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Empathy and willingness to provide care for suicide patients in emergency departments: a cross-sectional study

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ABSTRACT

Background: Suicidal ideation and self-harm are significant and growing worldwide health concerns. Emergency department (ED) physicians are usually the first line of care for patients presenting with those concerns, and their attitude toward these patients plays a crucial role in their outcome. Therefore, this study aimed to assess the ED physicians' perception, empathy, and willingness toward these patients.

Methods: An anonymous survey was distributed to ED physicians (residents, fellows, and consultants) to assess their attitude toward suicidal patients using the Understanding of Suicidal Patients (USP) Scale, a scale designed to assess healthcare professionals' understanding, willingness, and empathy to provide care for suicide attempters, with 11 items rated on a four-point Likert scale, in which a lower score indicates a more positive attitude.

Results: Overall, physicians demonstrated a positive attitude toward patients with suicidal ideation with a USP mean score of 20.67 ± 3.76. Even though it was not statistically significant, male participants had lower scores than their female counterparts, which might suggest a trend toward higher empathy among male participants. Age and years of experience showed no statistically significant difference between the participants. The majority of the participants found that evaluating a patient with a suicide attempt is troublesome for them, and a third of them reported that it is irritating to evaluate such patients. Overall, the results indicate a predominantly empathic and supportive approach toward suicide attempters, with only some aspects of patient assessment demonstrated as problematic.

Conclusion: Emergency physicians in Saudi Arabia showed generally positive and empathic attitudes toward suicidal patients, with no significant differences by age or experience. Male physicians showed a non-statistically significant trend toward higher empathy. Despite this, many reported difficulty assessing suicide attempters, and about one-third reported irritation, indicating overall positive attitudes alongside persistent challenges in patient assessment.

Keywords: Suicidal ideation, emergency department, empathy, Saudi Arabia, suicide prevention.

Introduction

Suicidality and intentional self-harm presentations to the emergency department (ED) are a growing problem in the United States. It is the second most significant cause of death globally for people aged 15 to 29 and a serious health issue [1,2]. A significant proportion of ED patients have suicidal ideations, with up to 5.7%-10% of ED visitors screening positive for suicidal thoughts [3-6]. In Saudi Arabia, a recent study conducted in 2024 reported that the lifetime prevalence of suicidal ideation, planning, and attempts was 4.90%, 1.78%, and 1.46%, respectively

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[7]. This underscores the importance of recognizing and addressing mental health issues in emergency settings, as a notable percentage of patients presenting to the ED could be at risk of suicide [3]. Approximately one-third of those who go on to commit suicide had visited an ED at least once in the year before they passed away [5,6]. Clinical practice, patient experience, and outcomes are all influenced by competence and attitudes [6-8].

Negative attitudes, including rejection and a lack of empathy towards individuals who have attempted suicide, can have profound consequences, hindering healthcare professionals' ability to address the underlying problems these patients are struggling with. This, in turn, may contribute to an increased risk of suicide [9], especially in smaller communities where there is a lack of knowledge and appropriate skills for assessing suicide risk [10]. A recent scoping review demonstrated that individuals who attempt suicide are frequently labeled as "attention-seeking" or personally responsible, which reflects enduring public stigma and attributional bias. This stigma encompasses negative stereotypes, judgment, and blame, as well as internalized stigma that fosters shame and diminishes help-seeking behaviors. These perceptions may also be present among healthcare providers, leading to less empathetic communication and underestimation of suicide risk. As a result, such biases can compromise psychosocial assessment and contribute to suboptimal or delayed care [11], highlighting the critical need for unbiased and compassionate care, particularly in the ED [12]. Self-harming behavior necessitating treatment is often the reason suicidal patients present to the ED. Of those patients with self-harm, 6% will go on to commit suicide [13]. Furthermore, some patients will not be forthcoming regarding thoughts or attempts [14]. Busy EDs affect the time provided by ED physicians towards patients, specifically suicidal patients, which likely affects the treatment provided to them. When examining documentation practices for patients presenting with self-harm in EDs, previous studies have highlighted significant gaps. Essential details such as past self-harm attempts, suicidal ideation, risk factors, and mental state assessments were often inadequately recorded [15]. These findings may reflect ED physicians' time pressures and perhaps a lack of adequate training in psychosocial risk assessment [16]. Research suggests that patients who self-harm or who are suicidal are less than satisfied with ED care and feel inferior to 'medical' patients due to healthcare providers' negative attitudes towards them [8,17,18]. To improve patient outcomes and ensure proper management strategies are in place, it is crucial to comprehend emergency physicians' knowledge, attitudes, and willingness to provide care for this patient population.

This study aims to assess ED physicians' perceptions, empathy, and willingness to provide care for patients presenting with suicidal ideation or suicide attempts. Specifically, it seeks to evaluate these attitudes using the understanding of suicidal patients (USPs) scale and to examine whether demographic factors such as age, gender, and years of experience influence physicians' empathy and approach to care.

Methodology

Measures/survey

We developed an online survey composed of two sections: the first included three questions to collect participants' demographic data, while the second consisted of the USP scale, a validated scale adapted by Suokas and Lönnqvist and Suokas-Muje [19] and further modified by Samuelsson et al. [20]. This scale was designed to assess healthcare professionals' willingness to provide care for suicide attempters, as well as their understanding and empathy toward these patients. The scale includes 11 items rated on a four-point Likert scale, with responses ranging from 1 (completely agree) to 4 (completely disagree), where lower scores indicate more understanding and empathy. Earlier studies used a five-point scale, and scores below 23 were considered positive attitudes [19,21]. In the original study, the reliability of the USP scale was indicated by a Cronbach's alpha of 0.74 [20], while in this study, it was measured at 0.73. The questionnaire was pilot-tested for content and clarity by five emergency consultants. The final questionnaire is provided in Supplementary File 1.

Study design and population

The survey was conducted in English and distributed between December 2023 and February 2024 through a Google Forms link to emergency physicians to be answered anonymously. The study population consisted of emergency physicians working at King Saud University Medical City (KSUMC), a large academic tertiary care center in Riyadh, Saudi Arabia. To be included in the study, participants had to be employed as ED physicians (i.e., residents, fellows, or consultants) working in KSUMC. Physicians who were not working in the ED (i.e., non-ED physicians), those working in hospitals other than KSUMC, and nurses or other healthcare providers were excluded from the study.

Statistical analysis

Data were tabulated using Microsoft Excel and analyzed using SPSS (version 28.0; IBM Corp., Armonk, NY). We first performed descriptive statistics, calculating frequencies and percentages for categorical demographic variables (gender, age group, and years of experience), while the USP Scale results were expressed as mean ± standard deviation. To ensure the reliability of the 11-item USP scale within our sample, Cronbach's alpha [22] was calculated. For the correlation analysis, Pearson's correlation was used to assess item-total consistency within the scale, while Spearman's rank correlation was applied to evaluate the relationship between categorical demographic groups and empathy scores. For the comparative analysis, inferential statistics were utilized to assess differences across subgroups. Furthermore, a logistic regression analysis was conducted to evaluate the association between gender and empathy levels, providing Odds Ratios (OR) and 95% Confidence Intervals (CI). All significance testing was two-tailed, with a p-value <0.05 considered the threshold for statistical significance.

Results

The study population (n = 63) was predominantly male (69.84%) and largely composed of young physicians, with the majority (55.56%) aged 30 years or below and 29.68% aged between 31 and 40 years. Most respondents (53.97%) had less than 4 years of experience in emergency medicine, while 31.74% had more than 10 years of experience. Population characteristics are summarized in Table 1.

The response category for each statement on the USP scale was assessed using a four-point Likert scale, where "Strongly Agree" was scored as 1 and "Strongly Disagree" as 4. Scoring results are presented in Table 2 and illustrated in Figure 1 for enhanced clarity. Lower scores on this scale indicate higher levels of empathy. Items 2, 6, and 9 were reverse-coded to align with the scale's directionality, where a lower score reflects higher empathy. "Item-total correlation" reports the Pearson's correlation coefficient used to assess the internal consistency of each item within the scale.

No statistically significant differences in empathy scores across age groups or levels of experience in emergency medicine were found. While male participants had slightly lower empathy scores than their female counterparts, which might suggest a trend toward higher empathy among male participants, this result was not statistically significant. Logistic regression analysis results, as shown in Table 3, revealed that gender explained 26.7% of the variance in levels of empathy and that male respondents were approximately 2.7 times more likely to exhibit high empathy; however, this relationship was not statistically significant at the conventional 0.05 level. Overall, the results painted a predominantly empathic and supportive approach towards suicide attempters, with only some aspects of patient assessment demonstrated as problematic. The model's R^2 value was 0.267, indicating that gender accounts for approximately 26.7% of the variance in empathy levels.

Discussion

The primary objective of this cross-sectional study was to evaluate the attitudes, empathy, and willingness of ED physicians to provide care for patients presenting with suicidal ideation or attempts. Our key findings indicate that emergency physicians generally exhibit high levels of empathy and a predominantly positive attitude toward these patients, as evidenced by a mean score of 20.67 ± 3.76 on the 11-item USP Scale. Demographic factors, including age and years of experience, did not significantly influence these attitudes. Although male physicians showed a trend toward higher empathy, this association was not statistically significant and should therefore be interpreted with caution. Despite this empathic baseline, most respondents found clinical evaluations "troublesome," with one-third reporting irritation. This may reflect internalized societal stigma, leading to frustration or subtle misunderstandings during patient interactions [23-25].

When comparing these results with relevant regional and international literature, our cohort's USP mean score was closely aligned with the findings of Samuelsson et al. [20], suggesting a consistent level of empathy among medical professionals across different cultural contexts. Notably, our participants demonstrated more favorable responses than those reported by Kishi et al. [26] involving Japanese nursing personnel.

Regionally, our findings regarding the lack of correlation between empathy and demographic variables like age or gender mirror a Tunisian study by Amamou et al. [27]. This suggests that empathy in the ED may be more closely tied to the specific clinical environment or individual personality traits rather than fixed career milestones. This perspective is further supported by the large mixed-methods study of Urizaki [28] in Japan, which demonstrated that attitudes were more strongly influenced by factors such as cognitive-emotional engagement during patient interactions, training background, anxiety related to patient care, perceived patient behaviors, interprofessional dynamics, and social comparison—variables not captured in our demographics-based model. Together, these findings suggest that organizational and educational factors may account for more variation in empathy than age or years of experience alone.

Conversely, our findings contrast with studies from the UK [29] and Germany [30], which revealed that junior doctors often felt under-qualified or lacked the confidence to manage psychiatric emergencies. This discrepancy may suggest that while Saudi ED physicians feel empathetic and possess a satisfactory understanding of suicide risk, they still face operational hurdles similar to those identified by İnan et al. in Turkey [31]. Their work indicates that high difficulty ratings in assessment often stem from a heavy biomedical focus, time constraints, and inadequate clinical settings. These systemic barriers explain why physicians may feel significant friction at the point of care despite maintaining high levels of empathy.

The facility-based cross-sectional study by Wordefo et al. [32] in Ethiopia also quantified the clinical burden of suicidal behavior at 8% and attempts at 6.3%, mainly among young adults, with social reasons and hanging commonly cited as methods, putting our predominantly young, early-career emergency medicine workforce in perspective and underscoring the need for high empathy alongside effective assessment processes; their recognition of the lack of a single preponderant risk

Table 1. *Socio-demographic characteristics of the subjects.*

Demographics	*N* (%)
Gender	
Male	44 (69.84)
Female	19 (30.16)
Age	
≤ 30	35 (55.56)
31-40	17 (29.68
> 41 years	11 (17.46)
Years of experience in EM	
0-4 years	34 (53.97)
5-9 years	9 (14.29)
> 10 years	20 (31.74)

Table 2. *The 11 items comprising the USP scale and their corrected-item total for reference.*

Item	Mean ± SD	Median	Item total correlation	Completely agree	Agree	Disagree	Completely disagree
Patients who have tried to commit suicide are usually managed well in my department.	2.238 ± 0.836	2	0.122	11 (17.46%)	31 (49.21%)	16 (25.40%)	05 (7.94%)
I sometimes get irritated while managing patients who have attempted suicide.*	2.222 ± 0.850	2	0.322	04 (6.35%)	19 (30.16%)	27 (42.86%)	13 (20.63%)
A person who has made several suicide attempts is at significant risk of committing suicide.	1.571 ± 0.640	1	0.186	32 (50.79%)	26 (41.27%)	5 (7.94%)	0
I treat patients who have tried to commit suicide as willingly and sympathetically as I treat other patients.	1.492 ± 0.564	1	0.556	34 (53.97%)	27 (42.86%)	2 (3.17%)	0
Because the patients who have tried to commit suicide have emotional problems, they need the best possible treatment.	1.683 ± 0.643	2	0.491	26 (41.27%)	31 (49.21%)	06 (9.52%)	0
I often find it difficult to understand a person who has tried to commit suicide.*	2.142 ± 0.779	2	0.147	03 (4.76%)	15 (23.81%)	33 (52.38%)	12 (19.05%)
I want to help a person who has tried to commit suicide.	1.381 ± 0.551	1	0.410	41 (65.08%)	20 (31.75%)	02(3.17%)	0
I try to do my best to speak with a patient who has attempted suicide about their problems.	2.015 ± 0.813	2	0.327	18 (28.57)	28 (44.44)	15 (23.81%)	02 (3.17%)
It is usually troublesome to evaluate a patient who has tried to commit suicide.*	2.730 ± 0.627	3	0.423	4 (6.35%)	40 (63.49%)	17 (26.98%)	02 (03.17%)
I am usually sympathetic and understanding towards a patient who has tried to commit suicide.	1.683 ± 0.590	2	0.515	24 (38.10%)	35 (55.56%)	4(6.35%)	0
I try to do my best to make a patient who has tried to commit suicide feel comfortable and secure.	1.508 ± 0.535	1	0.570	32 (50.79%)	30 (47.62%)	01 (1.59%)	0

*Reverse coded.

factor also concurred with our recognition that basic demographic variables provided little explanatory hint [31].

Overall, our results concur with the broader literature in demonstrating a high baseline of empathy but underscoring that attitudinal and performance gaps are concentrated around workflow, training, and contextual factors—areas emphasized by multifactorial models and qualitative work rather than around fixed demographics [29-32].

When considered within the context of ED practice, the high empathy scores are encouraging; however, the "troublesome" nature of assessments points to underlying systemic stressors. The high-pressure, biomedical orientation of the ED often clashes with the time-intensive psychosocial needs of suicidal patients. The reported irritation and difficulty in evaluation likely stem from a combination of high patient volumes, inadequate private spaces for psychiatric assessment, and the inherent complexity of mental health triage. These practical frictions can inadvertently lead to "secondary victimization" where patients may feel inferior to those with other medical conditions, potentially discouraging future help-seeking behavior.

Table 3. *Logistic regression analysis of the association between gender and empathy levels in managing suicide patients.*

Variable	OR	*p*-value	95% CI
Intercept	0.51	0.0754	0.249-1.069
Gender (Reference: Female)	2.70	0.0848	0.872-8.357

OR, odds ratio; CI, confidence interval.

Using the validated USP scale is a notable strength of this study, which enables direct comparison with international datasets, along with its focus on a specific, high-stakes population of ED physicians in a major academic center. Nevertheless, certain limitations should be acknowledged. The single-center design may restrict the generalizability of the results to other regions of Saudi Arabia, and the reliance on self-reported, subjective data introduces the potential for social desirability bias, whereby participants may overestimate their empathic attitudes.

Future research should utilize objective measures of clinical behavior and incorporate a multi-center approach involving various medical specialties, such as family medicine and psychiatry, to provide a more comprehensive view of the national landscape of suicide care.

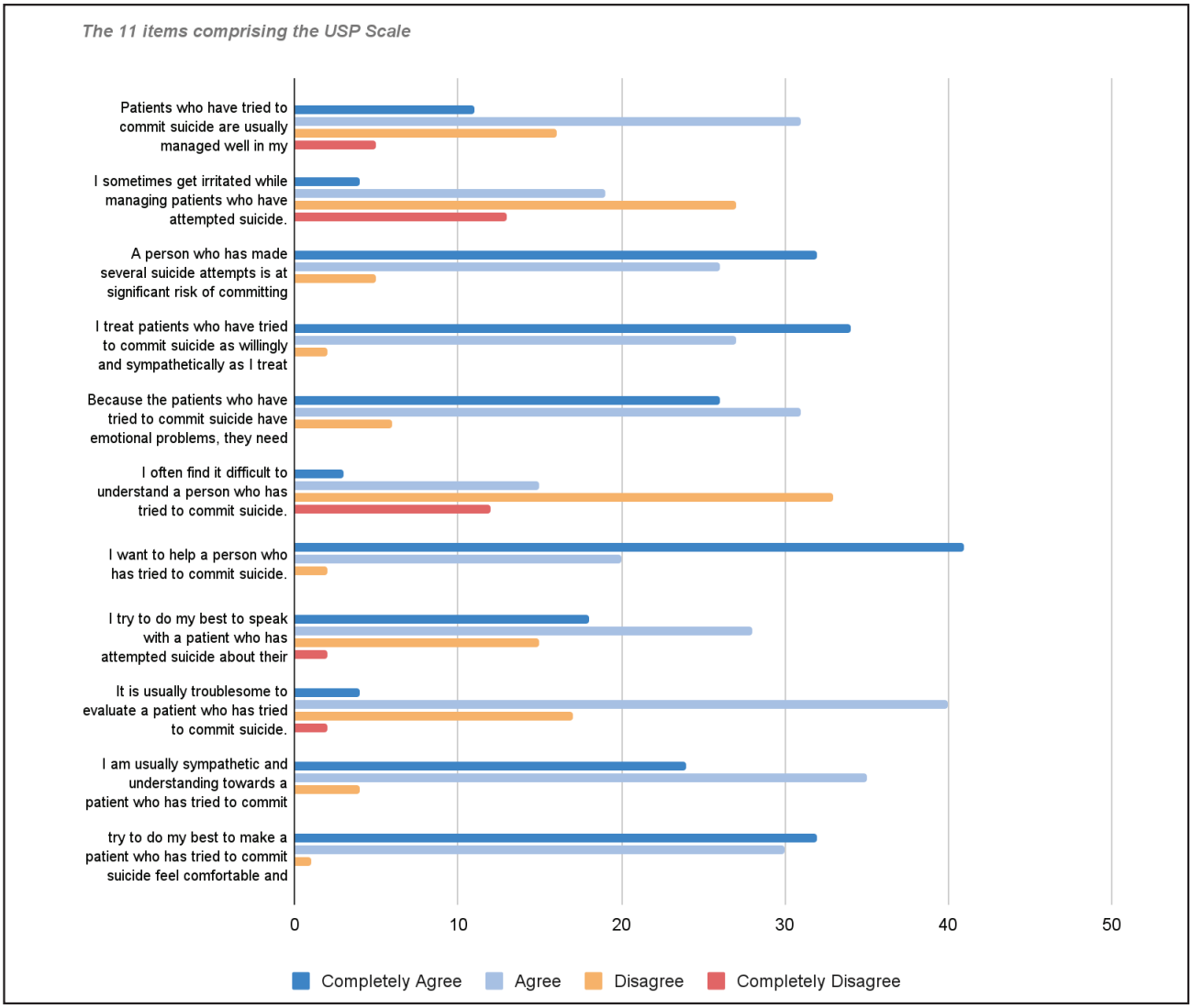


Figure 1. *The 11 items comprising the USP scale and their corrected results on the four-point Likert scale.*

Conclusion

Emergency physicians in Saudi Arabia demonstrated an overall positive and empathic attitude toward patients with suicidal ideation, as reflected by a mean USP score of 20.67 ± 3.76. No statistically significant differences in attitudes, skills, or empathy were observed across age or years of experience. Although male physicians showed a trend toward higher empathy (OR ≈ 2.7), this was not statistically significant. Despite the generally positive attitudes, a substantial proportion of physicians reported challenges in assessment, with the majority finding evaluation of suicide attempters troublesome and about one-third reporting irritation. These findings indicate a predominantly supportive approach with specific difficulties related to patient evaluation.

List of Abbreviations

CI	Confidence interval
ED	Emergency Department
KSUMC	King Saud University Medical City
OR	Odds ratio
SD	Standard deviation
USP	Understanding of suicidal patients

Conflict of interests

The authors declare that there is no conflict of interest regarding the publication of this article.

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Consent to participate

Informed consent was obtained from all participants before participation. Participation was voluntary, and confidentiality was ensured.

Ethical approval

This study was approved by the Institutional Review Board at King Saud University, College of Medicine (Ref. No. 23/0283/IRB), and approved on the 3rd of May 2023.

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Supplementary content (if any) is available online.

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