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What Did I Miss? A Qualitative Assessment of the Impact of Patient Suicide on Hospice Clinical Staff

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Abstract

Background: Patient suicides can affect clinicians both personally and professionally, with frequent reports of psychological and behavioral changes occurring in response to this type of patient death. Although hospice clinicians have regular exposure to dying patients, the impact of patient suicide on this group has been understudied.

Objectives: This study examined the personal and professional impact of patient suicides among hospice clinical staff, the coping strategies used by this group, and their recommendations for staff support after a patient suicide.

Design: Utilizing an online survey, 186 hospice staff qualitatively described the impact of patient suicides on them as people and professionals, their resulting coping strategies, and any recommendations for supporting others. Three study investigators coded all of the staff responses at a paragraph level and summarized the most common emergent themes using grounded theory procedures.

Setting/Subjects: One hundred eighty-six clinical staff members who worked in an academic nonprofit hospice setting.

Measurements: An open-ended, qualitative survey was used to gather data about demographics, clinical experience, exposure to known or suspected suicides, recommendations for support in the event of a patient suicide, the personal and professional impacts of suicide, and coping strategies.

Results: The themes expressed by the hospice staff in reaction to patient suicides included: psychological responses such as feelings of guilt and self-doubt, changes in professional attitudes, and changes in clinical practice such as greater sensitivity to signs of suicide. When coping with a patient suicide, hospice staff described the use of team-based support strategies, debriefings, and personal spiritual practices. Recommendations for future support included facilitated debriefings, individual counseling, spiritual practices, leaves of absence, self-care activities, and educational interventions.

Conclusion: Data from this small study may help clinicians and administrators more fully understand the impact of patient suicides on hospice staff and may serve as a foundation for the development of effective strategies to support staff after a patient suicide.

Introduction

THERE IS EXTENSIVE LITERATURE examining the impact of patient suicide on mental health clinicians and trainees. These studies, using a variety of methodologies, have shown that patient suicides can affect clinicians both psychologically and professionally.^{1–3} Adverse psychological outcomes include feelings of anger, sadness, anxiety, guilt, embar-

assment, helplessness, and symptoms of posttraumatic stress disorder.^{1,2,4–13} Effects on professional behaviors include the loss of self-confidence in professional judgment, having difficulty with decision making, hospitalizing patients more often to prevent further suicides, increased interest in suicide-related issues, hypervigilance regarding patient suicide, and preoccupation with medico-legal concerns.^{10–14} In order to cope with patient suicide, clinicians often request further

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training in recognizing signs and symptoms of suicide, seek clear professional guidelines regarding how to deal with suicide, and look for new ways to support the bereaved family.⁷

At present, there is limited published work on suicide in the hospice population and incidence rates regarding suicide in hospice patients are currently unknown.^{17,18} Furthermore, although there is robust literature examining the impact of patient suicide on mental health clinicians, to our knowledge there are no studies that look specifically at the effects of patient suicide on hospice workers. Because of the unique nature of hospice work, one might expect a patient suicide to have a distinctive impact on hospice clinical staff, and knowledge about supporting staff in the aftermath of a suicide might be of value to hospice organizations. The aim of the current study was to use qualitative methods to examine the impact of patient suicide on hospice staff, and to elicit their recommendations about what support services may be helpful after such events occur.

Methods and Analysis

This study was conducted at an academic nonprofit hospice that provided care to more than 1200 seriously ill patients per day. Recruitment targeted all clinical staff, who were invited via two pairs of sequential e-mail and voice-mail announcements to participate in a confidential, anonymous online survey about the impact of patient suicide. The use of an online survey was chosen for the study in order to enhance efficiency and encourage participation across all staff; particularly since online surveys have a greater perceived anonymity and can thereby encourage people to discuss sensitive topics they might not otherwise discuss in person.^{19–21} The survey requested demographic data, then utilized open-ended, qualitative items to gather written responses from staff regarding their exposure to known or suspected suicide, and recommendations for support in the event of a patient suicide. Please see Table 1 for a list of the questions. In addition, participants who reported having been involved in the care of a patient known or suspected of committing suicide were further asked to provide written narrative about the personal and professional impacts of the suicide and coping strategies used. The survey was approved by the Institutional Review Board at The Institute for Palliative Medicine at San Diego Hospice.

The qualitative responses from staff were analyzed using the method of "Coding Consensus, Co-occurrence, and Comparison."²² Initially, three study investigators independently reviewed all of the hospice staff responses in the dataset. The investigators subsequently used a consensus process to identify the general themes seen across the data. A coding matrix was developed based on the identified themes. Two investigators used the coding matrix to analyze all responses independently at a paragraph level, with multiple codes being used when numerous themes were present. After independently coding all responses, the two investigators discussed each code and resolved disagreements in code assignment by consensus. After deriving consensus, each code was tallied in order to identify the most common themes emergent in the data, and salient quotations from the staff were identified so as to help illustrate the nature of each theme. Additionally, in order to assess interrater reliability, the third investigator independently coded a randomly se-

lected subset of 130 responses (27% of the overall dataset). The third investigator's independent coding was 87% in agreement with coding derived by the other two investigators, indicating a high degree of concordance.^{23–25}

Results

A total of 186 individuals (34% of all clinical staff at the hospice) participated in the full survey, providing 486 open-ended responses to qualitative items. Participants were predominately female (78%), and the average age was 52 years (range, 28–72). Respondents included nurses (39%), social workers (20%), primary providers (physicians or nurse practitioners, 14%), spiritual counselors (12%), licensed vocational nurses (7%), and others. On average, participants reported 21 years of clinical experience (range, 3–50), and 11 years of practice in hospice (range, 1–27). A total of 59 individuals (32% of all respondents) either experienced a patient suicide ($n=45$) or believed they had but were not certain ($n=14$).

Responses were found to code into five major thematic domains: psychological and physical impact, changes in attitude, impact on clinical practice, modes of coping, and recommendations for support. Table 2 summarizes the sub-themes that emerged from within each domain.

Psychological impact

Feelings of guilt and self-doubt were reported by staff as psychological responses to the patient suicide. Concerns about having "missed" signs of suicide, or having "failed" in some regard, were also present as exemplified by the following responses:

TABLE 1. QUALITATIVE QUESTIONS REGARDING THE IMPACT OF PATIENT SUICIDE

Personal and Professional Impact

- Are there other comments you would like to make about how the suicide affected you personally?
- Are there other comments you would like to make about how the suicide affected you professionally?
- Sometimes, an event like a patient suicide can spur significant personal and professional growth. Was that the case for you?
- Did the experience with patient suicide contribute to feelings of burnout?

Coping Strategies/Resources Used for Support

- Were there other resources or strategies you used to help cope with the suicide? If so, please elaborate.
- Were there other resources or strategies your team used to help cope with the suicide? If so, please elaborate.
- Were there any resources or strategies your team used that you found harmful?

Recommendations for Support

- What resources for support would you advise colleagues use after a patient suicide?
- What interventions would you recommend a team use to help work through the effects of a patient suicide?
- What sorts of supports or strategies would you recommend the agency adopt in order to help hospice workers after a patient suicide? Are there interventions that might be harmful?

Guilt was the biggest part. Could I have done more?

I felt guilty that I had missed something during my visit. I went over and over how I could have missed the suicidal ideation.

The experience made me question my clinical judgment and ability to successfully perform my job.

I felt I had failed to do my job of helping her die peacefully.

Relatedly, staff perceived that they were judged or blamed by colleagues in the aftermath of the suicide, for example:

I felt like everyone in the organization knew it was my patient and I had a big “S” on my forehead.

Respondents also described vivid and intrusive memories of the event:

When someone brings up the topic of suicide, I have a visual memory of the event—particularly the plastic bag around the patient’s head.

Changes in attitude

Staff reported changes in attitude about patient suicide, as well as an increased regard for patient autonomy:

It made me view suicide differently in terms of it being a choice by the patient rather than pathology...I can now see how for some patients it is a choice rather than the absence of alternatives, mental illness, etc.

I now see it as the ultimate act of patient autonomy. Death is what we do, and suicides will ultimately be a part of that.

Similarly, there were themes of coming to accept the limits of one’s responsibility as a provider:

I found it important to not take full responsibility for a suicide.

It reaffirmed that I did all I could, and that we cannot control outcomes when people don’t ask for help.

Impact on clinical practice

Staff reported becoming more attuned to thoughts and feelings about suicide in their patients, with a higher degree of sensitivity to patients’ distress. These changes in clinical practice were often coupled with a sense that the experience had come to enhance their care of patients:

It made me more attuned to what patients and their families are not saying or doing; looking for more clues and signs of suicidal ideation.

It definitely made me look at myself and gain insight. I’m a better social worker now and hopefully more in sync with patients’ needs.

Modes of coping

Staff reported a variety of modes of coping with the distress of a patient suicide, including both team-based interventions and personal practices. Team-based support and debriefing experiences were most commonly reported, but spiritual practices, counseling, and other forms of self-care were also described.

Recommendations for support

Staff provided a diverse range of recommendations for support when a patient suicide occurs. Staff-based support efforts were readily recommended, such as facilitated de-

briefing, informal group support, and individual counseling. Respondents also recommended support for individual spiritual practices, paid leaves of absence, self-care activities, and educational interventions designed to equip staff with the ability to identify and respond to patients with suicidal ideation.

Two cautionary themes emerged in relation to recommendations for staff support. First, respondents emphasized that individual staff will have unique responses to patient suicide and so different kinds of resources may be needed and should be provided on a voluntary basis:

Allow the person to choose who they feel they need to share the experience with.

Acknowledge and honor the right of each worker to feel whatever they feel.

Second, respondents echoed the sentiment that avoiding talk about the event would be generally detrimental to staff coping:

The most harmful intervention would be to ignore the situation or keep it “hush hush” and make it seem as if it never happened.

Too often we quickly move on to the next patient and bury any thoughts or feelings that a patient’s unexpected death may bring.

Discussion

This small study used qualitative methods to elicit the perspectives of hospice clinical staff concerning the suicide death of a patient. The findings are broadly consistent with previous research focused on mental health clinicians,^{1–14} which have described a variety of adverse psychological and professional outcomes following patient suicide. Important themes emerged regarding the perception of blame by colleagues, as well as feelings of guilt about having “missed something” and consequently “failed” in the perceived task of facilitating a particular kind of death. Interestingly, clinicians also reported changes in attitude and impacts on clinical practice that were generally positive—such as increased respect for autonomy, acceptance of one’s limits, and improvements in attunement to patients—reflecting that these events, while distressful, were also opportunities for personal and professional growth.

A wide variety of strategies were used to help cope with patient suicide. Respondents emphasized the importance of talking to others, particularly through team debriefings or professional counseling. Individual spiritual practices were also a reported source of coping in this sample of hospice clinicians, a finding that distinguishes this work from studies focused on mental health professionals.¹¹ While prior research has explored individual strategies for support,²² little is known about effective organizational and systems-level approaches to help staff in the aftermath of a suicide. Such strategies may be particularly important in the hospice setting, since clinical care is organized around a multidisciplinary team model, and team-based support services may need to be coordinated at a systems-level.

There are several clear limitations to this study. Since participants were drawn from a single hospice agency, generalizability is limited. Additionally, as the methodology was restricted to use of an online survey, there was no opportunity to follow-up with participants in greater detail, as would have been the case if focus groups or interviews were used instead. Also, responses were anonymous and not linked to individual

TABLE 2. EMERGENT THEMES OF RESPONSES TO PATIENT SUICIDE

<i>Domain</i>	<i>Subtheme</i>
Psychological and physical impact	Guilt/self-doubt Perception of blame/judgment by colleagues Anger Sadness Physical symptoms Flashbacks Avoidance
Change in attitude	Increased respect for patient autonomy Acceptance of things beyond one's control Acceptance of own performance
Impact on clinical practice	Improved attunement to suicidal feelings in patients Improved self-care/work-life balance
Modes of coping	Team support/debriefing Spiritual practices Counseling Self-care Leave of absence Supportive relationships with family/friends
Recommendations for support	Team and collegial support/debriefing Counseling Spiritual practices Education about suicide in general Paid leave of absence Self-care practices Supportive relationships with family/friends

respondents, so it was not possible to derive meaningful measures to capture the relative prevalence of the emergent themes. Also of note, the methods did not permit verification of the suicide, nor did the survey assess for any information about the suicide event. Incidents that are known to be suicide (via firearm, for example) are likely to be more conspicuous and potentially more traumatic than incidents only suspected of being suicide (via overdose, for example), and these differences may impact clinicians in unique ways. Also, it is likely that both temporal proximity to the suicide and emotional closeness to the patient influence the impact on clinicians, and neither of these were assessed in the survey.

This study raises a number of questions that might be pursued in future work. First, the sense of failure experienced by staff speaks to the unique nature of hospice work: it is a setting in which death is expected, and where notions about the very purpose of hospice work (to prevent “bad” deaths, for example) may frame clinicians’ judgments about whether or not they have been successful. In this unique setting, clinicians may be more likely to experience suicide as a direct professional failure. The data also raises questions about the interaction between experiencing patient suicide and clinicians’ judgments about suicide, as captured in the responses that suggest a shift in attitude about the acceptability of sui-

cide in this population. Future work might systematically examine the ways in which the experience of working with a dying patient who commits suicide may influence a clinician’s sense of success or failure, and shape their prior views about suicide itself.

In closing, this study is the first to assess the impact of patient suicide on hospice staff. Even though hospice is a setting in which patient deaths are expected (indeed, the focus of care), suicide can have a significant impact on hospice clinicians in a variety of ways. This work and further investigations may serve to help individual clinicians to better cope with suicide, as well as enable hospice organizations to effectively support clinicians when these events occur.

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Author Disclosure Statement

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