[Edited for grammar and clarity by CAMH]

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Patient suicide and its impact on residents and psychiatrists with Dr. Juveria Zaheer

[Musical intro]

It's the call we dread. Perhaps from a family member or a nurse in the clinic where we work. He's died and they believe the cause was suicide. Many of us, perhaps most of us, have had that experience. But what's the impact on us?

David Gratzer: Welcome to *Quick Takes*. My name is Dr. David Gratzer. I'm a psychiatrist here at the Centre for Addiction and Mental Health. Joining us today is Dr. Juveria Zaheer, who is a psychiatrist at CAMH, as well as being a Clinician Scientist with the Institute for Mental Health Policy Research. She's also an Associate Professor at the University of Toronto. In fact, she's just gotten her academic promotion. So, congratulations to you, Dr. Zaheer, and welcome back! This is your fourth appearance in our podcast series, I believe. [Edit: was her third appearance.]

Juveria Zaheer: Thank you so much. It's so great to be here.

David Gratzer: Now, you've just written an important paper published in the *Canadian Journal of Psychiatry*. Tell us a bit about the paper.

Juveria Zaheer: So, it takes me back to 2017 and I had been in practice for several years. My program of research was in suicide prevention, and I worked in the emergency department at CAMH. So, we had a lot of experience assessing suicide risk, working with people, experiencing suicidality. But to that point, I had not had a suicide loss in my own career, and I'll never forget when it happened. I had seen the person a couple of times. I remembered them very fondly. I thought that they were getting better. I heard a little bit about their family, and I heard a little bit about their interests in the arts, and it was someone who I wouldn't have thought of. And when I found out, it was it was a really destabilizing experience. I think I thought of myself as someone who was really good at this, who knew what they were doing, who provided good care, even though I knew that my colleagues were excellent and who provided excellent care every day to patients that had the same thing happen. It just it felt so jarring. I didn't know what to expect. I didn't know what the policies and procedures were, even in my own institution. I didn't know that it was going to cause me difficulty sleeping and that was going to be something that I was going to think about, and that's something that was going to feel sad about.

I didn't know how I would manage working with families afterwards and talking to families and processing this loss with them. And I also didn't know what my practice was going to look like. Would I be more cautious? Would I be more nervous? What would we like to see someone who reminded me of that person? And so sometimes when we have a lot of complicated feelings, there's lots of different ways to channel them. And for me, it was wondering what had been written on the subject. And we'd found that up to 80% of psychiatrists

experience a suicide loss in their careers. And we know from survey data people feel really awful. So, a lot of grief, sadness, depressive symptoms, anxiety, worried about the consequences. But this was all survey data. We had no idea what the people's experiences were: What helped? What didn't? How can we build supports for people in our profession? And how can we move forward from this tragedy in a safe and supported way. And so, we did a study, and that's what we'll be talking about today.

David Gratzer: And the title of this study is **"I was Close to Helping him but Couldn't Quite get There": Psychiatrists' Experiences of a Patient's Death by Suicide**. You suggest so many of us have had this experience. I think back to my training, around the time dinosaurs roamed the earth, and while we did talk about suicide and risk assessments, I can't remember ever attending a lecture discussing what it would be like to lose a patient, which is particularly remarkable given that most of us will lose a patient over a career.

Juveria Zaheer: No, I think that's exactly right. And I think sometimes we worry, and we think about the parallels, right? Sometimes in communities and in families, we don't want to talk about suicide because it seems so scary and we're worried that we're going to make it happen. I wonder if there's some of that in our profession. So, it's well, it should never happen, so why would we talk about what happens afterwards? And I think too, in medicine, we are in the life-saving business. We don't see ourselves in the business of coping with these terrible outcomes, especially within psychiatry. And I never had any training on this either and didn't know if my own experience was sort of outsized or whether it was typical and what we could do to benefit people, especially residents, going through the program. And I'm happy to say that this past April was the first year that the University of Toronto had a session on how to cope with suicide loss. And it was very well received and had a lot of residents reach out to me afterwards. And so, we're so glad that at least that change is coming.

David Gratzer: Your colleagues have also talked about loss. You work in an emergency department. It's part of our work, and yet it's a deeply unsettling part of the work. What are things people have said to you over the years that that struck a chord?

Juveria Zaheer: It almost feels like when someone brings this up, they don't know what to expect from the respondent, which I think is really interesting. So it's people often start off tentatively like, "this happened. I don't really know what happened. I don't know how I feel about it." And it's almost like people need a little bit of permission to say, I feel sad, or I feel scared, or I don't know what's going to happen, or was it my fault, or wasn't it my fault, or I feel angry, I feel abandoned. And so, it's one of the things that surprised me both in my own experiences and in the study. I think we often think that people are worried about things like litigation or practice. The overwhelming theme for me has been grief. People are sad. You lose someone that you're close to, that you have some kind of relationship with. You lose someone who you think about a lot. You lose someone who you're caring for. And I think that kind of profound grief and sadness is what most people talk about. And I think it's a little bit surprising. And we have patient partners who work with us as members of our study team. And I think they were really moved by the fact that you think you're just a patient, but you're you have such an impact on the people in your life, including your care team.

David Gratzer: Do you think the physician reaction is a bit jarring, in part because so much of our training tries to take us away from emotions and human reactions?

Juveria Zaheer: Yeah, absolutely. And I see that in in kind of the dynamics too, between residents and staff. So, we suffer a loss in residency when you are also being evaluated, so you want to look strong and capable, and you don't want to cause difficulty for your supervisor. You don't really know where your supervisor is coming from. And I think as physicians, too, we sort of think of ourselves as leaders. So, if I express my sadness and distress, who's going to support the nursing team and the social work team? Who's going to support the family? And I think a lot of medical training is sort of taking us away from those emotional pieces to say that we need to be strong, and we often do, and at the same time, both things can be true and our feelings and our responses matter. And I think when we try to push them down and act like nothing bad is

happening, I think that's when we can get into trouble.

David Gratzer: And the paper directly talks about emotional response of psychiatrists and residents of psychiatry. Why don't we talk about that for a moment? The paper talks about other things, but let's focus on that for a moment. This is a qualitative analysis. Seventeen interviews. What were some of the emotions identified by the people you interviewed?

Juveria Zaheer: I think the big one was grief and sadness, this idea that they were really disturbed by the loss, that they lost someone who was a human being with unique qualities, and they built a relationship with that person. Another emotion people experience is shock. It's a trauma when you hear this, you know, you don't expect to hear it, you don't expect to get this call. And I know we try to talk about high risk and low risk, but it's always surprising and it's always a terrible shock when something like this happens. Anxiety is a big one. These spikes of anxiety, this undercurrent of anxiety, this idea of like, am I going to get in trouble with my institution? What is the family going to think of me? How am I going to manage what comes next? Who am I supposed to speak to? Is this going to happen to me again? Am I a bad psychiatrist? So the anxiety ranges from, like, really practical things to really existential things. When I did the interviews, I could see people almost reliving that anxiety in the moment. We don't get away from it.

And then the last piece that I think was really important is guilt and shame. David Goldbloom always says psychiatry happens in behind closed doors. "Surgery happens in a theatre, but psychiatry happens behind closed doors." And we want to protect our patients and their confidentiality. But when things are behind closed doors, they can feel shameful. And when we feel shame, it's hard to talk about how we're feeling. And I think one of the things that's interesting is that when you talk to people outside of medicine or even in other specialties or people not in psychiatry, people say the same thing. It's like, "Oh, it wasn't your fault. Like these things happen." But for us in this role, it does feel really devastating. I know. I remember one respondent told me that they had had two suicides in a month. And they said I was worried about what my administrative assistant would think of me. I was worried about what my resident would think of me. It's just this idea of our professional identity is so wrapped up in who we are, and it comes as a real shock to us when these things happen.

David Gratzer: I think about a particularly devastating loss that I suffered, a patient I had known on and off for years. And he took his own life. And I remember when I was looking over the chart, I found a small clerical error. I had written down the date wrong because it was just in my written notes. It was around a long weekend, but everything was fine. It was clear that this was just a minor error and didn't have anything to do with the mental status exam or the treatment plan, all of which were fine. And I remember lying in bed at night thinking, the college is going to review my notes and they're going to think, this guy can't even write down a date and a time properly and they're going to strip me of my license. And then I thought, I don't know what I'm going to do. I mean, I'm not trained to do anything else. I'm going to have to do something else, but I'm not qualified. The anxiety was crushing.

Juveria Zaheer: And that rumination, too. You know, it's almost like – I know we both have children – when children are little, there's this idea of magical thinking that if I do everything right, nothing bad will happen. Or if I did this one thing wrong, something terrible will happen. And I think we kind of go back into that place of maybe both on both ends. Like maybe if I said something differently or I did something differently, or it may not have affected care, but I documented the wrong thing or I didn't write a note or I didn't talk to the right person. And we, I think, hold ourselves to such a high standard that that script happens over and over. And we've done a lot of research with family members who've lost loved ones to suicide, too. And it's a similar grief, much more palpable and much with so much tragedy that comes with it. But are the families are experiencing the same thing? What did I miss? Did I say the wrong thing? How could I have helped? And so, I think sometimes that's something that's worth connecting with. When you work with families after a suicide loss that they are at the centre of the circle of grief, but you are also grieving and you can understand what each

other are going through because it's similar.

David Gratzer: You bring up David Goldbloom, our common friend mentor, who in fact wrote quite extensively about the loss of one patient. It was published in a national newspaper, and he talked about going to share the grief by attending a funeral for a patient. We don't do a lot of that, but when I read his description, I wondered why.

Juveria Zaheer: Yeah, absolutely. And I think so much of psychiatry we talk about boundaries, and we talk about, you know, maintaining a frame. And it's sometimes it can be difficult to know what to do. Is it a breach of confidentiality to go to a service, for example? But in the study, when we talk to people, I remember one respondent said to me, I had a mentor who said, always go to the funeral. And I took that to heart. And of course, the family's feelings come first, but we're very often welcome at these places. And I was speaking with a colleague recently who had brought flowers, and brought flowers from the team, and spoke with the family. And I think we don't realise how much we can touch people and how much we can affect them. And so if it's something that the family feels comfortable with and appreciative of, I think it can be a really important way to heal. I think it's also interesting because we see people kind of cross-sectionally in our office and to see their whole full, meaningful life and the people who are really meaningful for them can be very helpful as well.

David Gratzer: You've talked about the emotional response. What else came up in these interviews?

Juveria Zaheer: Another piece that was very helpful for us to understand is that in our careers, we may face different types of loss. We may have suicide losses, we may have other losses, and I think it was important to point out. And one of the things that was surprising to me in this study is that your response is dependent on all kinds of things. So, you may have two losses and one may hit really hard and one may be tragic and sad but doesn't have the same emotional impact. And so one of the things that comes up is if you're going through a lot in your personal life, if you are going through a lot in your professional life, that has a really deep impact on how you're going to process this loss. So if you are experiencing depression or marital difficulties or other types of stress, if you were already feeling anxious in your workplace and thinking about making a change, it's a lot of what people talked about. These things become like really tied together. I remember when I had my loss, my dad was very ill and I was going back and forth to Kitchener, to the hospital, and I can't think about one without the other in many ways. Or when I've had subsequent difficult outcomes, you know, there was less going on in my life and I had more time, I think, to process and to grieve.

Another piece that can be very helpful or challenging are institutional responses. And so I think sometimes the people who we're talking to for support are also people we report to, and that can be really challenging. But one of the most helpful things is talking to a colleague. Closing the door and sitting in a safe place and saying, "I went through this too." And I'm quite forthcoming with residents and with my colleagues about the loss that I had and how I reacted to it, because it gives them a safe place to comment on what's going on. And it's a lot easier to talk to another psychiatrist or mental health care provider about this than it is anybody else, even if they're in health care, because it's a very specific kind of grief and loss. And then I think the last piece is your relationship with the patient. So, if you're if you see them once in an emergency department, you may feel shock, anxiety, fear. If it's someone that you've followed for years as an outpatient, the grief may be the most significant piece – and the sadness. And so I think the circumstances of the loss and the patient: Who do they remind you of? Did you think that this was going to happen? There's a lot of nuances there.

David Gratzer: Your paper is a little bit unusual and perhaps that much more important because you actually close by making some recommendations. You've touched on this already. Let's talk about those recommendations.

Juveria Zaheer: Yeah. So I think the first piece that we really that came through in all of our transcripts was that people really didn't know what to do. And it's like learning to – I don't ski, but I understand that you

probably don't want to learn to ski on a double black diamond course, you know, with somebody chasing you in the middle of a rainstorm. You want to learn skills in a safe way and have a big strong foundation before you have a critical incident. And so one of the things that we recommend is starting this training within residency programs and even within medical school. And this training can include things like nuanced discussions about suicide prediction and prevention, the evidence, philosophical and ethical considerations, training about speaking with teams and patient families after a patient suicide. These are not skills you want to learn for the first time when you're going through such a traumatic experience. I think it's really important to normalise common behavioural and emotional experiences so people don't feel silly or weak to know that many of us feel really distressed when this happened and can have depressive symptoms, can have symptoms of anxiety, can second guess, you know, our career pathways. I think it's important for people to know kind of what's within normal limits and what help is available. And I think presentations both didactically and informally from senior psychiatric staff with past experience about suicide loss, I think is really important.

The second recommendation was to build really clear policies and procedures about what happens. So maybe separating a debrief from a postvention procedure, from an incident review, making sure that these are done in neutral, non-judgmental language, kind of having an easily accessible, specific document that lets you know exactly what you need to do, who you need to reach out to, what to expect, what kind of supports are available. And I think finally, one of the things that happens is and residents have said this to me, sometimes you get all of this support all at once. So everybody's checking in, everybody's reaching out, your amazing supervisor, your site director, your mentor, and then nothing really happens after that. And that's human nature. We think that things are kind of resolved and better. But one of the things that I think we really strongly recommend is working with the person who's had the loss to develop like a plan, like, I'm going to check in with you in three months. Let's check in again in six months because you never know what's going to happen. It could be that you've had another loss. It could be that you've been working with patients that remind you of that patient. It could be a year anniversary. These things can all hit us a little bit differently. So I think recurrent check ins should be the norm as well.

David Gratzer: You wear an administrative hat. How have you changed in that role given these recommendations in your conversations with residents and other clinicians over the years?

Juveria Zaheer: You know, I was in charge of medical education in the CAMH emergency [department] for many years, and we were always protective of our residents and we want to provide them with support. I was always so proactive in reaching out to them and talking to them and seeing what they were going through. It was interesting when I moved to my role now, which is medical head overseeing psychiatrists. I think what this work showed me is sometimes we think our colleagues are fine and that we're being intrusive; they have too much to do and they don't really want to talk about it or they don't want to talk about it with you specifically. But what I think this showed me is that people really do need a space to feel safe. People really do appreciate the check in. I think giving people options is really good to know that I'm always available. I'm always here. Here's my cell phone number. Let's talk. But it's you know, you can take the lead on it so you're not, you know, having to be beholden to having these conversations. But I think that we often minimise our own distress as we become staff. And I think if we can get that support that we need, it also allows us to be more empathic to our residents and to our colleagues because it'll be a bit easier for us to access how we're feeling rather than pushing it down.

David Gratzer: This paper and so much of your work focuses on qualitative analysis. For those of us who aren't churning out paper after paper as you are, how would you summarise your approach?

Juveria Zaheer: This paper I wrote with Zainab Furqan, who is an extraordinary qualitative researcher, a junior scientist at UHN, and Zainab worked with me for a long time, and we talked about how to do qualitative research. And one thing I told her is that people will answer all kinds of questions. And you want to take an approach where you're systematic and gathering information while maintaining a very supportive frame. And

then everything people tell you is important. And I always think about Lego. So if you take Lego, Lego has qualities, it has a colour, it has a shape, it fits with other Legos. And it's the same with data. We take each piece that someone tells us and we understand in all kinds of different ways, like their emotional experience, the content of it, how it relates to other things that they've said, how it relates to their stage of training or their gender or their culture. And we take all of those pieces of information, those Legos, and we understand them in every way, and then we systematically sort and rebuild them into something that makes sense, that incorporates everybody's experience, that is honest and true to the data, and that you do a lot of it's like a little bit of a of pruning and building and reconstructing to make everything fit. But it is a really meaningful process and when done well, I think can really reflect a wide variety of experiences from a wide variety of people.

David Gratzer: Doctor Zaheer, what advice might you give to a colleague who's just had such a loss?

Juveria Zaheer: I think the first thing I would say is that you're not alone and that this happens to many of us. And it is a consequence of providing care to people who are unwell. I think what I would say is that you need to take time to reflect on how you're feeling and to figure out what you need. And the most important thing is to pick up the phone and call someone who you trust, who's a colleague, because they'll be very happy to hear from you. And you hearing what they've been through makes all the difference in the world. I think thinking about what your institutional policies are, all of that, is really important, but I think the most important thing is connecting because the more connected we are, the less alienated we feel.

David Gratzer: Dr. Zaheer it is a tradition of *Quick Takes* that we do a rapid-fire minute. Of course, you're an old hand at this because you're a returning guest. Are you ready?

Juveria Zaheer: Ready.

David Gratzer: All right. Shall we put one minute on the clock?

Juveria Zaheer: Yes.

David Gratzer: Here we go.

David Gratzer: Doctor Zaheer, what's one thing you think administrators should do differently when thinking about suicide?

Juveria Zaheer: Less protocol. More connection.

David Gratzer: You've suggested in the paper distinguishing between an opportunity to talk and a formal review. Can you explain?

Juveria Zaheer: I think it's really important to provide emotional support, first and foremost. And I think people do want to have review of their practice. People do want to get better, and that can be done in a safe and supportive way through incident review that is focused on everybody improving and improving patient care rather than figuring out what someone did wrong.

David Gratzer: Biggest surprise in writing this paper?

Juveria Zaheer: How emotional it was for me to do these interviews and to have these conversations. I wasn't expecting to be so moved and so grateful to my colleagues for sharing their stories.

David Gratzer: And at the buzzer, one final answer. A prominent Russian writer who wrote about the gulag. What is the question?

Juveria Zaheer: [Laughter] Solzhenitsyn [Solzhen-it-syn] is how you pronounce it.

David Gratzer: Now, for those who are listening and might not have watched every episode of *Jeopardy!* For the last five years, can you explain this inside joke?

Juveria Zaheer: I was on *Jeopardy!* in May, and I thought I was going to be fine because I'm used to emergency psychiatry settings. But it was much more frightening than that. And I know the works of this gentleman quite well. We have them on the bookshelf. And when I saw the clue, I said, Great. I'm going to answer this. And as I buzzed in, I realised I had never said his name out loud. And I guess neither of the other two women had either because everybody pronounced it incorrectly. But now I will know how to pronounce it correctly, forever.

David Gratzer: And in fact, you made CNN for your mispronunciation, but with a view many of us, including myself, have that that you were robbed.

Juveria Zaheer: I'm going to write a letter. We'll see!

David Gratzer: Doctor Zaheer, we appreciate all of your answers and the thoughtfulness with which you've approached this topic.

Juveria Zaheer: Thank you so much.

[Outro:] *Quick Takes* is a production of the Center for Addiction and Mental Health. You can find links to the relevant content mentioned in the show and accessible transcripts of all the episodes we produce online at CAMH.ca/professional/podcasts.

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