Suicide of a patient is a very distressing event for a consultant psychiatrist and can adversely affect both their personal and professional life. Consultant psychiatrists have been shown to have higher levels of work-related exhaustion than their medical and surgical colleagues and patient suicide potentially contributes to this. A review of studies from the USA, Canada and the UK suggests that 50–70% of consultant psychiatrists will experience the suicide of a patient at some point in their career. Despite it potentially being one of the most distressing events in a psychiatrist’s career, the number of studies in the literature is relatively small and there has been only one Irish study to date. The studies conducted thus far have all identified patient suicide as a cause of considerable distress, yet it is an event for which training leaves psychiatrists under-prepared. We conducted a nationwide study of all consultant adult psychiatrists in Ireland to establish the impact on their personal and professional life.

Method

We sent a confidential postal questionnaire to 292 consultant psychiatrists in Ireland (not including child and adolescent psychiatrists), identified through records held by the Irish Medical Council and the Irish Medical Directory (www.imd.ie) that were cross-checked with each individual hospital. To maintain confidentiality and thus optimise our response rate, the questionnaires were not coded or numbered in any way and were sent with a non-coded, stamped, addressed return envelope. However, each participant was assigned a number and was sent a corresponding numbered envelope and asked to post this simultaneously with their questionnaire, to aid identification of non-responders. Non-responders were contacted again by post after 10 weeks and after a further 8 weeks they were contacted by email if available.

We examined each consultant’s most recent experience of patient suicide as well as the suicide they perceived to be most distressing. We did not specify that the deaths had to have been recorded as suicides in the coroner’s court, instead leaving the choice of case to each individual’s judgement.

Results

Study sample

A total of 292 questionnaires were sent. We received 182 responses, of which 4 were excluded owing to incomplete information; this gave us a response rate of 61%.
More than half of the consultants (56%, n = 102) were male. The majority (55%, n = 101) had been working in psychiatry for 10–20 years and 33% (n = 60) had between 10 and 20 years’ consultant experience. Over three-quarters of the consultants (76%, n = 138) worked in general adult psychiatry, with 13% (n = 24) in old age psychiatry, 4% (n = 7) in forensic psychiatry, 3% (n = 5) in rehabilitation psychiatry, 2% (n = 4) in liaison and 2% (n = 4) in addiction psychiatry. More than half of the consultants (56%, n = 102) worked in a mixed urban and rural setting, with 30% (n = 55) working exclusively in urban and 14% (n = 26) in rural settings.

Overall, 143 respondents (80%) reported having had at least one patient die by suicide during their consultant career; 33% (n = 60) reported only one suicide (mean = 4, range 0–30). For those working as general adult psychiatrists, the mean number of suicides was 5.2; the mean was 1.8 for old age psychiatrists and 1.7 for all other subspecialties combined.

**Most recent suicide experienced**

All consultants who had experienced at least one patient suicide (n = 143) provided information in this section; 68 of the suicides (48%) had occurred in the same calendar year as the survey. The majority (68%) of the patients were male and 33% were aged 17–30. The most common diagnosis was unipolar non-psychotic depression (25%); 20% had a dual diagnosis of major mental illness with alcohol and/or substance misuse. Almost half (49%) of the suicides had occurred by hanging; drowning was the next most common method (22%). As much as 44% of the deaths had occurred in the patient’s own home, with 8% taking place in a psychiatric hospital. At the time of the suicide, the majority of individuals (81%, n = 116) were out-patients, 14% were in-patients and 5% were day-care patients. Of the in-patients, 85% were of voluntary status and 75% were on routine work practices, with increased nursing observation and detention under the Mental Health Act (17% (n = 24) and 8% (n = 11) respectively). A more detailed analysis of the self-reported effects of patient suicide on psychiatric consultants is presented in Table 1.

**Effect on personal life**

Some disturbance of personal life was reported by 87% (n = 124) of consultants. The most common effect reported was a preoccupation with the suicide (84%, n = 120), persisting for up to 1 month in 70% (n = 83) of cases. A sense of guilt or blame was reported by 69% of consultants (n = 99) and lasted up to 1 month in 70% (n = 69). Other effects reported were disturbed sleep (27%, n = 39) and low mood (21%, n = 30).

**Effect on professional life**

Some effect on their professional and working life was reported by 88% (n = 126) of consultants. A heightened awareness of risk was the most frequently reported effect (87%, n = 124), persisting for longer than 6 months in almost half of the sample (46%, n = 57). Consultants’ confidence was affected in 52% (n = 75) of cases, and this lasted for up to 1 month in 65% (n = 49) of cases. A quarter had altered their work practices, with increased nursing observation and detention under the Mental Health Act (17% (n = 24) and 8% (n = 11) respectively). A more detailed analysis of the self-reported effects of patient suicide on psychiatric consultants is presented in Table 1.

**Support**

In the aftermath of the suicide, 95% (n = 136) of consultants sought support informally from colleagues, with 66% (n = 94) also seeking support from family and friends; 61% (n = 87) undertook a formal case review or psychological autopsy. No one reported having sought formal support such as professional counselling, debriefing or other psychological intervention. Two consultants (1%) described hostility from the bereaved family as quite distressing; another two recalled having briefly thought of a career change. Conversely, two other consultants believed that suicide was ‘part and parcel’ of the job of a psychiatrist and thus not a cause for disruption to one’s personal or professional life.

**Most distressing experience of suicide**

Information on the most distressing patient suicide was provided by 143 consultants. For 33% (n = 47) of them it was

**Table 1** Effects of the most recent suicide on personal and professional lives of consultant psychiatrists in Ireland

<table>
<thead>
<tr>
<th>Duration, months</th>
<th>Preoccupation with suicide, % (n)</th>
<th>Guilt, % (n)</th>
<th>Disturbed sleep, % (n)</th>
<th>Low mood, % (n)</th>
<th>Decreased confidence, % (n)</th>
<th>Increased risk awareness, % (n)</th>
<th>Increased nursing observation, % (n)</th>
<th>Increased use of MHA, % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>70 (83)</td>
<td>70 (69)</td>
<td>71 (27)</td>
<td>73 (22)</td>
<td>65 (49)</td>
<td>21 (26)</td>
<td>33 (8)</td>
<td>18 (2)</td>
</tr>
<tr>
<td>1–3</td>
<td>21 (25)</td>
<td>22 (22)</td>
<td>26 (10)</td>
<td>20 (6)</td>
<td>16 (12)</td>
<td>18 (22)</td>
<td>12 (3)</td>
<td>18 (2)</td>
</tr>
<tr>
<td>3–6</td>
<td>7 (8)</td>
<td>4 (4)</td>
<td>3 (11)</td>
<td>7 (2)</td>
<td>7 (5)</td>
<td>15 (19)</td>
<td>12 (3)</td>
<td>18 (2)</td>
</tr>
<tr>
<td>&gt; 6</td>
<td>2 (4)</td>
<td>4 (4)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>12 (9)</td>
<td>46 (57)</td>
<td>42 (10)</td>
<td>46 (5)</td>
</tr>
</tbody>
</table>

MHA, Mental Health Act.
Effects of the most distressing suicide on personal and professional lives of consultant psychiatrists in Ireland

Table 2  Effects of the most distressing suicide on personal and professional lives of consultant psychiatrists in Ireland

<table>
<thead>
<tr>
<th>Strength</th>
<th>Preoccupation with the suicide, % (n)</th>
<th>Guilt, % (n)</th>
<th>Disturbed sleep, % (n)</th>
<th>Low mood, % (n)</th>
<th>Decreased confidence, % (n)</th>
<th>Increased risk awareness, % (n)</th>
<th>Increased nursing observations, % (n)</th>
<th>Increased use of Mental Health Act, % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>4 (5)</td>
<td>18 (26)</td>
<td>58 (83)</td>
<td>64 (91)</td>
<td>32 (46)</td>
<td>12 (17)</td>
<td>74 (106)</td>
<td>89 (128)</td>
</tr>
<tr>
<td>A little</td>
<td>32 (46)</td>
<td>35 (48)</td>
<td>24 (34)</td>
<td>22 (31)</td>
<td>42 (60)</td>
<td>22 (32)</td>
<td>15 (21)</td>
<td>6 (8)</td>
</tr>
<tr>
<td>Quite a bit</td>
<td>46 (66)</td>
<td>32 (46)</td>
<td>12 (17)</td>
<td>8 (12)</td>
<td>18 (26)</td>
<td>44 (62)</td>
<td>6 (9)</td>
<td>2 (3)</td>
</tr>
<tr>
<td>A lot</td>
<td>18 (26)</td>
<td>12 (17)</td>
<td>6 (9)</td>
<td>6 (9)</td>
<td>8 (11)</td>
<td>22 (32)</td>
<td>5 (7)</td>
<td>3 (4)</td>
</tr>
</tbody>
</table>

Duration, months

| 1             | 37 (51)                                 | 39 (46)     | 62 (83)                | 60 (31)        | 42 (41)                     | 16 (20)                         | 30 (11)                              | 13 (2)                                   |
| 1–3           | 41 (56)                                 | 39 (46)     | 25 (34)                | 25 (13)        | 32 (31)                     | 17 (21)                         | 14 (5)                               | 33 (5)                                   |
| 3–6           | 15 (21)                                 | 14 (17)     | 8 (17)                 | 12 (6)         | 13 (12)                     | 15 (19)                         | 21 (8)                               | 27 (4)                                   |
| > 6           | 7 (10)                                 | 8 (8)       | 5 (9)                  | 3 (2)          | 13 (13)                     | 52 (66)                         | 35 (13)                              | 27 (4)                                   |

MHA, Mental Health Act.
20% (n = 29) felt there should be formal support, such as psychological debriefing, automatically offered in the aftermath of a suicide. A further 10% (n = 14) felt this should be available if required but not as an automatic response. A case review performed by an independent psychiatrist was suggested by 16% (n = 23) of consultants. Medico-legal assistance in the coroner’s court and in the event of litigation was suggested by three consultants (4%).

Discussion

We conducted a national survey of the effect of patient suicide on consultant adult psychiatrists in Ireland. Our response rate of 61% was comparable with or superior to similar studies internationally.4,6 When compared with the national population of consultant psychiatrists our respondents appear to be largely representative of this population (48% male and 43% aged 40–49, information obtained from the Royal College of Psychiatrists’ database). International studies have shown that patient suicide is a relatively common experience for consultant psychiatrists, with 50–70% experiencing it at least once.7 We found the effect on both the personal and professional life of the consultants to be consistent with or greater than previous studies, with up to 97% reporting some disturbance in their personal life.2,6

Informal support from colleagues was identified by the majority of respondents as the most effective support, which is again reflective of other studies.6,57 However, the number seeking formal and independent reviews suggests that, although many receive psychological support from family and friends, consultants would also welcome an objective review from a professional viewpoint. It is likely that such service, protected from legal disclosure, would be welcomed, although rather surprisingly fear of legal consequences was rarely cited by our respondents as a factor increasing their distress. This contrasts with Hendin’s study, which cites fear of litigation as one of four factors increasing their distress. This contrasts with Hendin’s study. This ambivalence towards employer-provided support is mirrored in Pilkinton & Etkin’s study.7 Formal interventions should ideally be consistent with or greater than previous studies, with up to 97% reporting some disturbance in their personal life.2,6

A number went on to suggest that there should be an independent and confidential support available such as a telephone helpline or debriefing. However, many felt that although such support should be available, it should be left to an individual consultant’s discretion whether to avail oneself of it and one should not be pressured into doing so. This ambivalence towards employer-provided support is mirrored in Pilkinton & Etkin’s study.7 Formal interventions should ideally be evidence-based and those availing themselves of them should be cognisant of the dangers as well as the benefits of debriefing.9

Chemtob et al identified a lack of established protocols to help a psychiatrist in the aftermath of a suicide.5 This was also borne out in our study and a number of psychiatrists were quite critical of this fact. As most services do in fact have existing protocols, these criticisms suggest that either the psychiatrists are not aware of them or that the protocols are perceived to be deficient or unhelpful in some way.

For 17% (n = 24) of our consultants a suicide was particularly distressing when it was unpredicted. This had been described before by both Alexander et al and Morris.6,10 Hendin et al8 identified guilt resulting from failure to hospitalise a suicidal patient and treatment decisions which in hindsight were perceived to have been wrong as contributing factors to severe distress in professionals. In Alexander et al’s study,6 some consultants stated that suicide needed to be regarded as inevitable in some cases, and a small number in our survey also reported this view. Gitlin11 argued that death is the natural history of severe medical disorders and should similarly be regarded as the natural outcome of severe psychiatric disorders. However, our mean number of four patient suicides in a group of consultants, many of whom have 10–20 years’ experience, argues against this view. Admittedly, such an attitude might lessen the sense of personal responsibility in the event of a suicide, but the danger of what has been described as ‘therapeutic nihilism’ might be enhanced.6

Greater emphasis on dealing with patient suicide during psychiatric training has been previously highlighted as a potential way to reduce the distressing effect on psychiatrists. In Dewar et al’s study,12 those who had received such training found it helpful in the long run. Chemtob et al9 and Hendin et al8 both identified trainee psychiatrists and those with less experience to be at greater risk of distress after a patient dies by suicide, and thus highlight the need for training; in one study only a third of psychiatric residents had received any instruction in this area.7 Such training should emphasise the likelihood of experiencing patient suicide and prepare the psychiatrist for their potential personal and professional reactions. It should also emphasise help-seeking, pointing to the finding that fellow professionals and family have been found most helpful. Resources such as the UK Department of Health policy documents might be useful in this training.13

Limitations of the study

The retrospective nature of the study lends itself to recall bias, particularly as regards the duration of the consequences – providing four different time scales was an attempt to minimise this (1 month, 1–3 months, 3–6 months, over 6 months). Furthermore, although there is a chance that those consultants who perceive patient suicide as particularly distressing were more likely to respond and those with a more pragmatic approach may not have done so, there is also the possibility that those who have a more robust or neutral approach to the issue might respond more willingly than those who find the topic distressing. Two attempts to follow-up non-responders were made in an effort to counteract this.

We did not use any validated rating scales in the questionnaire, as we felt that existing scales did not adequately reflect the aims of the study and might limit the potential responses. The questionnaire was designed based on our own personal experiences, which we hoped would be reflective of those of our colleagues, and a review of the literature.

About the authors

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Postcode lottery? Hospital transfers from one London prison and responsible catchment area

Simon Wilson,1,2 Katrina Chiu,3 Janet Parrott,1 Andrew Forrester2,4

Aims and method To consider the link between responsible commissioner and delayed prison transfers. All hospital transfers from one London prison in 2006 were audited and reviewed by the prisoner’s borough of origin.

Results Overall, 80 prisoners were transferred from the audited prison to a National Health Service (NHS) facility in 2006: 26% had to wait for more than 1 month for assessment by the receiving hospital unit and 24% had to wait longer than 3 months to be transferred. These 80 individuals were the responsibility of 16 different primary care trusts. Of the delayed transfer cases (n=19), the services commissioned by three primary care trusts were responsible for the delays.

Clinical implications There are significant differences in performance between different primary care trusts related to hospital transfers of prisoners, with most hospitals able to admit urgent cases within 3 months. This suggests that a postcode lottery operates for prisoners requiring hospital transfer. Data from prison services may be useful in monitoring and improving the performance of local NHS services.

Declaration of interest None.

Growing dissatisfaction with the state of the UK prison medical service throughout the 1970s and 1980s1 led to the publication by the government of The Future Organisation of Prison Health Care.2 This document set out plans for a formal partnership between the National Health Service (NHS) and the Prison Service. Various prisons, including the one in our study, piloted mental health in-reach teams in 2002, part of a process which ended with the NHS taking over the commissioning of health services for all prisons in 2006. The principle of equivalence of care states that prisoners are entitled to the same standard of healthcare as they would have were they not in prison.2–4 Those prisoners who have mental disorders of a nature or degree such that their needs can only be appropriately met by in-patient treatment are meant to be transferred from prison to hospital for treatment.5 Prison in-reach teams take referrals from a wide range of sources and generally support a high volume of prisoners with stable mental illnesses. The prisoners described in this paper represent the most acutely unwell.

Although the principle of equivalence is meant to underpin the working of a mental health in-reach team, there is no equivalent of a prison healthcare wing.6 A prison
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