[1] Doctors in Distress

Correspondence to: C Gerada
clare.gerada@nhs.net

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Doctors and suicide

Female doctors are still at higher risk than their non-medical peers

Clare Gerada, [1] Amandip Sidhu, [1] Frances Griffiths[1]

According to some estimates, one doctor dies by suicide every day in the United States,[1] and around one every 10 days in the United Kingdom.[2] This high rate is borne out by a linked meta-analysis by Zimmermann and colleagues (doi:10.1136/bmj-2023-078964),[3] which includes 64 observational studies on male (38 studies) and female doctors (26 studies) who died by suicide. These studies, with observation periods from 1935 to 2020 and from 1960 to 2020, respectively, report a suicide rate ratio of 1.05 (95% confidence interval 0.90 to 1.22) for male doctors, indicating no overall increase in risk compared with the general population. For female doctors, however, the suicide rate ratio was significantly increased at 1.76 (1.40 to 2.21). The authors also found that while standardised suicide rate ratios for all doctors had decreased over time, the risk remained higher for female doctors compared with the general population.

A strength of this study is that it includes searches extending to March 2024, providing the most comprehensive picture to date of suicide risk among male and female doctors. The authors acknowledge potential study limitations, including scarcity of studies from outside Europe, the US, and Australasia; high heterogeneity in findings among included studies; and likely underreporting of suicide as the cause of death because of stigma. However, their findings are broadly similar to those of previous studies, including meta-analyses.[4-6]

The reasons behind any doctor's death by suicide can be perplexing; even bereaved relatives often struggle to understand their loved one's motivation.[7] The American psychiatrist Michael Myers, in his book *Why physicians die by suicide*, writes that the act of suicide is a complex phenomenon involving the "convergence of genes, psychology, and psychosocial stressors that come together in a perfect, albeit horrific storm."[8]

Doctors share risk factors with their non-medical peers, including family history of suicide, past experiences of trauma or abuse, isolation, mental illness, or drug misuse. However, they have additional risks, including a high risk of burnout[9] and barriers to accessing timely help for poor mental health.[10] Selection for the medical profession favours personality traits such as perfectionism, obsessiveness, and competitiveness,[11] which in highly stressful work environments can result in a triad of guilt, low self-esteem, and a persistent sense of failure.[12] Doctors also have access to potentially dangerous drugs, including opiates and anaesthetic agents such as propofol, which have been implicated in the relatively high rate of suicide documented among anaesthetists.[13]

While causal inference is not possible from observational studies, some have reported links between mental illness and suicide and being the subject of a complaint or regulatory processes.[14] The protracted nature of complaints processes could also play a part. In one UK study, doctors receiving a complaint of any kind were significantly more likely to report moderate to severe depression than those who had never experienced a complaint (relative risk 1.77, 95% CI 1.48 to 2.13).[15] Doctors with current or recent complaints were two times more likely than others to report thoughts of self-harm or suicidal ideation. Distress and suicide ideation increased with the severity of the complaint, and levels were highest after a referral to the regulator. A study in the Netherlands reported similar findings.[16]

As Zimmermann and colleagues make clear, their new analyses highlight an ongoing need to reduce mental distress and suicide risk among doctors, particularly women. This means addressing longstanding systemic issues that create distress, such as poor work and regulatory cultures that name, blame, and shame people when mistakes or complaints occur rather than looking to correct the broader system. It means adopting working schedules that allow doctors a sensible work–life balance and paying attention to the basic emotional and psychological needs of all staff. Doctors should have timely access to psychological support, particularly during periods of high stress, such as during the investigation of complaints or serious incidents.[17 18]

Persistently high rates of suicide among female doctors need particularly urgent attention from researchers, health leaders, and policy makers, including studies to explore likely contributors such as discrimination and sexual harassment, to characterise those at highest risk, and to develop and evaluate gender specific interventions to protect female doctors' mental health. Finally, all doctors must have access to early intervention and confidential treatment services so that they do not suffer in silence.[19]

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