Foundations of Emergency Medicine
Foundations III: Guided Small Group Experience

Session 7: "Depression, Suicidality and Physician Impairment"
Unit: Personal Development

This session is in memory of Carlos, Kaleb and all those we have lost

- **Agenda and Learning Objectives**
  - **Case Part I –** Depression and Suicidality (20 min)
    - Describe direct and indirect clues that raise concern for depression and/or suicidal ideation
    - List resources available to residents for mental health supoort
  - **Case Part II -** Suicidality and Physician Impairment (10 min)
    - Define the three factors in Joiner's Theory of Suicide and explain how these may apply to residents
    - Discuss the findings regarding resident death as it applies to suicide
    - Practice making an individual crisis management plan
    - Discuss the difference between impairment, illness and professional development stress/overload
    - Identify the barriers for physicians to seek treatment- particularly for mental health issues
  - **Case Conclusion and Teaching Points (10 min)**

  Optional Activity: 2-minute video by Chris Doty, CORD President at the beginning or end of the session (please consider including, it's quite impactful)
  Just Ask: Christ Doty MD – World Suicide Prevention Day (1:30)
  https://www.youtube.com/watch?v=4DUJAzA-D3c

- **Note to Facilitators**

  Though the logistics of running this session are simple, a question guided large group discussion with a short 5-minute individual activity and a suggested 2-minute video (link above), it may be a particular difficult session to facilitate as it involves resident depression, mental health impairment and ultimately a resident suicide. Please prep well in advance for this session and spend some time familiarizing yourself with your institutional resources. If your residency has a faculty who is particularly interested in this topic it may be wise to have them facilitate this session. It may also be useful to have a second faculty member in attendance in case a resident has a significant emotional response to this session and needs one-on-one attention (though this is exceedingly rare).

  From a practical standpoint, please consider printing off blank emergency plans for your residents to fill out during the session. There is a 5-minute individual activity to allow residents to create their own mental health emergency plan. There is also an example plan included in this facilitator guide. It may also be helpful to obtain pamphlets to hand out to

the residents for your institutional EAP program. Lastly, you may consider posting the suicide prevention hotline number (800-273-8255) during the session.

Finally, please read the disclaimer at the beginning of the session to the residents in order to help prepare them for what's coming. Email Loice Swisher, Vice-Chair of the CORD Wellness and Resilience Committee (middletonswisher@msn.com) or Natasha Wheaton, Foundations III Co-Course Director (wheaton.natasha@gmail.com) with any questions or concerns.

"Be brave. Change the conversation. Change the trajectory."

- Loice Swisher (CORD Wellness and Resilience Task Force Vice-President)

❖ **Facilitators, please read to residents prior to start of session**

Although it is an extremely difficult topic to discuss, suicide is an occupational hazard for physicians with an increased rate of 1.41 times the general population for male physicians and 2.27 times for female physicians. When studied, the frequency of resident suicidal ideations is around 10%. Another study showed suicidal ideation increased 370% in the first three months of internship. In order to change this risk and trajectory, we must be able to talk about physician suicide openly - for ourselves and each other. Some will find this session more difficult than others particularly if a co-medical student, resident, faculty, friend or family member has died by suicide. Others may personally have had suicidal ideation, crisis or attempts. If people share personal information during the session please give the professional respect of confidentially. In addition, if this session touches too closely and you need to leave, feel free to step out from the session. Know that we are all in this together. If you feel at-risk or concerned know there is help.

❖ **Case Part I –** Depression (20 min)

JS is 25-year-old male intern who moved across country 3 months ago to begin his residency in emergency medicine. He shows up to conference a half hour late in rumpled scrubs an unshaven. He grabs a seat next to you and starts texting on his phone. At the break you ask what's happening. He confides he finds the night shifts brutal as he isn't able to sleep well at his apartment. It is too loud and too bright during the day. In addition, a few days ago a guy that he thought had a kidney stone crashed and later died on the OR table from a ruptured AAA. He hadn't thought about doing an ultrasound but was looking to find the UA to see if there was blood in the urine. It surely is going to be an M&M and he feels as if it is his fault. He asks you not to tell anyone - particularly not the program director because he doesn't know what she would say. He is not sure he wants to do emergency medicine anymore but there doesn't seem to be another choice right now.

❖ **Discussion Questions with Teaching Points**

- **The ACGME expects resident to know the symptoms of burnout and depression. Are you concerned that JS has burnout, depression or suicidal ideation? Or is this just typical of being a tired intern?**
  - In July 2017, the ACGME added Wellbeing requirements to the Common Program requirements → all programs are expected to educate residents and faculty in the

identification of symptoms of burnout, depression and substance abuse including the means to assist those experiencing those conditions (good news, this counts!)
    - Without a deeper discussion, it is impossible to know the level of risk → the important thing is to recognize risk factors and red flags in order to know when to dive deeper and ask more questions

- **What are JS's risk factors for suicide? Why are physicians, and particularly residents, at higher risk for suicide attempt and ultimately completion?**
    - JS risk factors include lack of local support network, sleep deprivation, questioning choice of specialty, bad patient outcome and perceiving himself as a burden to those around him
    - Joiner's theory of suicide states that to die by suicide, people need to acquire the capability to die at their own hand and they need to develop the desire for suicide
    - Physicians have increased knowledge regarding lethality and variety of suicide means and have access to more lethal medications
    - Physicians become habituated to people's pain and death that may overcome feelings of self-preservation
    - In addition, residency can create a perfect storm for perpetuating suicidal feelings
    - The nature of changing rotations does not allow for a close day to day support network directly at work
    - There is a correlation between sleep disturbances and suicide
    - One study showed that suicidal ideation increased 370% in the first three months of internship
    - In addition, an ACGME study revealed that the first three months of internship were a high-risk period for resident suicide
    - Suicide is the #2 cause of death for all residents and the most preventable cause of death

- **Are there red flags in JS's situation for depression or suicide?**
    - Often red flags are hard to see except hindsight
    - Many things which could be 'clues' to suicidality may be phrased in a way to seem normal or written off to stress or fatigue
    - It important to look for indirect signs indicating hopelessness or not wanting to be around anymore
    - Physicians are very good at masking their true feelings and realize what not to say if they don't want to get 'caught'

- **What would you do in such a situation? Both on the resident side as well as on the program side?**
    - The most important thing is to show concern and connect → it is those that are working and living next to a person that can make a difference
    - Discuss resources available to the residents such as employee assistance programs, hotlines, program or institution options such as psychologists or psychiatrists available
    - Second victim or peer-to-peer support options can be particularly important (Session 15 of Foundations III will further discuss this topic)

- Encourage every resident to develop a personal crisis management plan that includes three people to call when he or she feels like they have hit a crisis point and a listing of the resources
    - We will give the group 5 minutes later in this session to develop their own plan
- The ACGME encourages residents to alert the program director if they are concerned about another resident → most of these conversations can be kept confidential unless there is a concern about a resident's immediate safety or the safety of others

❖ **Case I Conclusion**

JS agreed with you to go talk with one of the chief residents who assured him that many of these struggles were common to most starting residency- dealing with night shifts and bad outcomes. Lack of sleep can make problems seem overwhelming and out of proportion. She offered some of the strategies she employed for shift work to handle sleep issues as well as taking a nap in the hospital call room if needed. She also said she had a bad case as an intern. She went to talk with someone from the peer-to-peer support services that really helped because it was another doctor who understood exactly what she was going through and it was anonymous. After a heartfelt conversation, JS says he feels relieved and less stressed. The chief said she would check with him later that day and made sure he had her phone number for any reason. She asked him to put in his phone the names and numbers of 3 people he would call when he felt stressed or overwhelmed. She alerts her PD about her conversations who informally checks in with JS a few days later and he says "I'm doing better, thanks for checking in!".

❖ **Case II –**Physician Impairment and Suicide (20 min)

It' January. LM is a 28-year-old second year resident. In her first year, she was initially active in putting together resident monthly meet-up but after she failed her first-year in-service exam she decided she was going to pull back from social events in order to concentrate more on her studies. Her mother died suddenly during her second year of medical school after Christmas and the holidays are tough for her. She saw someone at that time to help her through her grief but she doesn't want to see anyone here because she got through it… and besides it might keep her from getting a license later and she just doesn't have time. Although you only seem to see her in didactics as your rotations haven't overlapped as much as last year, she seemed fine. Today, out of nowhere, she texts you for the first time in a couple of months:

LM: Go out tonight?
You: Got a shift.
LM: OK. Maybe I'll hang out somewhere tonight.

❖ **Discussion Questions with Teaching Points:**

- **What concerns may you have about LM? What risk factors does she have for suicide?**
    - LM potentially has issues with burdensomeness with the failed in-service and that it will be coming up again soon

- She also may have some issues with failed belongingness with the anniversary time of her mother's death and also having pulled back the year before from social events so may not have developed a strong network of support
- However, the most concerning is an abrupt change in behavior
- The second thing that is concerning is the odd wording of the response – "*hang out somewhere*" → when something seems **unusual or odd, this is the time to ask further questions.**
- The time of year is also concerning → the ACGME report of resident deaths from 2000-2014 indicates that the third quarter of the academic year is a higher risk time
  - The article speculates "post-holiday midwinter, midyear academic, and seasonal factors may have particularly severe effects on some residents, possibly leading to depression, isolation and even suicide"

- **What would you do next?**
  - There are no right or wrong answers to exactly what one should do → the problem is that high-risk conversations can be so indirect that these can be perceived as normal in the moment
    - If there is something odd, unusual or just seem off, that is the time to ask some follow-up questions, to establish a connection and potentially offer an alternative plan- go out tomorrow night, chat now, etc.
    - If you are concerned, ask directly!
      - "That sound's weird. What is going on?" → It will **not** make things worse and if a person is at risk they may open up and disclose suicidal feeling
  - If you can't check up on someone for whatever reason, please ask someone else to!

- **Why would LM not seek help for mental health issues?**
  Note to Facilitators: Consider writing these barriers down to aid in brainstorming potential solutions in the next questions.
  - Time
    - This is one of the biggest issues for residents
    - It is difficult to find the time to locate a new therapist or psychiatrist and then there is difficulty finding the time to go to session
    - The ACGME has attempted to ease this issue by requiring programs to allow residents time to see their doctors including for mental health issues
    - Establishing care early in intern year for residents with a history of mental illness (ie during orientation) is crucial
  - Impact on colleagues
    - Residents, and physicians in general, do not want to be seen as a weak link
    - If the resident needs to have accommodations to see a therapist regularly there could be the concern that this could affect others schedules to provide coverage
  - Lack of confidentiality
    - If one is seen within their own system there often is the concerns of who will see them and how secure are the records

        - Even if seen outside of the system, there is the concern of the reason for schedule accommodation getting out
        - Many institutions have special mechanism to protect the health information of their employees → ask what your institution's policy is
    - Financial
        - Residency may be the first time that an individual had his or her own insurance which can be overwhelming to decipher
        - In addition, out of pocket expenses may be difficult to handle on a resident's salary
    - Impact on professional standing and licensure
        - Some states as well as hospital credentialing forms ask about mental health issues (we will discuss this in more detail later)

- **Before we move on, what can we do as individuals and as an institution to overcome these potential barriers?**
  Note to Facilitators: This is a brainstorming exercise with no right or wrong answers

    a. Is the concern over licensure issues a real one?

    - Unfortunately, there is no easy answer to this question though there are steps being taken to decrease the impact of seeking mental health care on physician licensure
    - Because there is significant variability among states and there is little transparency regarding the consequences of seeking mental health treatment this is an issue as residents, and indeed many physicians, worry about
    - Dyrbye and colleagues found that 40% of physicians reported they would be reluctant to seek formal medical care for treatment of mental conditions because of concerns about their medical licensure
    - The state variability may be from no questions on mental health issues at all (safe haven states) to "From xxx to present, have you received treatment for psychiatric, addictions or substance use?"
    - In 2016, the AMA adopted a policy calling **"on state medical boards to refrain from asking applicants about past history of mental health diagnosis or treatment and focus on current impairment by mental illness or addictions and to accept "safe haven" non-reporting, which would allow physicians-in-training who are receiving mental health treatment to apply for licensure without having to disclose it"**
    - The licensure concern is not only over state medical boards but also insecurity over where else such information is required to be reported → there are worries that such information many have to be disclosed to places such as letters of recommendation, hospital credentialing forms and even questions about ABEM
    - Most times only impairment needs to be reported not simply illness and treatment (see below for more information)
    - Also, many resident issues (ie acute stress reactions, PTSD) is not classified as true mental illness as it can be temporary and situational

- **What is impairment vs illness? If you see a counselor or psychiatric during residency is it always reportable somewhere?**

- *Impairment* is a functional classification that impacts the ability of a physician to perform one's duties and therefore has the potential to negatively affect a patient's care and safety → this is the classification that is almost always reportable
- On the other hand, *illness* is just the existence of a disease → this may or may not be reportable
- Illness and impairment are **not** synonymous but may exist on a continuum
- Many issues that come up in residency are neither impairment nor illness but rather professional development and temporary situational stresses
- Stress, overload, fatigue and 'mini-PTSD' events occur and generally are rarely ever reportable, as they do not impact patient safety or the ability of the resident to perform their duties
- In fact, addressing such issues early can potentially avoid deterioration that could eventually lead to impairment
- **As a rule,** it is much better to seek care early → this is much less likely to be reportable than waiting until things escalate and true impairment occurs at which point it may be reportable

- **Now, let's take a few minutes and have each of you draft your own crisis management plan Here are some points to consider when drafting a crisis management plan:**
  Note to Facilitators: Please consider handing out the provided black emergency crisis management plans to the group. Also, all of these points can be loaded into a free app called MY3 that can then email you your plan. Another useful free app with similar features is the Virtual Hope Box.
  - **Warning Signs:** what situations make you feel anxious, incompetent or bad starting a downward spiral
  - **Coping Strategies:** what activities distract your mind in a positive way
  - **People**: name 3 people can you call
  - **What things you should you avoid to keep yourself safe**
  - **What is most important to you and a reason to live**

  Example:
  Warning Sign: when there is a complication with a patient and I think I missed something or did something to cause it
  Coping Strategies: positive mantras, looking at pictures of those things that are important to me, remembering those patients that did well because of me
  People: KAM (111-1111), JMP (222-2222), FAS (333-3333)
  Things to Avoid: alcohol, sleeping before doing anything serious
  Most Important: My family

❖ **Case Conclusion and Summary**

There have been no further texts. LM is found the next day hanging in her apartment. The family states that LM had a history of depression since college and had been on an SSRI during medical school. She hadn't gotten a psychiatrist or a family doctor when she started residency. It seemed that she had been developing a suicide plan for months but no one knew or expected it.

This is an extremely difficult topic to discuss but is unfortunately a reality of life as doctors and tragically, some cases do end like this. Again, if this case brought up difficult feelings for you or you are particularly worried about a colleague, please reach out. Your faculty and program leadership are always there for you and there are confidential resources through your GME and hospital. There are also national resources such as the national suicide prevention hotline (1-800-273-8255). Don't stay silent. Let's come together as a profession and support each other. Talking about it is one small step towards preventing one more loss in our ranks.

- **Session Teaching Points Summary**
  - Suicide can be thought of as an occupational hazard for physicians
    - Rates are 1.41x in male physicians and 2.27x in female physicians compared to the general public
    - Suicidal ideation in residents is up to 10% and increases 370% in the first 3 months of training
  - There are verbal, behavior and mood clues that a person many have depression or suicidal ideation
  - Physicians are particularly adept at hiding these clues so one has to have a high index of suspicion during high stress situation and especially concerned with talking about personal death in any way
  - Be on the watch for sudden odd or unusual behavior from your colleagues
  - Ask directly when concerned or something just seems off → it will **not** make things worse
  - Joiner's interpersonal-psychological theory of suicide states that people will not choose to die by their own hand unless they have both the desire (both a sense of isolation and a sense of failure) and the capability to carry it out
  - Unfortunately, residency can create a perfect storm
  - Become familiar with available resources which may include EAPs, hotlines, counseling services, peer to peer supports and others
  - Encourage establishing care (both physical and mental health) early in residency training → think about included this in your semi-annual check in's with residents and provide names/numbers for easily accessible physicians to remove another barrier
  - Develop a personal crisis management plan to be more prepared when crisis hits
    - This should include 3 people to call and a list of available resources
  - Impairment is a functional classification that impacts the ability of a physician to perform one's duties and therefore has the potential to negatively affect a patient's care and safety
  - On the other hand, illness is just the existence of a disease
  - Illness and impairment are not synonymous but may exist on a continuum
  - Generally, impairment is reportable while illness is not always
  - Many residency issues that would benefit from mental health services (acute stress reactions, mini-PTSD events) are neither impairment or illness and thus are rarely reportable
  - **As a rule,** it is much better to seek care early → this is much less likely to be reportable rather than waiting until things escalate at which point it may become reportable

❖ **Facilitator Background Reading:**

Depression and Suicidality

Although suicidality is not always associated with depression, the path culminating in suicide crisis often starts with a low mood. A low mood can come from both internal and external factors. As factors build and a person's pain exceeds his or her coping skills, some will move down a suicidal ideation pathway from passive thoughts to active thoughts to a moment of crisis. It often is possible to interrupt this self-destructive journey if the person is able to decrease the pain and increase coping skills.

Joiner's interpersonal-psychological theory of suicide states that people will not choose to die by their own hand unless they have both the desire and the capability to carry it out. He further proposes that there are two factors needed to develop a suicidal desire. The first is a sense of 'thwarted belongingness" (a sense of isolation). The second is "perceived burdensomeness" (a sense of failure or inadequacy). Finally, the patient has to acquire the capacity to die by suicide.

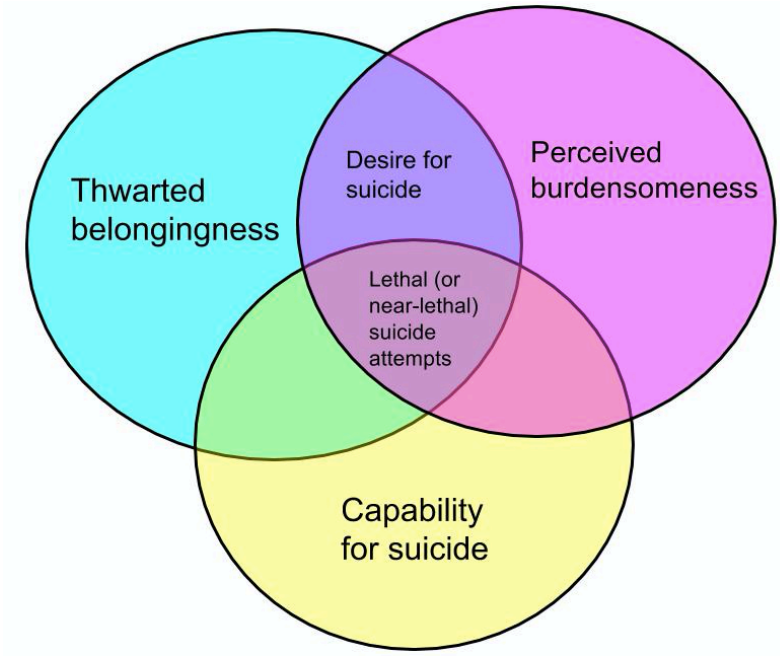

Figure 1: Joiner's Interpersonal-Psychological Theory of Suicide

It can be argued that residency is a perfect storm for the development of suicidal ideation:

> Belongingness is 'thwarted' from the start as many interns move from their medical school home to other institutions or even to entirely different geographic areas. Those rare individuals who stay at their home medical school often lose their close friends to other places. And once one start training there is the constant switch of rotations. Burdensomeness may be perceived in several areas such as significant financial debt to missing family obligations to a sense of imposter syndrome or incompetence at work.

Capacity for suicide includes developing knowledge, acquiring the means and overcoming self-preservation. Medical school teaches and residency fine-tunes the knowledge required to understand self-inflected fatal options. In addition, access to medications either in the hospital or with prescription authority creates overdose potential. Lastly, both sleep deprivation and repeated exposure to pain or death may overpower protective factors for self-preservation.

After two interns jumped from building during August 2014, the ACGME chose to focus attention on resident mental health emergencies including suicide.

First, the ACGME published the most extensive statistics regarding residents' deaths on a cohort of 381,614 residents spanning 15 years (from 2000 to 2014). During that time period, 324 residents died. The findings showed:

- Overall, the most common cause of death was malignancy
- Suicide was the 2nd most common cause of death (1st in males)
- The high-risk periods were early in training and the first and third quarters of the year → in addition they noted that transitions are a particularly high-risk time with suicidal ideation increasing as much as 370% in the first three months of residency
- Suicide is the most preventable cause of death in residents

Secondly, in July 2017, the ACGME instituted common program requirements on wellness. The subsection VI.C.1.e addressed issue regarding burnout, depression, substance abuse, suicidal ideation or the potential for violence. This included:

- Residents and faculty must be educated in the identification of symptoms of burnout, depression and substance abuse including the means to assist those experiencing those conditions
- Residents and faculty must also be educated to recognize those symptoms in themselves and how to seek appropriate care
- Encourages residents and faculty to alert the program director or other designated person when they are concerned that another resident, fellow or faculty member is displaying signs of burnout, depression, substance abuse, suicidal ideation or the potential for violence
- Provide access to appropriate self-screening tools
- Provide access to confidential, affordable mental health assessment, counseling and treatment including access to urgent and emergent care 24 hours a day, seven day a week

Common Program Requirements

Many people who ultimately go one to kill themselves exhibit suicide-warning signs in the days to weeks before their death. The problem is that often these are indirect and may not be seen as a warning sign until after the fact. One must be particularly concerned about a sudden change in behavior or unexpected behavior. Warning signs tend to fall in three groups:

Verbal

- Direct - One states the desire to kill oneself or suggests any method to kill oneself (such as "I should just shoot myself")
- Indirect - hints at being dead or gone

- Hopelessness - “There is no hope for me”
- No reason to live - “It isn’t worth it anymore”
- Unbearable pain - “I can’t take any more of this”
- Feeling trapped - “There is no way out”
- Being a burden - “It would be better if I wasn’t here anymore”

Behavior

- Increased drug or alcohol use
- Risk-taking
- Isolation and withdraw
- Increased sleeping or fatigue
- Aggression

Mood

- Anxiety
- Depression
- Loss of interest
- Irritability
- Anger and agitation
- Sudden improvement of mood

Often physicians will mask the signs so one has to watch carefully for worrying signs and also make mental health checks on each other. In addition, it is common for people to avoid help as the problems worsen. Since those working closest with a person have the greatest opportunity to recognize signs, it is extremely important for co-residents and faculty to be versed in available local resources and the logistics on how to access them. These resources may include:

- Employee assistance programs (EAPs)
- Institutional, local and national hotlines
- An in-program or institutional psychologist or psychiatrist
- Personal options through insurance
- Peer to peer support
- Physician health programs

Given the fact that the incidence of suicidal ideation for medical students and residents is approximately 10% and that by virtue of being a physician, and a human being in general, high degrees of stress are likely to occur from such things as untoward patient events, malpractice suits, divorce, sick family members, addictions or other factors, it is reasonable for every physician starting in internship to develop a personal crisis management plan to cope more effectively with such events. At the very least this should be a listing of people to help and a listing of available resources.

Impairment

Residents and attending physicians tend to be highly reluctant to seek help for any emotional, mental or psychological issues. Barriers include time, privacy/confidentiality concerns, concerns over the impact on colleagues, insurance/financial concerns and concerns over other

professional impact. One of the biggest professional concerns revolves around licensure. Dyrbye and colleagues found that 40% of physicians reported they would be reluctant to seek formal medical care for treatment of mental conditions because of concerns over their medical licensure.

Unfortunately, this is a difficulty issue as the licensure wording varies from state to state and the consequences of the answers are not transparent. The Federation of State Medical Boards has moved to try to delineate the difference between impairment and illness, however, not all states have followed suit at this time.

Impairment is a functional classification that impacts the ability of a physician to perform one's duties and therefore has the potential to negatively affect a patient's care and safety. This is the classification that is almost always reportable. On the other hand, illness is just the existence of a disease and may or may not be reportable depending on the state or institution. Illness and impairment are not synonymous but may exist on a continuum.

Additionally, many issues that come up in residency that residents seek mental health care for constitute neither impairment nor illness but rather a part of their professional development and can be attributed to temporary situational stressors. Stress, overload, fatigue and 'mini-PTSD' events occur and are almost never reportable as they do not impact patient safety or the ability of the resident to perform their duties. In fact, addressing such issues early can potentially avoid deterioration which could lead to behavior that might constitute true impairment and as such, is almost always reportable.

Currently about half of states ask only about impairment, however, some have more draconian wording such as:

From xxx to present, have you received treatment for psychiatric, addictions or substance use?"

Many have concerns that wording like this constitutes a violation of the Americans with Disabilities Act and many of our medical advocacy groups are lobbying against such questions. In addition, such wording acts as a barrier for physicians who might benefit from seeking mental health care.

In 2016, the AMA adopted a policy calling "on state medical boards to refrain from asking applicants about past history of mental health diagnosis or treatment and focus on current impairment by mental illness or addictions". Further, it advocates for "safe haven" non-reporting which would allow physicians-in-training who are receiving mental health treatment to apply for licensure without having to disclose it. Hopefully such measures will help remove one potential barrier to physicians seeking mental health care.

- **References**
  - **Author:** Dr. Loice Swisher (Vice Chair CORD Wellness and Resilience Committee)
  - **Editors:** Dr. Natasha Wheaton and Dr. Christopher Doty (CORD President)

- **References:**

Suicide

Article

Yaghmour N, Brigham T, Richter T, et al. "Cause of Deaths of Residents in ACGME-Accredited Programs 2000 Through 2014: Implications for the Learning Environment. " Academic Medicine July 2017. Vol 92 (7) 976-983.

Podcast

The Darkside of EM
EMRAP- April 2017
https://www.emrap.org/episode/burnout/burnout

Suicide Risk in Physicians
EMRAP-August 2017
https://www.emrap.org/episode/suicideriskin/suicideriskin

Video

Make the Difference-preventing medical trainee suicide
https://www.youtube.com/watch?v=I9GRxF9qEBA

Time to Talk about It: Physician Depression and Suicide
November 29, 2016
https://www.mededportal.org/publication/10508/

Website

MEDiC Series- The Case of the Resident At-Risk

ALiEM- February 3, 2016
https://www.aliem.com/2017/02/medic-case-resident-at-risk/

Expert Commentary-February 17, 2016
https://www.aliem.com/2017/02/medic-case-resident-risk-expert-review-curated-commentary/

Preventing Physician Distress and Suicide
https://www.stepsforward.org/modules/preventing-physician-suicide

After a Suicide: A Toolkit for Physician Residency/Fellowship Programs
http://www.acgme.org/Portals/0/PDFs/13287_AFSP_After_Suicide_Clinician_Toolkit_Final_2.pdf

Impairment:

Dyrbye L, West C, Sinsky C, et al. "Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions." Mayo Clinic Proceedings. October 2017. Vol 92 (10), 1486-1493.

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Policy on Physician Impairment- Federation of State Medical Boards
https://www.fsmb.org/globalassets/advocacy/policies/physician-impairment.pdf
June 2010.

AMA Adopts Polices to Support Physician Wellness, Mental Health
AMA Wire- November 15, 2016
https://www.ama-assn.org/ama-adopts-policies-support-physician-wellness-mental-health