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Review Article

Suicide of Physicians and other Healthcare Professionals

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Abstract

It is suggested that suicide among healthcare professionals is under-reported. It is still unknown if the under-reporting is due to considerations and empathy of colleagues, "blind-spot" of co-workers or any other reasons. In any case elucidation should lead to preventative measures.

Keywords: Suicide; Healthcare; Public-Health; Stress; Physicians

The problem

Is suicide of physicians a mental health blind spot?

--An actual case-based dilemma

A while ago, when I served as a faculty at a New York USA prominent medical school a colleague Professor of Psychiatry committed suicide. This was a surprise to all faculty because the deceased was the Psychiatrist-chief of one of the main University affiliated hospitals and won praises for being a role model Professional and Academic leader as well as an excellent very efficient administrator who ran a well-oiled financially successful operation with loyal personnel even in tough times.

Retrospectively it was revealed that for a long time he suffered of bipolar disorder (BD) and sought treatment with a well-known Psychoanalyst who later expressed guilt feelings that he had not prescribed any pharmacological mood stabilizers nor recommended any other intervention that might be more adequate for a patient diagnosed with BD. The immediate pre-suicide report was that, following a Psychoanalytic session the colleague self-referred himself to the main academic Emergency Department (ED) and expressed his turmoil and concerns to the ED physician in charge. The Chief told him "You are one of our best Psychiatrists, you know what to do". He went home where he lived by himself following separation from his wife and hung himself.

In the next meeting of the Department of Psychiatry Executive Committee (EC) the Chair opened the meeting with a statement "I am shocked, that never happened here", a member of the EC who specialized in Thanatology (the science of death) responded "that is in-accurate, I demonstrated that suicide among the college Medical faculty is quite frequent" and went on to show the numbers. He was invited to present the data at the next meeting which he did.

He convincingly reported that interviews with personnel and families revealed that in our local medical system colleagues who filled out death certificates of MD`s who passed away of overdose wrote "Cardiac arrest" as the cause of death, or when strangulation happened the official statement was "respiratory failure", "asphyxia" or a similar medical phrase. According to that expert it has been advantageous to avoid attribution of suicide because of insurance and legal issues as well as emotional best-interest of families.

Pertinent issues

The case described here should shade light on several aspects that may be of importance to well-being of healthcare professionals

- Is there reluctance of healthcare and especially mental healthcare professionals to seek care within their own system?
- How to maintain confidentiality, privacy, self-assurance and well-standing with colleagues when a professional feels a need for help?
- Is there a bias when a known colleague is involved? Is there "a blind spot" for mood problems of co-workers?
- May an expert`s professional judgment concerning his/her situation be trusted when s/he is the subject?
- When healthcare professionals feel suicidal ideation, do they consider different modes of suicide as compared to the general population? Are they more "sophisticated" in choice of methods?
- Are there noticeable behaviors or signs that may raise suspicion of pending self-harm?
- Are there situational or environmental predictors of professionals` distress?
- How to sensitively approach a colleague in suspected distress? Especially when s/he verbally declares "all is great".

Are there preventative steps that may be pursued?

Future directions

How may the hypothesis that suicide of health professionals is under-reported be confirmed or disconfirmed? This issue may be of significant Public Health and individual well-being significance. A retrospective survey of background and symptoms prior to Cardiac Arrest and asphyxia of healthcare professionals is methodologically and ethically not easy but it is needed. Preferably it should be conducted in different cultures. A departure point for a survey may be death certificates. It is of interest whether reported deaths of professionals are different from other strata of society. Reports may be influenced by considerations of legal and insurance ramifications as well as empathy to the colleague`s family.

The possibility of "a blind spot" of colleagues in the working place to behavioral and mood changes of an individual with whom they regularly interact should not be ignored. It`s elucidation may contribute to implementation of preventative measures. Distress may be manifested by physical symptoms or changes in consumption of medications [1]. If such symptoms or changes are noticed by co-workers and colleagues, should they be reported? To whom? How?

Conclusion

An under-reporting of suicide among healthcare professionals is suggested. Awareness to such a possibility may contribute to improvement of well-being of healthcare professionals. Therefore, further elucidation of the magnitude of the problem, its causes and manifestations are of importance.

Bibliography

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