Suicide amongst doctors

Roger Mulder, Frank Frizelle

Mental health conditions are a significant part of the national burden of disease.[1] Burnout, depression and anxiety are increasingly common diseases amongst doctors that impair their ability to perform at home and at work, as well as cope with life stressors.[2,3] Burnout has been documented to affect 45% in a consultant survey in one New Zealand hospital prior to the COVID-19 pandemic, and this is likely to have increased with the present frustrating work environment.[4] Overseas counties have found increased mental health issues amongst doctors in the present phase of the COVID-19 pandemic.[5,6]

Documentation of increased suicide risk among doctors dates back to the nineteenth century. Estimates of suicide vary but are generally considered to be higher than the general population. The first published systematic review in 2004 estimated doctors' relative risk at 1.41 (95% CI 1.21–1.65) for men and 2.27 (95% CI 1.90–2.73) for women compared with the general population.[7] However, a second more recent systematic review and meta-analysis reported that male physicians had a *lower* rate compared with men in general (0.67; 95% CI 0.55–0.79), and while female physicians still had a higher rate (1.46; 95% CI 1.02–1.91), it was considerably less than that reported 15 years prior. The study also compared suicide rates before and after 1980 and showed a significant decrease over this time.[8]

Despite this encouraging news, there remain headlines,[9] expressing concern over the suicide risk of doctors. It is possible that rates have again risen since the data used in the most recent review predated COVID-19. Furthermore, the fact remains that although female rates have dropped, they remain significantly higher than the general population.

The most common contributors to suicide risk are burnout, depression, alcohol and drug disorders, and compassion fatigue.[10] Most surveys report that rates of burnout and depression in doctors are higher than rates found in the general population. A series of meta-analyses estimate the prevalence of depression to be 27% in medical students, 29% in resident doctors, and up to 60% in practising doctors.[10]

Rates of depression and thoughts of suicide in doctors are reported to be significantly higher than other professionals leading to speculation that personality traits associated with good doctoring—perfectionism, obsessiveness and competitiveness—may act against them when stressed.[11] In a system where doctors feel unable to deliver the care required by their patients, they may suffer guilt for events beyond their control. Defences that are useful in surviving medical practices such as intellectualisation, dissociation and sublimation may make it harder to create attachments to others, or to recognise when the emotional burden of work becomes too much, therefore contributing to the spiralling of discontent and increased risk of suicide.[11]

In addition, doctors tend to neglect their own need for psychiatric, emotional, or medical help, and are more critical of themselves and others.[7] They are more likely to blame themselves for their illnesses and feel they have failed by becoming mentally unwell. Henderson et al. (2012) studied doctors out of work with mental illness and reported that most felt guilty, ashamed and fearful. They were also stigmatised within and outside the profession, leaving them isolated and sad. Most described a lack of support from colleagues, which may help explain why 41% of doctors said they would not disclose their mental illness.[12]

Complaints and disciplinary processes are increasingly recognised burdens that weigh heavily on doctors, adding to their risk. A survey of doctors, comparing those with recent or current complaints, found that they were more than twice as likely to report thoughts of self-harm or suicidal ideation and, of those referred to the General Medical Council in the UK, around one in four had moderate to severe depression and/or anxiety.[13]

In summary, suicide in doctors appears to be associated with multiple factors including: organisational and occupational stressors, such as long working hours, increasing administration, lack of support, and dealing with death; individual differences, such as personality, coping style, and skill set); and life stressors, such as relationship breakups and complaints and litigation.

What can be done?

Interventions are more likely to be effective if there are good data. New Zealand does not have this. As far as we can ascertain, there are no data on New Zealand doctor suicide or attempted suicide rates. We have some data on doctors' burnout which, at 45%, appears similar to most Organisation for Economic Co-operation and Development (OECD) countries.[4] These rates in New Zealand medical students are higher, with around two-thirds reporting burnout.[14]

There are no specific, evidence-based interventions to reduce suicide. The most useful interventions are those that focus on improving doctors' mental health, since this is the most potent risk factor associated with suicide. The most comprehensive available review is one done recently by the Society of Occupational Medicine, on UK doctors.[15] They noted that primary interventions, such as reducing workload and improving teamwork and communication, are the most effective. However, changing organisations is complex, time-consuming and costly, and almost impossible in the present time given the difficulty in bringing in staff from overseas at present. So, healthcare organisations prefer introducing initiatives that help individuals enhance their stress management skills. These secondary interventions include mindfulness, psycho-education modules, and general stress management training. Meta analyses suggest that these produce only minor benefits, and then only in those motivated and interested in them.[15] The responsibility for protecting one's health is firmly placed upon that person, with the organisation erroneously believing that these methods are sufficient to tackle what could be a pathogenic work environment.

Tertiary interventions are used when a doctor experiences ill health, to rehabilitate them and adapt their working conditions to their needs and circumstances. These are often implemented via occupational health and return-to-work programmes. Doctors may avoid treatment, as they fear sanctions from their employer and professional regulator, such as the Medical Council of New Zealand (NZMC). Their fears are not irrational, with examples of doctors who have spoken publicly about their mental health problems being disciplined.[11] In New Zealand, doctors can discreetly inform the Te Kaunihera Rata o Aotearoa Medical Council of New Zealand, and the health team there plays an important role in supporting doctors. Medical Protection Society (MPS) and Medical Assurance Society (MAS) also fund access to confidential counselling services for their members, and doctors who need support should reach out to these organisations. The utilisation of these services has increased markedly in the last few years.

In summary, a systemic approach that incorporates primary, secondary and tertiary types of interventions is recommended. Primary interventions typically have the strongest impact on doctors' mental health. The creation of Te Whatu Ora seems an ideal time to review workloads, administrative teamwork, and the complaints procedures that doctors are exposed to. There is evidence that integrating secondary interventions, such as resilience training, as part of primary changes can increase the success of both.[16] It has been argued that burnout among doctors arises from maladaptive behaviours developed during medical education, and subsequently reinforced in healthcare organisations. Interventions to improve doctors' mental health will only be effective if the "pathogenic" culture from which they work is addressed.[15]

Resources

1737, Need to talk? – Free call or text 1737 any time for support from a trained counsellor.

Lifeline – 0800 543 354 or (09) 5222 999 within Auckland.

Youthline – 0800 376 633, free text 234 or email talk@youthline.co.nz or online chat.

Samaritans – 0800 726 666.

Suicide Crisis Helpline – 0508 828 865 (0508 TAUTOKO).

For MAS and MPC members – you can access EAP Services directly on 0800 327 669 24hrs a day or make contact via their website: (https://www.eapservices.co.nz/).

COMPETING INTERESTS

Nil.

AUTHOR INFORMATION

Professor Roger Mulder: Department of Psychological Medicine, University of Otago, Christchurch, New Zealand.

Professor Frank Frizelle: Editor in Chief *NZMJ*; Professor of Surgery; Clinical Director of General Surgery, Department of Surgery, University of Otago Christchurch, New Zealand.

CORRESPONDING AUTHOR

Professor Roger Mulder: Department of Psychological Medicine, University of Otago, Christchurch 1840, New Zealand. E: roger.mulder@otago.ac.nz

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