Guidelines

Guidelines on suicide amongst anaesthetists 2019*


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Summary
Anaesthetists are thought to be at increased risk of suicide amongst the medical profession. The aims of the following guidelines are: increase awareness of suicide and associated vulnerabilities, risk factors and precipitants; to emphasise safe ways to respond to individuals in distress, both for them and for colleagues working alongside them; and to support individuals, departments and organisations in coping with a suicide.

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*These guidelines are dedicated to all colleagues who have ended their lives so tragically, whatever the circumstances.

This is a consensus document produced by expert members of a Working Party established by the Association of Anaesthetists. It has been seen and approved by the Association of Anaesthetists’ Board of Directors. It has been endorsed by the Defence Medical Services, NHS Practitioner Health, College of Anaesthesiologists of Ireland, and the Royal College of Anaesthetists.

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Recommendations

1 The recording and/or reporting of suicides as a cause of death should be improved. In particular, where the deceased is a doctor there should be an improved mechanism for identifying and recording his/her specialty.

2 All anaesthetists have a part to play in supporting the mental well-being of colleagues and contributing to the creation and maintenance of a mentally healthy workplace.

3 All anaesthetic departments should identify an individual(s) – who may not be an anaesthetist – with a lead role in supporting the mental health of at-risk staff. This person should act as a focal point for information and signposting and, where necessary, liaise with other relevant staff (e.g. occupational physicians, Trust well-being leads, human resource departments, clinical directors, College Tutors, etc.) and keep abreast of national and local initiatives regarding mental well-being.

4 There should be ongoing education within departments and organisations about suicide and safer ways to intervene. Such educational activity should include efforts to counter the stigma associated with mental ill health, and to support colleagues who may be struggling, for example, with financial, relationship or professional stresses including complaints and/or disciplinary procedures.

5 Specialist medical input should be involved early, with the anaesthetist’s consent; this may include his/her general practitioner (GP), psychiatrist, occupational physician or external agencies such as the Practitioner Health Programme. The confidentiality of individuals must be respected at all times.

6 Individuals at particular risk, or in distress, should be encouraged to draw up a ‘safety plan’. All staff should be registered (or encouraged to register) with a GP.

7 All departments should have a plan for managing staff-related crises including death by suicide.

What other guidelines are available on this topic?
There is much guidance available about mental health and well-being, and mental illness including suicide, but limited resources are directed specifically at anaesthetists or anaesthetic departments (the Welfare of Anaesthetists Special Interest Group of the Australian and New Zealand College of Anaesthetists has produced an adapted version of guidance published by the American Society of Suicidology, on the management of a colleague’s suicide [1]).

Why was this guideline developed?
There has been increasing concern about stress in the medical workplace and, in particular, evidence suggesting an increased risk of suicide amongst anaesthetists [2–4]. Anaesthetists’ experiences of suicide suggest a need for such guidance [5].

How and why does this statement differ from existing guidelines?
This guidance is aimed specifically at anaesthetists, their departments and their employers, attempting to bring relevant resources together and make them accessible to anaesthetists.

Introduction
The link between anaesthesia and suicide has long been recognised [6–12]. Supporting anaesthetists’ well-being is one of the main activities of the Association of Anaesthetists, which has become increasingly concerned about reports of suicide within the specialty. The aim of this guidance is to raise awareness of suicide and its risk factors, and of possible intervention and support[2] – both for colleagues at risk and those managing the aftermath – amongst individuals, departments and Trusts.

Suicide rates
Suicide is a major public health issue in the UK [13, 14]. According to Office for National Statistics (ONS) data, UK suicide rates in the general population have been generally falling over the last 40 years, although at a slower rate of decline than many other major causes of death. Three-quarters of the reported suicides occur in men, with the highest risk age of 45–49 years in both men and women [15]. The most recent ONS figures show a significant increase in suicide rates between 2017 and 2018, the first increase since 2013 (Fig. 1). This may be partly related to a change in July 2018 in the standard of proof used by coroners when certifying death by suicide [15].

Doctors are at increased risk compared with the general population, with the increase greatest for female doctors [16, 17]. In England, this trend may account for an apparent reduction in the male:female ratio over the last 4–5 years of data (Fig. 2).

1 Most of the work into this area has focused on anaesthesia and anaesthetists, but the term ‘anaesthesia’ is used hereafter to refer to related specialties, for example, intensive care, pain management, etc. – and also non-medical staff working in the same environment – unless specifically mentioned otherwise.

2 See Appendix S1 for a list of organisations offering support.
Data from the ONS suggest similar numbers of suicides registered in medical practitioners (11–20 per year) between 2001 and 2016 [19], which might suggest a falling rate as the number of doctors has increased over this period [20], although the same concerns apply regarding the accuracy of the data as noted below regarding anaesthetists (with the exception of uncertain medical specialty).

Anaesthetists have been highlighted as having a greater risk of suicide than other specialties, although only a handful of studies with information specific to anaesthetists have been published after the year 2000 [2–5]. Theories include access to, and knowledge of, potentially lethal drugs and means of their administration; the particular stresses of working within the specialty; and the personality type of doctors entering anaesthesia. The importance of the first is highlighted in ONS data (2001–2015) relating to deaths by suicide in anaesthetists, in which 86% were due to poisoning, most often (83%) with anaesthetic medication [19]. Recent case reports would also suggest an increasing use of propofol as a drug of abuse [21, 22]. The difficulties in ascertaining accurate numbers of deaths by suicide within the specialty are well described (Table 1).

Risk factors and precipitants
Risk factors for suicide in the general population include being male; self-harm; bereavement by suicide; a history of mental illness such as depression; and adverse life events such as relationship or financial issues. However, risk factors alone do not reliably predict suicide attempts [25]. Risk factors in the medical profession include stress arising from complaints or bullying; high physical/mental demand, the effects of ageing, fatigue and uncontrollable long hours/shift working with social or professional isolation, compounded by examinations and frequent rotations for trainees [26, 27]; a perfectionist personality type – that while predictive of good doctors, can also increase the risk of developing mental illness [28] – and reluctance to seek medical help [29]. This reluctance may arise from fear of stigma, a lack of time, a misplaced work ethic or concerns over privacy/confidentiality including potential regulatory
or disciplinary procedures [30, 31]. In addition, there may be differences in the way that doctors are treated as patients, and how they manage their own treatment including registering with a GP [32]. Altogether, these factors place doctors at higher risk of work-related stress, burnout and mental ill-health [33]. The Horsfall report found that undergoing fitness to practise and other regulatory investigations are further significant stressors [34]. Although there is little work in this area, the over-representation of international medical graduates in regulatory/disciplinary proceedings [35], plus the additional stressors that many IMGs face (e.g. the practicalities of migration, cultural adaptation and changes in their social support) may indicate additional risk of mental illness in this group [36].

Additional occupational risk factors particularly relevant for anaesthetists include the ever-present risk of serious adverse patient outcomes including death [37]. Substance misuse is a particular hazard and is more likely to involve potent analgesics or anaesthetic agents in anaesthetists [23]. Furthermore, anaesthetists have access to (and knowledge of) powerful means with which to take one’s own life.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Barriers to recording accurate numbers of suicides in anaesthetists [23, 24].</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of deaths</td>
<td>Lack of consistent classification of a death as a suicide (e.g. unclear, non-specific, open or narrative conclusions in coroners’ reports)</td>
</tr>
<tr>
<td></td>
<td>Uncertainty over cause of death</td>
</tr>
<tr>
<td></td>
<td>Uncertainty over intent (e.g. accidental overdose in drug addiction)</td>
</tr>
<tr>
<td></td>
<td>Delays in reporting and coronial systems</td>
</tr>
<tr>
<td>Identification of specialty</td>
<td>Absence of specialty area listed in Medical Register (e.g. trainees before 2016, a other grades without specialist registration or association with a recognised training programme)</td>
</tr>
</tbody>
</table>

*aGMC, personal communication.
bFor example, a staff grade anaesthetist or clinical/non-clinical fellow who has not achieved a Certificate of Completion of Training, or who is not part of a GMC-recognised training programme.

**Suicide and ideation**

Suicide is more than a single act; it is a process beginning with suicidal thoughts (ideation), followed by a plan that may or may not result in an attempt [38]. However, not all those with ideation disclose it, so that the apparent absence of ideation (or plan) may be falsely reassuring; conversely, suicidal ideation is not in itself a reliable predictor of suicidal intention [39]. The speed with which transition between the stages occurs is also unpredictable, although 90% of unplanned and 60% of planned attempts occur within 1 year of the onset of ideation [38]. Suicidal ideation may also fluctuate over very short periods of time. A change in behaviour whereby a previously stressed/struggling colleague suddenly seems at peace with him/herself and his/her problems may indicate that the person has developed a plan with intent to carry it out.

**Box 1**

I recently left work in a moment of crisis, recognising that I was too stressed and unwell to continue safely. My one regret was that I didn’t remember to take my exit drugs home with me. Although I am not currently suicidal, my main fear about returning is having access to lethal drugs.

**Box 2**

When in training, I ended up taking a period of leave following a breakdown at work, triggered by a mix of pressure of work and personal issues resulting in depression. I had frequent episodes of suicidal ideation and had gathered drugs and equipment to attempt this. Had I not received help at that time, it is entirely possible I may have carried through with my intended plan. Over 20 years later, I’ve had one further period of depression, but otherwise have been pretty stable. But, particularly now, after 20 years, nothing feels to have changed, conditions if anything seem to be getting worse despite expectations becoming higher, and the constant fear that one mistake will result in a career-ending catastrophe. And those thoughts of 20 years ago are now somehow becoming rational.

3 For the source of the text in this and subsequent Boxes, please see Acknowledgements.
The most recent data on the incidence of suicidal ideation in the medical profession come from the ‘Beyond Blue’ survey of over 11,000 Australian doctors [17], in which 10% reported suicidal thoughts within the last 12 months and 25% before the last 12 months. Surveys specific to anaesthetists or intensivists have suggested a 3–25% incidence of suicidal ideation, depending on how it is defined – the lack of a consistent definition remaining a problem in surveys of this nature [37, 40, 41]. A recent study of 397 responding anaesthetic trainees found that 11 (3%) reported suicidal ideation within the previous 2 weeks [26].

**Effect on others**

There may be a multitude of people who are affected before a person takes his/her life, as well as after the death (Table 2). Many of these experiences have been captured in the Association of Anaesthetists’ survey on suicide conducted in late 2018 [5].

**Aims of this guidance**

The aims of this guidance are to raise awareness of suicide amongst anaesthetists and of potential opportunities for intervention within departments and organisations; and to support those affected by the suicide of a colleague. The guidance is based on evidence where available, while recognising that in many areas the evidence is weak; therefore, much of the guidance is based on expert opinion and current ‘best’ practice. The guidance also draws on the results of the Association of Anaesthetists’ survey on suicide [5].

Although it may seem at first glance that this guidance is aimed at leaders and managers, there is much that individuals can consider and do themselves, not only from the perspective of looking after their own mental health but also as colleagues, creating and contributing to teams, departments, Trusts and national strategies in promoting healthy psychological well-being.

**Prevention**

Establishing reliable ways to prevent deaths from suicide is difficult because there is no entirely predictable set of causative factors for any individual case [24, 43]. However, there are well recognised risk factors (see above) that can be addressed at multiple levels – by individuals, departments, organisations and external organisations. The Working Party feels that the approach to intervention needs to be at all these levels.

**Individuals**

Everybody should be registered with, and/or have access to, a GP. They should also be aware of the risk factors, symptoms and signs of stress and mental illness [44] – while recognising that loss of insight is often a feature. They should also recognise those situations that are particularly stressful, especially in combination and over a prolonged period, when they may become more vulnerable to mental distress. Furthermore, they should understand the importance of seeking professional help early. This may include consulting their GP, psychological support/counselling and/or occupational health services.

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**Box 3**

The prettiest girl in my year at medical school died from an overdose of fentanyl when she was an anaesthetic trainee. There is no way of knowing if it was accidental or not. We were all devastated, she was a lovely person.

**Box 4**

For me, the main reasons for wanting to take my life were not having to cope with the pain any longer (depression feels like pain), and to reduce the burden on my family (and anyone else).

**Box 5**

I felt suicidal for months. I felt like an irrelevance and unimportant at work, the only use to my family was as an income provider, and they’d get money when I was dead. The culture at work at the time was oppressive, blaming and critical, and there was a story in the press every other day about doctors’ mistakes and the public humiliation they faced, whilst I was working in an under-resourced hospital, with patients’ expectations in the realms of fantasy. A malignant cocktail.

**Box 6**

There have been some very dark times despite lots of support from friends and work. I did plan the time, place and method of killing myself, but did not take the thiopentone home. I am not in such a dark place now, but it felt like not existing any more would be the easiest option rather than continuing the struggle.
The importance and value of non-professional support—such as from colleagues, friends and family and from volunteer organisations such as the Samaritans—also should not be underestimated [45].

Those with current or previous suicidal ideation, and those at particular risk of this, should consider making a suicide ‘safety plan’, a written set of escalating steps to be followed until the person is safe. Such a plan might include strategies for dealing with stressful situations, resources and contact details including ‘crisis’ numbers should the person be actively contemplating suicide (Table 3)[46–50; see also https://www.stayingsafe.net]. Tools exist for creating such a plan online/on a mobile device [49, 50].

Individuals’ ability to influence their friends, colleagues and departments through their own actions and attitudes regarding a mentally healthy environment should not be underestimated. There are also many ways of getting involved in local supportive initiatives, for example, Schwartz rounds (see http://www.theschwartzcenter.org). In particular, those who are concerned about the well-being of others should not feel inhibited from checking whether they are alright; there are many accounts of how planned suicides were averted by a friend’s enquiry or by talking to a stranger [51, 52]. Individuals also have a role in encouraging others to seek appropriate help (see below), as well as considering safety and governance within the organisation.

### Departments and directorates

Departments should realise that prevention opportunities present at many junctures and need to have a strategy to maximise this. Normal governance practice (e.g. appraisals, performance reviews, incident reviews, complaints, job planning, etc.) may highlight concerns around an individual’s well-being, and a pathway for following up such concerns should be present. Locum staff may present a particular challenge as they may fall through some of these processes.

There should be awareness of well-being and support structures/resources within and outside the organisation (see below) – and where possible, encourage involvement

### Table 2 How others may be affected before and after a suicide.

<table>
<thead>
<tr>
<th>External factors that contribute to suicide and suicidal ideation</th>
<th>Although not necessarily having suicidal ideation, family/friends and colleagues may be exposed to the same stressors, for example, financial difficulties, oppressive demands/limited resources at work. Within the specialty, this has implications for the general stress and well-being of anaesthetists in the workplace [5, 42]</th>
</tr>
</thead>
</table>
| The individual’s suffering | Those around him/her may be concerned about the person’s well-being  
There may be safety issues potentially placing others (including, but not confined to, patients) at risk |
| The death itself | Discovering the body is hugely upsetting, whether this occurs at home, at work or elsewhere  
The immediate response has far-reaching and distressing effects, for example, police involvement; informing relatives, colleagues and others; handling the media; management of clinical work-load (whether or not the death occurs at work) |
| The aftermath | From a professional point of view, the effects of a suicide can be considered at several levels, for example, individuals; departments; Trusts and other organisations; and nationally. These are considered below and include maintaining service provision while staff are grieving, attending the funeral, receiving counselling, etc. If the death was at work, there may be additional issues over where it occurred and how that impacts on the use of that area  
Distress (even to the point of developing suicidal ideation oneself), guilt and/or anger may be felt – and support needed – by those even without direct involvement with the deceased or his/her department  
Staff with managerial/educational roles within the department or organisation may themselves need additional support, to help them with the considerable stress of managing the aftermath of a suicide |

### Table 3 Elements of a suicide safety plan. The person drawing up the plan (with or without assistance) would record those elements relevant to their own situation/experiences. Adapted from [46].

<table>
<thead>
<tr>
<th>Step</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Warning signs (thoughts, images, mood, situations, behaviours) that a crisis may be developing</td>
</tr>
<tr>
<td>Step 2</td>
<td>Internal coping strategies (i.e. without involving another person), for example, exercise, relaxation</td>
</tr>
<tr>
<td>Step 3</td>
<td>People and social settings providing distraction</td>
</tr>
<tr>
<td>Step 4</td>
<td>People to be contacted for help</td>
</tr>
<tr>
<td>Step 5</td>
<td>Professionals and/or agencies to be contacted in a crisis</td>
</tr>
<tr>
<td>Step 6</td>
<td>Making one’s environment safe</td>
</tr>
<tr>
<td>At all or any stage(s)</td>
<td>Reason(s) why life is worth living</td>
</tr>
</tbody>
</table>
of department members within internal structures – and how to access them, with prominent information and inclusion in staff induction programmes. Initiatives such as the Association of Anaesthetists’ #CoffeeandaGas may be helpful (see https://anaesthetists.org/Home/Wellbeing-support/Mental-wellbeing/Coffee-a-gas).

There should be regular reinforcement of the importance of mental well-being, for example, at departmental teaching and to coincide with national or international programmes such as Time to Change (with the Time to Talk Day each February in the UK; see https://www.time-to-change.org.uk), Mental Health Awareness Week (each May in the UK; see https://www.mentalhealth.org.uk/campaigns/mental-health-awareness-week) and World Suicide Prevention Day (each 10th September; see https://www.iasp.info). A constant message, that suicide needs to be talked about and may not be predictable and is potentially preventable (and anyone should feel able to intervene), should be stressed. Departments should encourage regular reflection regarding mental health, substance intake and suicidal ideation. In particular, every effort should be made not to attach stigma to mental health issues [53, 54].

All departments should have a plan for managing staff-related crises such as the untimely death of a staff member, and this should include death by suicide. The potentially devastating effect of a suicide in another department (e.g. a different department in the same hospital, or the anaesthetic department of a different hospital), should also be considered (see below).

Each anaesthetic department should appoint a consultant or staff and associate specialist (SAS) grade doctor as a well-being lead, to co-ordinate the above activities and act as a reference point, with appropriate training (which will depend on the local/regional support structures available). This role may include other related areas such as the critical care unit and operating theatres, depending on local organisational structure.

Access to powerful drugs has been highlighted as a particular issue in the suicide of anaesthetists [23, 37], and departments should ensure that local policies follow national guidance [55]. It should also be remembered that potentially fatal drugs may be stored in many other areas outside the operating theatres.

**Grade-specific issues**

There are stressors and risk factors that may be common to all grades, albeit to varying degrees. However, some may be particularly pertinent to certain grades. For example, being named as the ‘responsible’ clinician for cases places an additional burden on consultants in terms of both clinical management of challenging cases and dealing with the aftermath should the outcome be poor. Staff and associate specialist grade doctors are more likely to have trained in non-NHS programmes [56] and a recent survey has found a significant proportion are under pressure to cover additional shifts to cover rota gaps, and their on-call is more likely to be a resident than a consultant [57].

Regarding doctors in training, the challenges of progression through the training process, career development and passing professional examinations are particular stressors. Health Education England (HEE) has recently conducted a review of mental well-being [58]. Sudden death and suicide in doctors in training have been addressed in a series of documents produced by HEE Postgraduate Deans, who already support trainees in such instances. These documents describe a systematic approach amongst Postgraduate Deans within England, including suicide awareness, possible preventative steps and interventions. Recommendations include a supportive team structure, particular care after illness or failed examinations, or in the case of investigation/complaints etc., and support of trainees as they rotate between different employers – including co-ordination of transfer of information and issues surrounding confidentiality. The documents are a valuable resource for all those who train, support or employ doctors in training (see

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**Box 7**

At work I was smiling and chatty. No one noticed. Except one consultant who said “you aren’t right are you?”. I wept with relief at that comment and took action to continue and get help. There must be more support, and support for those looking after those people.

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**Box 8**

My period of mental illness was used to undermine me, demote me and exclude me socially and professionally from colleagues by other ambitious people in the department. I was also treated patronisingly, told I had no resilience or emotional intelligence, and any attempts to further my career in a competitive and often toxic environment were thwarted or undermined by my admission of mental ill health.

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https://www.hee.nhs.uk/our-work/doctors-training/sudden-death-doctors-training). For anyone in a training post in England, this approach applies from Foundation doctors to the most senior specialist registrars until they complete their training, and trainees should be advised to contact their Postgraduate Dean for further local information. In Scotland, trainees who are struggling may be supported locally via their Deanery or through NHS Education Scotland’s Performance Support Unit (see https://www.scotlanddeanery.nhs.scot/trainee-information/support-for-trainees/performance-support), whereas in Wales and Northern Ireland, both Health Education and Improvement Wales and the Northern Ireland Medical and Dental Training Agency offer support through their Professional Support Units (see https://www.nimdta.gov.uk/professional-support, respectively). The Royal College of Anaesthetists is currently considering how to include well-being and mental health in its training curriculum [personal communication, C. Carey]. In Ireland, the College of Anaesthesiologists of Ireland’s College Tutor and Training Directors networks provide equivalent support (see https://www.anaesthesia.ie/training/wellbeing).

A recent survey and interview study of anaesthetic trainees within South West England and Wales reported a high prevalence of perceived stress and risk of burnout and depression [26, 27]. The investigators emphasised the need for cultural change within the specialty and organisations in terms of attitudes to, and support for, well-being, while highlighting the conflict between work satisfaction and the demands of training. One specific recommendation, in addition to addressing other stressors already discussed above, was the provision of protected time for non-clinical activities [26, 27].

**Employers**

All employers have an obligation to support their employees’ well-being, and guidance exists regarding suicide amongst employees [59]. Within the NHS, there are resources relating to mental health available for employers [60–63], and specific advice exists about the well-being structure within Trusts, including governance and reporting pathways to Trust boards [58, 64].

Trust Occupational Health departments and their associated psychological services may be a valuable source of support for employees. There is evidence that doctors tend not to access support for mental ill health via their Occupational Health departments (nor trainees via their deanery or equivalents), with key obstacles being concerns about being labelled and over confidentiality, and not knowing what support structures were available [65]. It has, therefore, been recommended that Occupational Health departments should be more proactive, promote well-being more actively and be more readily accessible to all staff – and that supervisors should be aware of the appropriate routes of referral [65, 66].

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**Box 10**

I was actively suicidal after repeatedly failing the Primary and losing my training number. I could not speak to my College Tutor or Educational Supervisor as I was too upset, and I was also very aware that nothing is confidential with these people and everything you share becomes coffee-room gossip. PHP saved my life; I am 100% certain that I would be dead now without them.

**Box 11**

Once my crisis point was reached, I sought help from the GP who instantly gave me time off. Both my Training Programme Director and Educational Supervisor were extremely supportive. Thankfully together with their and the GP’s support, attending psychotherapy sessions provided by the Deanery (free of charge), taking time off and commencing SSRIs I came out the other side a much happier person. On return to work, to my surprise, my colleagues were also very supportive (with others even sharing their stories not too dissimilar to mine). I can happily report that the dark thoughts have not returned since, but I am more mindful now of looking out for the warning signs/triggers in order to get help earlier rather than later.

**Box 9**

I tried to take my life whilst I was a trainee. I was trying to seek help at the time, but the department would not let me out of work even to attend an appointment. They made everything so much worse and I still don’t forgive them for it. It has been a long slog to get to where I am today.
Employees who present with suicidal ideation to a Trust Occupational Health department might expect the following approach, after their immediate safety has been ensured: In an acute crisis, the Occupational Health physician will involve a relevant third party support system, for example, liaison psychiatrist, crisis team or emergency department; in other situations, the physician will undertake a suicide risk assessment to review the individual’s risk and any protective factors, with a focus on identifying modifiable targets for intervention [66]. In addition to supporting employees’ ability to avoid suicidal behaviour, they will also be signposted to their GP and/or psychiatrist for further treatment.

Doctors who are expressing suicidal thoughts have the same rights regarding confidentiality as any other patient in a similar position. If the examining doctor – or indeed, friend or colleague – feels that the doctor is at serious risk of harming him/herself or others, and lacks capacity, then one would need to escalate concerns, for example, to the doctor’s GP or close relative. In other situations, the doctor’s confidentiality is paramount, and a doctor’s serious past medical/psychiatric history or previous suicide attempts should not be communicated to others without explicit consent.

Within the employing organisation, with the affected doctor’s consent, the Occupational Health physician can liaise with the key person(s) in the anaesthetic department to exchange information on a need-to-know and confidential basis, in order to protect and improve the doctor’s health. Alternatively, a case conference with the doctor (patient), key person(s) and Occupational Health physician could be a helpful alternative approach. Doctors may need accompanying to appointments, especially in the early stages of their recovery, to maintain their engagement with the process/services and to support them. Discussions should include all areas of work, including the private sector.

**Defence anaesthesia**

The particular stresses and risks to mental health affecting military personnel are well recognised [67]. The Ministry of Defence’s “Defence People Mental Health and Wellbeing Strategy 2017–2022” has four main areas of intervention at its core: prevent; promote; detect; and treat [68]. The Defence Medical Services (DMS) has a key role in supporting this strategy. Military anaesthetists and trainees, as part of the serving community, have access to a range of mental health interventions in these areas, including the provision of specific stress management briefs before, during and after operations, as well as peer support in the wake of traumatic events (Trauma Risk Management – TriM [69]). Internal DMS research has demonstrated that military doctors, although reporting lower levels of mental disorder symptoms, are less likely to seek help and report higher levels of stigma [70]; overcoming barriers to care and accessing care are, therefore, important target areas in this group.

All anaesthetists in the UK Armed Forces have access to enhanced mental health services open to all serving personnel. This means that they have ready access to the full range of mental health interventions for common mental health disorders through a network of 11 Departments of Community Mental Health and 5 associated Mental Health Teams. Care is accessed through referral by Primary Care, and routine referrals are normally seen within 15 working days and urgent referrals within 1 working day. This mental health service is supported by a robust Occupational Health service embedded in Primary Care to ensure that actions are also taken in the workplace to support the restoration of mental well-being. The DMS is also currently running a phase-2 pilot project to ascertain the viability and effectiveness of self-referral directly to mental health services. After-hours support can be accessed through a 24-h MOD helpline.

**External organisations**

There are many external organisations with overlapping areas of interest and support regarding mental well-being. These may be involved to varying degrees, depending on the circumstances. For example, the Association of Anaesthetists has a long history of work in well-being and support (see https://www.aagbi.org/professionals/welfare), and may offer help to departments and individuals, for example, through guidance and access to mentoring. The Colleges (in the UK and in Ireland) have a particular role in the case of training, as does HEE, while the British Medical Association (BMA) offers support on general well-being and work conditions, and specifically for those undergoing regulatory investigation (the latter service commissioned by, and confidential from, the GMC). Support is also available from several other bodies, some of which are listed in the Supporting Information (Appendix S1). Departments and Trusts should consider compiling their own list of local contacts and resources.

**General healthcare and support**

All doctors should be registered with a GP. However, GPs themselves might not be experienced enough in addressing the issues with which mentally ill doctors might present. In addition, anaesthetists may be fearful that an admission of substance misuse or addiction
might lead their GP to refer them to the regulator. NHS Practitioner Health (formerly the Practitioner Health Programme (PHP)), a confidential NHS service for doctors and dentists with mental health and/or addiction issues, has created a competency framework for GPs that covers these potential deficits [71]. In the first 10 years since its establishment, ~6% of the cases seen by NHS Practitioner Health have been anaesthetists (approximately half women, half men). Anaesthetists, dentists and emergency practitioners were more likely to present with problems related to addiction than those in other specialties (19–20% of cases within each specialty) [36]. In Wales, the Welsh Government funds a counselling service for doctors, Health for Health Professionals Wales (see https://www.hhpwales.co.uk).

Suicide awareness and mitigation training
Individuals experiencing suicidal thoughts or following self-harm are often treated with a lack of empathy and sometimes hostility by those they encounter, including healthcare professionals [72]. This may be due to a lack of understanding about the causes and nature of suicidal thoughts and self-harm, and the anxiety that suicidal individuals can provoke in others. Healthcare professionals may also be unwilling to acknowledge that a colleague is at risk of suicide, for fear of being expected to manage that risk. There may also be a widespread belief in the inevitability of suicide, which may be an institutional impediment to the adoption of some suicide prevention strategies and may dissuade suicidal individuals from seeking help [73].

Effective training in suicide awareness and prevention has been described in several settings [74–78] and several programmes and courses exist at individual, group and organisational levels. The concept of mental health first aid (MHFA) training arose in Australia in 2001, as a means of training the public to help adults with mental health problems including suicide, and now exists in several countries and settings, including the workplace. Although there is evidence of improved mental health awareness and support for those with mental health problems up to 6 months after training [79], few studies of adequate quality have focused on the workplace. A rapid review commissioned by the HSE and conducted in 2017 concluded that there was consistent evidence that MHFA training improves employees’ awareness of mental health issues, and limited evidence that it leads to sustained improvement in their ability to help colleagues experiencing mental illness. There was also limited evidence that the content of MHFA training has been adapted for workplace circumstances, leading the review group to conclude that the effectiveness of MHFA training in the workplace was yet to be proven, largely through a lack of studies in this setting [80].

It is the Working Party’s view that some sort of basic training in mental health awareness should be considered mandatory for all staff in NHS (and Irish equivalent) organisations. Specific adaptation for anaesthetic departments should include the increased risk of suicide in this specialty area, and emphasise the points made in this guidance.

Mental health issues constitute a considerable proportion of presenting symptoms in a general Occupational Health clinic. Therefore, specialisation in Occupational Health medicine involves appropriate mental health training and Occupational Health physicians will have managed several cases involving mental health issues during their journey to becoming a specialist [81]. Occupational physicians could, therefore, be a valuable source of advice regarding the effects of work on psychological well-being and vice versa.

Aftermath
The most immediate requirement in the event of a colleague’s suicide is to acknowledge that the death will have a significant effect on psychological health in the organisation, beyond immediate friends/family and colleagues [82]. Typically, feelings of sadness and guilt will predominate, and these may affect non-clinical as well as clinical staff.

There are two broad but overlapping areas that require attention and/or action following an anaesthetist’s suicide (see Appendix S2): the immediate and early response, dealing with both operational issues and the initial emotional reaction; and recognising and addressing the risk of harm to others affected by the death, including the risk of post-traumatic stress disorder, depression and suicidal ideation/or suicide in others, some of whom may already be at higher risk themselves.

**Box 12**
The threshold for treating doctors should be much lower as we tend to seek help so late and underplay symptoms. Treatment protocols must also be significantly more proactive: doctors cope and cope then fall off their perch late, which is what I did.
(such intervention has been termed ‘postvention’ [83]). Staff directly involved in providing medical care to their colleague (e.g. resuscitation and/or withdrawal of care) may be particularly affected and even start to question the quality of their care, however unjustified this may be. There are many resources available that cover what to expect in the workplace in the event of a suicide, and of the range of interventions that might be useful [1, 84–87]. The Association of Anaesthetists’ survey on suicide suggests that a lack of support and/or signposting to available resources, poor communication including a lack of open discussion/support, and insensitive prioritising of clinical work above all other considerations, may lead to significant distress, guilt, anger and/or resentment amongst surviving colleagues [5]. Senior staff attempting to manage the aftermath of a suicide may themselves need additional support.

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References


Supporting Information
Additional supporting information may be found online in the Supporting Information section at the end of the article.

Appendix S1. Useful links and resources relating to mental health and suicide (correct as of 10/09/2019).

Appendix S2. Areas to be addressed in the response to an anaesthetist’s suicide (n.b. relating to a death in the workplace; similar considerations might apply to a death outside the workplace). Details of local departments and/or personal etc., including external agencies, can be entered in the third column.

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