

Sudden Death of Doctors in Training

Introduction

This document has been written to provide guidance for those tragic occasions when doctors in training have died unexpectedly. Its purpose is to provide a framework to support Postgraduate Deans and their teams to respond promptly, comprehensively and appropriately in these circumstances. The document deals with a particularly difficult set of issues and very difficult circumstances. We will define (where appropriate) the areas covered in the document.

The death of any individual is distressing. This is even more so when the death is unexpected or deliberate, as in suicide. Postgraduate Deans have a responsibility and duty of care to doctors in training. As the health service finds itself under unprecedented pressure and demand, all members of the health and care team experience correspondingly higher levels of work intensity and so this issue is in sharper focus than ever before.

Postgraduate Deans within England will in future apply a systematic approach to such events. This will also include suicide awareness, where the guidance indicates possible preventative actions and interventions where appropriate. It is hoped that this approach may reduce the incidence of such events in future.

A joint NHS document has been produced and endorsed by Public Health England: *Reducing the risk of suicide: a toolkit for employers*¹. This document contains a large amount of advice with regards to suicide prevention for any employee in the workplace.

On an individual level, recognition that this has occurred and understanding the repercussions on family, friends, colleagues and other members of the health and care team is essential to ensure a systematic and planned response to the tragedy.

Definitions

Suicide - the action of killing oneself intentionally

Sudden (but expected) death

It is sometimes known that illness has befallen an individual. However, support is still required for colleagues, faculty and occasionally family.

Unexpected and accidental death.

¹ wellbeing.bitc.org.uk/sites/default/files/business_in_the_community_suicide_prevention_toolkit_0.pdf

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This is also an event where Postgraduate deans must be prepared. Sadly, violent and accidental deaths of medical students on electives as well as those of junior doctors have and will unfortunately continue to occur. Repercussions can be felt far and wide and for a considerable time afterwards.

Self-harm - deliberate injury to oneself, typically as a manifestation of psychological or psychiatric disorder. This area *is not* covered in the guidance.

Unexpected death due to suicide in doctors – the evidence

Due to a number of events seen in the North East of England, research was conducted on behalf of HEE NE by Newcastle University into the incidence and risk factors for suicide in junior doctors in training.

In the UK population as a whole, death from suicide is three times higher in men compared to women. Although the numbers of suicides in doctors are not increased compared to the population, the numbers of deaths remain a great concern.

The difference in risk between men and women is a concern. Although in the UK the overall rate of suicide among men predominates, Medicine appears to have some protective effect (SMR 63 for male doctors), whether from selection or from experience. While for men the overall increased risk of suicide is a societal issue, for women (where the risk is slightly increased in doctors-SMR 124) it may be a more specifically professional one.

Personal and professional factors may both be associated with increased risk, and organisational stakeholders in education, employment and regulation may all have a role in addressing those risks.

The guidance is divided into the following sections:

Prevention

Key elements of suicide prevention should include consideration of the following:

Working Environment

Fostering a working environment where mental health issues and awareness are openly discussed is an important part of any prevention strategy. Acknowledging that mental illness can and does affect anyone is also helpful. Making sure that these issues are discussed at induction and signposting trainees to the multiple sources of help available are especially important.

A working environment should value its employees and their families, promote respect, open communication, a sense of belonging, emotional wellbeing and encourage people to seek help when they need it and to support each other.

Both HEE and NHSI have recognised that these are all issues in the current NHS working environment and the following resources have been produced to support employers and HR departments^{2 3}.

Work should be carried out with NHS Trust Boards and chief executives to understand the impact that the NHS working environment has both personally on the individual, organisational reputation and therefore workforce recruitment and retention. These are all current areas of major concern for the NHS.

² www.hee.nhs.uk/sites/default/files/documents/Junior%20Doctors%27%20Morale%20-%20understanding%20best%20practice%20working%20environments.pdf

³ improvement.nhs.uk/resources/Engaging-supporting-and-valuing-doctors-in-training/

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The promotion of wellbeing and wellbeing initiatives in the workplace should be further developed and evaluated.

Helplines with national reach and issue focus should be signposted across the workplace, such as Samaritans and national domestic violence helplines.

Specialised suicide awareness and prevention training for the workplace's Employee Assistance Programme (EAP) providers and/or HR staff should occur.

Clear policies, procedures and practical guidance to help employees who need support around issues such as mental health, long-term health concerns, domestic violence and financial insecurity should be available. NHS Employers have a considerable amount of advice and support on their web pages⁴.

Internal communications and Induction programmes where acknowledging the issues around mental health and wellbeing amongst staff and providing clear sign-posting to the multiple sources of help and support is particularly important.

Education and training on mental health, including suicide awareness, should be provided for all employees, especially line managers, and for doctors in training clinical and educational supervisors.

Specific initiatives that can be implemented in the workplace to support doctors in training.

Teams and 'firm' structure that allow individuals to work together, support each other and so notice when there may be changes in behaviour or trigger factors. This includes the concept of the 'modern firm'.

Particular care should be taken after a period of sickness and exam failure, or in an environment where bullying may be known to be taking place.

Doctors undergoing investigation and in particular if referred to the regulator should also be supported.

Junior doctors in training not within a Lead Employer arrangement will change employers and so potentially be subject to varying policies multiple times within their training programme. This is unlike most other professional groups within the NHS. Reducing such changes is a benefit of a lead employer arrangement, but all junior doctors should be supported regardless of the employment model.

Occupational Health departments can have a very significant role to play in the support of doctors in training and early involvement of OH is advised in situations where there are concerns about the mental or physical health of a trainee-and explaining and promoting access to OH should form part of signposting at induction events.

There should be consideration to ensure that adequate pastoral support is available.

Identifying Doctors in Training at potential risk

This can occur through multiple sources:

- Personal contact from the trainee or the trainee's family
- First aid and triage

⁴ <http://www.nhsemployers.org/your-workforce/retain-and-improve/staff-experience/health-work-and-wellbeing>

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- Personal stresses
- Professional stresses
- Work load Factors

In situations where risk is identified, Postgraduate Deans should recognise the circumstances where breach of confidentiality is permitted.

The following toolkit identifies several areas where employers can impact.

There are **Six Management Standards** to be considered:

Demands	Workload, work patterns and the work environment.
Support	Encouragement, sponsorship and resources provided by the organisation, line management and colleagues.
Role	Understanding of their role and whether the organisation ensures that they do not have conflicting roles. Appropriate ID badges are vital for this reason, amongst others.
Control	How much influence the person has in the way they do their work.
Relationships	Promoting positive working to avoid conflict and dealing with unacceptable behaviour
Change	How organisational change (large or small) is managed and communicated

In addition, the **inability** to act increases risk. Therefore, inability to modify the order and workload of activities poses additional risks.

The following are suggested screening questions:

Can employees modify the order and workload of their activities?

Are employees regularly faced with emotional situations, like dealing with diseases, death and threatening situations?

Are there alternating shifts and night-time work?

Is there a high time pressure?

Is it possible to easily schedule the working hours?

Is it possible to have regular breaks?

(Source: Preventing and managing suicidal behaviour: A toolkit for the workplace)

These are all routine aspects of life as a junior doctor, and increasingly for all doctors and most clinical staff within the NHS.

1.1. Gender

Men remain the most at-risk group and are three times more likely to die by suicide than women. Some men are less likely to seek help and there is an increasing range of innovative ways being used to reach men, and to ensure services are accessible and relevant for them. The suicide rate for women, although far lower than for men, has been increasing.

1.2. Age

The age group with the highest suicide rate is 45 to 59 years, for men and women.

1.3. Recent Bereavement

Men and women are at higher risk of suicide after the death of a family member or friend. A death by suicide is a significant risk factor.

1.4. Sexual orientation and gender identity

The risk of suicide is significantly higher among the lesbian, gay, bisexual and transgender community. Whilst some research exists into the increased risk, precise data can be difficult to establish because many LGBT people feel unable to be open about their sexuality or gender identity.

1.5. Mental illness

Around one-third of people who die by suicide have been under specialist mental health services in the year before they die. This includes treatment for illnesses such as depression, bipolar disorder and schizophrenia.

1.6. Behavioural

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Some patterns of behaviour can indicate a risk of suicide. These include alcohol and substance dependence. Self-harm, which is most common in people under 25, is also an indicator of suicide risk.

1.7. Psychological and attitudinal

- Unexplained absenteeism
- Changes in productivity
- Changes in social functioning
- These can be seen in the work place as
 - Erratic periods of sickness
- Raising of clinical concerns with Clinical and Educational Supervisors
- Difficult clinical cases
- Allegations of undermining behaviour, bullying and harassment
- Social media - virtually expressed – either personal or group concerns

However, there may be no such warning signs.

All junior doctors would therefore seem to be exposed to risk factors.

Under our responsibilities under the Equality Act 2010⁵ it is appropriate to not only collect but monitor data, in order to put in place appropriate services and support.

It is also good practice (in the event of a sudden or unexpected death) to ensure there is a record for the next of kin.

1.8. Previous Suicide Attempt

Vigilance is needed in those who have previously attempted suicide. These situations need appropriate co-ordination of transfer of information, Occupational health and clinical supervision.

2. Prevention

The employer's toolkit should be shared widely via Postgraduate Medical and Dental Networks. Due to the complex employment and training relationships in place, many responsibilities are shared across the NHS.

Each local office should have guidance available with local contacts, resources and how support is accessed.

The Employers toolkit and National Association of Clinical Tutors (NACT) documents should be circulated widely.

Educational and clinical supervisor training, Training Programme Director (TPD) and Heads of school will be aware of local arrangements in such situations.

⁵ www.gov.uk/government/uploads/system/uploads/attachment_data/file/85041/equality-duty.pdf

Staff within local offices who may come into direct contact with a junior doctor in training should also have appropriate staff training.

3. Who to inform if you believe a junior doctor is at risk?

This may occur as a longstanding health or other issue or more acutely.

3.1. Transfer of Information processes

If a doctor is believed to be at risk, and transferring from undergraduate to postgraduate training, one programme to another, one site to another, one employer to another or one supervisor to another then the appropriate use of the Transfer of Information (TOI) processes should be made. It would be expected that the doctor in question was involved in the detail of the information shared. The Responsible Officer and Director of Medical Education must be kept informed.

3.2. New Concerns

If it is believed that a junior doctor is at risk of or contemplating suicide then a number of individuals can be approached. These include clinical or educational supervisor, TPD, Head of School, Associate Dean, (Clinical) Director, Medical Director and the Postgraduate Dean.

Care should be taken to ensure that information is shared confidentially and appropriately.

If the Medical Director or Postgraduate Dean has been informed directly then it is the responsibility of those individuals to inform each other and ensure that

1. A named senior individual will act as the point of primary contact
2. That there is support in place for the doctor concerned either through the Professional Support Unit (PSU), Training support services, Health services or family members
3. Patients are safe and that alternative arrangements for clinical cover are made should the doctor be scheduled for clinical duty.

The doctor may be reluctant to have others involved and this will need to be handled with great sensitivity and understanding.

NACT has produced guidance-*Supporting Trainees: A Guide for Supervisors. Practical Advice for Educational and Clinical Supervisors May 2018.*⁶

This is a very useful document for this and other situations where trainees may be in difficulty and in need of help and support.

For any doctors at risk or with other health issues they may be required to seek Occupational Health assessment via the employer or access care and support from their GP. Further onward referral to specialised support services can be made as necessary.

⁶ www.nact.org.uk/

3.3. Foundation Doctors

This group of doctors may be at particular risk. As they are new to Postgraduate Training particular attention must occur with regards to transfer of information across the Undergraduate to Postgraduate interface.

Postgraduate Deans have a responsibility to ensure their supervision arrangements are robust.

Buddying and peer mentoring resources should be considered if appropriate.

3.4. Responding to a suicide attempt

If the junior doctor has survived then a formal occupational health referral is required as well as exploring any work related or educational reasons for the action. Clearly the individual was in a position of extreme distress and any correctable risk factors that sit within the oversight of the Postgraduate Dean should be addressed if possible. All of these actions will need to be approached with great sensitivity and tact by all parties involved.

Employers should also be made aware of any further potential absences or support reasonable adjustments that may need to be put in place. Local educational support mechanisms should be initiated as necessary.

Ensuring access to support is available

If a junior doctor has been identified at risk, then the above individuals and networks should be approached. If concern remains then the Postgraduate Dean should be informed.

This is very distressing and care must be taken to support all members of the team, and anyone who may have known the doctor. This includes porters, volunteers and others.

Awareness of a “local map of support” for such circumstances:

Recognise the human and professional responses, and their boundaries.

The majority of problems relating to trainees can be handled well with the usual procedures and people. However, an appropriate response to suicide may mean usual resources/responses are not adequate.

An extraordinary response may be needed, and should be regarded as an educational ‘major incident’.

In any major incident, because most are unique, initiative is needed. There does however need to be a framework within which all can work though. The presence of a structure reduces the risk of important items being overlooked.

The following is a suggested structure when there are significant time pressures associated with the incident:

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* Command and control

* Safety

* Communication

* Assessment

* Decision making

* Support

4.1. Command and control

There needs to be a nominated lead both within the local office and the LEP/employer/clinical site.

4.2. Individuals

The default head, preferred deputy and other possible deputies of teams at each level will be:

	Deanery	LEP
Nominated Contact	Director/ Associate Dean of the postgraduate school relevant to the trainee	Director of Medical Education
Responsible individual	PG Dean	Medical Director

4.3. Safety

Protecting the well-being of individuals will take priority over all other considerations such as institutional reputation (except legal responsibilities).

The method of communication must be established early (e.g. mobile phone number) together with the initial frequency of communication and the information that needs to be shared.

4.4. Communication

In the initial phase of the response, communication must be between the leads, rather than others.

Information should be recorded.

Communication to Family – It may be required for the family to be informed. This should be done by a senior individual and support offered if available.

Communication to colleagues – This should ideally be done face to face. If possible supervisors should be informed first, and confidential rooms booked if appropriate as ward/practice staff and peers need to be made aware. For junior doctors and in particular foundation doctors, there may be the requirement for wider notification, particularly if there are partners in training elsewhere locally who may need support.

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One to one support may be required for some individuals. This can include trained coaches, mentors, counsellors, hospital chaplain staff, educational staff, PSU, and senior doctors. Those affected may not be able to return to work and appropriate arrangements need to be made to cover the service as well as support the individual.

There should be consideration of the impact of the funeral arrangements on friends and colleagues, individually and on the service as a large number may wish to attend.

Involved staff should consider attending/being represented at the funeral, depending on the wishes of the family. Support from the appropriate level of involved organisations may be required-again sensitively taking into account the detailed circumstances and family wishes.

Letters of condolence/sympathy should be sent to the next of kin.

The doctor should be removed from mailing lists. This should include communication with the GMC to inform them of the event.

4.5. Assessment

The Postgraduate Dean will oversee the process and ensure the requirements as already outlined are met. The Postgraduate Dean is also responsible for establishing a review of the incident to identify possible or actual causes.

There may need to be an investigation required at the LEP/elsewhere and the process for this will be dependent on the policy of the organisation where the death occurred, particularly if the death was on a clinical site.

An important question to address is whether the work setting is known to be an area that has distressed other trainees.

Actions and interventions should be recorded and monitored for effectiveness.

4.6. Decision making

The local office lead will be responsible for the planning of overall response and priorities, which will be communicated to the LEP lead who will be responsible for detailed planning and effecting the plan and ensuring local requirements are met. It is likely they will delegate work to others – this must be clearly understood by all and should be written down and shared.

4.7. Teamwork and mutual support

The response to such an incident will be most effective when all involved in it work together as an effective team and where all involved support each other.

A key part of the leads' role is to ensure that this happens in a timely, sensitive and co-ordinated manner.

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