Suicide by health care professionals

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Health professionals are human beings — and therefore not immune to mental health problems

The paper by Milner and colleagues[1] is a useful reminder that the medical and associated professions are not immune to suicide. Based on data from the National Coronial Information System, it is the most comprehensive study of its type in Australia.

However, as would be anticipated in an examination of a low base rate phenomenon such as suicide, even their 12-year sample included only 369 suicides in a wide range of health professionals. Nevertheless, when grouped broadly into medical practitioners (79 suicides), nursing and midwifery (216), and all other health care professionals (74), some significant findings emerged.

The importance of the availability of a means of suicide was confirmed, with increased rates of suicide among health care professionals with ready access to prescription medications. Also confirmed in an age-adjusted analysis was a significantly higher suicide rate for women in both the medical and nursing professions than for women employed in non-health care occupations, and a non-significant increase in the suicide rate for women in other health professions. There was no significant difference between the suicide rates for male medical practitioners and for men employed outside the health care professions, but there was a significantly higher suicide rate among men in the nursing profession (including midwifery) and, perhaps unexpectedly, a non-significantly lower rate for men in other health professions.

It is interesting that a United Kingdom study (223 suicides by doctors over a 17-year period) similarly found an elevated suicide rate among female medical professionals, but also a significantly lower rate for their male colleagues than for men in the general population.[2] The UK statistics were sufficient to allow analysis of individual specialties: the risks for anaesthetists, community health doctors, general practitioners and psychiatrists were greater than for doctors in general hospital medicine.

It is pertinent to note that the comparison groups for these two studies were different, and this limits both the interpretation of the two studies and, more particularly, their comparison.

Milner and colleagues discuss a number of contributing factors that might explain their findings, including the potential importance of a perceived conflict of occupational gender norms, particularly for men who choose a career in nursing or midwifery. Similarly, the higher suicide rate for women in the medical professions could be interpreted as a result of their breaking into a male-dominated domain. However, although the sex ratio among medical practitioners has changed markedly over the past few decades, this would not explain the higher suicide rates in the other two health care professional categories.

It may be that the health care professions are particularly demanding and stressful, and it is fair to say that this is a common perception, particularly within the professions themselves. Indeed, it has been reported that female and younger medical practitioners in Australia perceive their work as more stressful than do other medical practitioners.[3] However, the authors who reported these findings, from a survey conducted by a market research company, conceded that the lower than ideal response rate meant that the results might not represent the views of all practitioners; further, they also acknowledged that few doctors reported being "highly impacted" by their mental symptoms.

It is easy and non-threatening to seek external explanations for these and similar findings. A less frequently canvassed factor may be that people select for themselves the helping professions in order to fulfil their own dependency needs. We are all subject to inherited, developmental, and psychodynamic influences; while this does not imply that any personal psychopathology is necessarily involved in pursuing a health care profession, none of us is impervious to our personal needs. If, as is inevitable in our careers, we are sometimes unable to fulfil all the expectations of all our patients — expectations occasionally fuelled by unrealistic depictions in the media of the outcomes that can be expected — anxiety and depression may ensue, at times paired with drug and alcohol misuse that can result in an increased risk of suicide.

Milner and colleagues suggest that further enquiries could shed light on opportunities for targeted prevention strategies, a not uncommon conclusion to studies in this area. However, while the proposition seems reasonable, it is hardly realistic, bearing in mind the low base rate of suicide and the challenges involved in identifying individuals at risk. For example, although the rate of suicide among female medical practitioners was significantly higher than in the broader female workforce, the term "suicide rate" is not particularly helpful when one considers that the total number of suicides by female medical practitioners in Australia over 12 years was 17 (by comparison: more than 2000 suicides are recorded each year in Australia).[4]

This comment should not be interpreted nihilistically, but as a pointer to the need for a more pragmatic and practical approach.

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Facets such as ensuring good workplace relationships and equal opportunity, eliminating bullying, reducing access to means of suicide, and addressing the stigma that still attaches to seeking help for mental disorders, are clearly important, as they are for all workplaces.

More specifically, as health care professionals we need to appreciate that we are not immune to mental disorders, including alcohol and drug dependence, and the latter is of particular concern because of our ready access to prescription drugs. For those experiencing emotional distress, the services of an empathetic GP are a good start. For those without a GP, peer review meetings, which can counter the isolation of some practices, and the advice of local professional bodies can be helpful. However, these cannot be seen as definitive approaches to the problem, but rather as facilitators for obtaining the professional care that would be offered to anyone in the community.

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If you or anyone you know is thinking about suicide, please call Lifeline on 13 11 14 (www.lifeline.org.au) or beyondblue (www.beyondblue.org.au) on 1300 22 46 36.

1 Milner AJ, Maheen H, Bismark MM, Spittal MJ. Suicide by health care professionals: a retrospective mortality study in Australia, 2001–2012. *Med J Aust* 2016; 205: 260-265.

2 Hawton K, Clements A, Sakarovitch C, et al. Suicide in doctors: a study of risk according to gender, seniority and specialty in medical practitioners in England and Wales, 1979–1995. *J Epidemiol Community Health* 2001; 55: 296-300.

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4 Australian Bureau of Statistics. 3303.0. Causes of death, Australia, 2014. 11. Intentional self-harm (suicide). http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3303.02014?OpenDocument (accessed July 2016). ■