individuals, this may be the only opportunity they take to receive help. A home visit enables support to reach several people all at once. It can create a powerful message in destigmatising suicide. Alternatively, if there is concern about safety for the GP, especially in circumstances of family anger and blame, a family gathering at the practice room may be preferable.
- Which staff would be most appropriate (ie emotionally available and best known to the family). Consider a team approach such as GP/nurse combination. Grieving along with the family can be mutually helpful for both doctor and family.

3. GPs should plan for the initial visit to last up to one hour. The objectives of this meeting are to:
  - Express condolences and sorrow about the death.
  - Listen to the experiences of the different family members regarding the suicide.
  - Address their concerns and questions, (eg police inquiry, coronial process, funeral).

**Table 1. Outreach to bereaved family**

Deceased person	+	Bereaved family	→	Immediate outreach and follow-up
Practice patient		Practice patient		Yes
Patient of another practice		Practice patient		Yes
Practice patient		Patients of other practice		Condolence phone call and referral to own general practitioner. Meeting to discuss cause of suicide (Action area 4.6)

- Acknowledge feelings of anger and blame openly if these are expressed. They are normal. Inform the bereaved that questions about why and how the person took their life are important and will be addressed in a later meeting. Refocus the meeting towards support for the patient/family. Should concerns be raised about the deceased's care prior to death, repeat that the purpose of this meeting is for immediate support and that these concerns can be addressed at a later meeting. (A lawyer should be informed of any concerns). Observe the privacy of the deceased patient in any discussion of events leading up to the death.
  - Assess the depth of the grief of individual members and presence or risk of depression and suicidality, as well as any serious complications from known medical conditions (eg diabetes).
  - If someone is considered at risk, arrange an immediate consultation after the meeting for further assessment and referral.
  - Assess the need for practical support such as child care, meals provision.
  - Provide information about postvention resources (refer to Resources for the bereaved) and a list of local and national emergency telephone numbers.
  - Arrange follow-up appointments and an urgent after-hours contact number, especially for those with identified physical or mental health risks.
  - Nominate a practice staff member whom the family can contact in case of urgently needing help.
4. To prepare for the meeting, the GP should:
- debrief about their feelings and enlist support for the visit with a practice staff member
  - consult with relevant suicide postvention outreach services (see Resources) about advice and support for people immediately after a suicide
  - form a team, if appropriate, and a plan of action for the meeting
  - collect the relevant information handouts for the family (see Resources for the bereaved).
5. Subsequent surgery consultations should focus on:
- listening
  - assessing the depth of grief, depression, trauma and suicidality
  - assuring the patient that their grief is normal
  - considering referral to a bereavement service, mental health team or psychiatrist
  - conducting a brief physical assessment especially considering cardiac function and existing medical problems
  - providing basic survival strategies, advice and contacts, such as regarding sleep, meals, activities, social support and local council services
- offering the continuing support of yourself and the practice.
6. The GP may need to prepare for a meeting to discuss why the suicide occurred. At some stage in their search for answers to why the suicide occurred, the bereaved family may approach the GP as an important source of information and expertise. A compassionate and honest mutual sharing of information can benefit both the family and GP in coming to terms with the complex issues surrounding the death.
- Issues discussed may include the care provided to the deceased and possible contributing factors to the suicide, including the mental state of the deceased before death, the role of mental ill-health and the associated neuroscience, and sociological factors. Information from the practice forum (Action area 2.4) may be useful. Another issue commonly raised is how much the person may have suffered in the dying process.
  - Planning for the meeting should involve determining staff in attendance, content, support, follow-up of the bereaved and debrief of staff (Action area 2.7).
7. The GP may need to plan a meeting to discuss the coroner's report. The coroner's report can be traumatising for the bereaved. Consequently, some states and territories send the report directly to the GP for them to prepare and interpret to the bereaved. In other states, the GP can suggest to the bereaved that they request the report be sent first to their GP for interpretation at a surgery meeting. When organising such a meeting, the GP should:
- arrange a meeting with all family members who wish to attend
  - plan the meeting to use wording acceptable to the bereaved
  - engage another staff member as support
  - record the meeting in the case notes
  - report any expressions of concern regarding general practice management to the indemnity lawyer
  - return the report to the family in a sealed envelope.

## 5. Resources

### For the bereaved

#### National response services

- StandBy, [www.standbysupport.com.au](http://www.standbysupport.com.au) or [standbynational@unitedsynerges.com.au](mailto:standbynational@unitedsynerges.com.au)
- Postvention Australia support groups, <https://postventionaustralia.org/finding-support/local-support-groups>

#### National telephone helplines

- Suicide Callback Service: 1300 659 467
- Salvation Army national help line (suicide bereavement): 1300 467 354 or 1300 HOPE LINE

## Websites

- Postvention Australia – the national association for individuals bereaved by suicide, <http://postventionaustralia.org>
- GriefLink, <https://grieflink.org.au/suicide-and-grief>

## Practice bespoke emergency postvention pack

- It is beneficial for a practice to maintain a current 'emergency suicide postvention pack' containing information and local and national contacts for staff and the bereaved.

## For doctors and staff

- Australasian Doctors' Health Network, [www.adhn.org.au](http://www.adhn.org.au)
- The Royal Australian College of General Practitioners' GP Support Program, [www.racgp.org.au/membership/the-gp-support-program](http://www.racgp.org.au/membership/the-gp-support-program)
- Employee Assistance Program Australia, <https://eapassist.com.au>
- GriefLink – health professionals' reactions to patient suicide, <https://grieflink.org.au/grief-suicide-health-professionals>

## Postvention information

- General Practice Mental Health Collaboration – After suicide: A resource for GPs, [www.racgp.org.au/FSDEDEV/media/documents/Education/GPs/GPMHSC/After-suicide-A-resources-for-GPs.pdf](http://www.racgp.org.au/FSDEDEV/media/documents/Education/GPs/GPMHSC/After-suicide-A-resources-for-GPs.pdf)
- Square: Suicide postvention counselling – An education resource for primary health care, specialist and community settings, Commonwealth of Australia 2007, [www.square.org.au/wp-content/uploads/sites/10/2013/05/Postvention-Counselling\\_May2013.pdf](http://www.square.org.au/wp-content/uploads/sites/10/2013/05/Postvention-Counselling_May2013.pdf)

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