



The impact of patient suicide and sudden death on health care professionals



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ARTICLE INFO

Article history:

Received 31 July 2014

Revised 18 September 2014

Accepted 19 September 2014

Keywords:

Suicide

Sudden death

Health care professional

Impact

ABSTRACT

Objective: To compare the professional and personal impact of patient suicide and sudden death on health care professionals (HCPs) and determine factors associated with these impacts.

Method: The sample was derived from a sudden death-controlled psychological autopsy study of suicide. HCPs were identified by deceased's next of kin, by other HCPs, from coroners' files and from medical records. The HCPs were interviewed about their last contact with the deceased and the impact of the death on their lives.

Results: Two hundred eleven HCPs were interviewed following suicide; 92 after sudden death. Suicide deaths were significantly more likely to impact upon the HCP's professional practice [suicide $n=79$ (37.4%); sudden death $n=9$ (9.9%); $\chi^2=22.06$, $P<.001$] and personal life [suicide deaths $n=55$ (26.1%); sudden death $n=12$ (13.0%); $\chi^2=5.58$, $P=.018$] than sudden deaths. Using multinomial logistic regression, being female and suicide within a week of the consultation predicted professional and personal impacts; having less than 5 years experience predicted professional impact and receipt of support/counseling predicted personal impact.

Conclusion: Suicide deaths have a greater impact than sudden deaths upon the life of HCPs. Clinical inexperience influences impacts on professional practice and availability of support impacts on personal life.

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1. Introduction

The suicidal death of a patient represents a challenging experience for health care professionals (HCPs). Common reactions include disbelief, shame, anger, betrayal, guilt, feelings of vulnerability, loss of self-confidence, powerlessness, impotence, denial and detachment [1–3]. The death may trigger feelings of inadequacy, including self-doubt about competence and fears that professional reputation might suffer [4].

Most research upon the impact of suicide on careers has focused on psychiatrists and other mental health professionals. The majority of psychiatrists have at least one patient who died by suicide in their professional career [2,3,5,6], and for many, this event first occurred during psychiatric training [7]. A survey of 178 psychiatry trainees in Australia and New Zealand found that 68% had experienced a patient death by suicide and over a quarter of the trainees felt that they had received no support after the suicide [8]. Although psychiatry training programs report some suicide content in their curricula [9], very few include the topic of postvention, and it is unclear how many focus on the needs of the trainees [10,11].

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Research on the impact of suicide on other HCPs is limited. One report found that while overall there was little difference between general practitioners (GPs) and psychotherapists, GPs reported less feelings of guilt, had fewer problems in showing their feelings to colleagues and were less likely to speak to a supervisor. There were also no significant differences between medical and non-medical HCPs [12]. A survey of GPs in Ireland found that 86% had at least one patient suicide in the previous 10 years. Most GPs reported that patient suicide affected their professional life with 54% increasing referrals to psychiatrists, 50% improving accuracy of medical records and 40% prescribing more antidepressants, while fewer GPs reported changes in their personal life with around 35% reporting guilt feelings and over 20% having disrupted sleep. Twenty percent of GPs sought support after the suicide and 62% said they would use a support system if available [13]. In a qualitative study involving 14 GPs in Denmark, Davidsen noted that patient suicide had a substantial emotional effect on the GPs including feelings of guilt and failure, particularly in cases where they had not explored the possibility of suicidal ideation [14]. With the already noted guilt reactions and a tendency to self-scrutinize professional decisions being common in GPs after patient suicide, it may not be surprising that GPs in the UK could feel that they are being “blamed” in the mandated Critical Incident Reviews that occur after patient suicide [15].

Most nursing research on the impact of patient suicide has focused on mental health nurses [16,17], and there are few reports of the impact on nurses in other settings [18]. A literature review found that nurses' reactions to suicide paralleled those found in psychiatrists and concluded that nurses needed a support system to help them cope with grief after patient suicide [16]. A survey involving 531 mental health nurses in Japan found that 55% had encountered an inpatient suicide, the majority in the previous 10 years. The potential impact patient suicide had on the nurses was measured by the Impact of Event Scale-Revised with the finding that 13.7% of the nurses were scoring in the range considered to be at high risk for posttraumatic stress disorder. Nearly 80% of nurses reported that a reminder brought back feelings of the suicide, and over 60% felt watchful or on guard. Only 15.8% of nurses had access to postvention support programs [17].

There is also evidence that other types of patient death can have an adverse effect on HCPs professional and personal lives. Studies have included hospital deaths [19], still births and neonatal deaths [20], cancer deaths [21,22], pediatric deaths [23], primary care [24] and emergency ward deaths [23,25]. The pattern of effects is similar to those described for patient suicide and range from doubts over professional competency to a sense of loss, grief and personal mortality [25]. To the best of our knowledge, there have not been any studies that have compared the impact of suicide and other sudden deaths on HCPs. However, a systematic review of controlled studies of non-HCP suicide survivors found that there were no significant differences between survivors of suicide and other bereaved groups regarding general mental health, depression, posttraumatic stress disorder symptoms, anxiety and suicidal behavior, although suicide survivors reported higher levels of rejection, shame, stigma, need for concealing the cause of death and blaming than all other survivor groups [26]. It is unclear whether these findings extend to HCPs.

The main aims of the present study are as follows: (i) to describe the professional and personal impact of patient suicide in a broad range of HCPs including psychiatrists, psychologists, mental health nurses, GPs and medical specialists; (ii) to compare the impact of patient suicide with patient sudden death; and (iii) to determine factors that are associated with these impacts.

2. Methods

The sample was derived from a controlled psychological autopsy study of suicide in persons 35 years and older which aimed to examine the last clinical contact subjects who died by suicide with HCPs, in order to determine whether this contact offers the opportunity for suicide prevention [27]. The present study involved HCPs who were identified through interviews with the next of kin of persons who died by suicide or sudden death between 2006 and 2008, by other HCPs involved with the deceased person, and from coroners' files and other medical records. A case-control study design was applied using sudden death victims as controls. The sudden death group included heart attacks, road traffic accidents (RTA) and other accidents; it excluded accidental overdoses, homicides and single-vehicle RTAs. HCPs were included only if the deceased had contact with them during the 6 months before death [28]. There were 437 letters sent out to HCP of suicide death, with 211 (48.3%) agreeing to participate, and 253 letters sent out to HCP of sudden death, with 92 (36.4%) agreeing to participate. The main reasons for not participating were as follows: unable to be contacted, not having contact with subject in 6 months prior to death, being busy or not interested.

The HCPs were offered interviews by phone, face-to-face or by e-mail. The audiotaped semistructured interviews were undertaken by trained mental health professionals; the structured questions had coded responses. The HCPs were asked about the circumstances and details of their last contact with the person who died by suicide, their reactions to the death, the impact the death had on their professional (Did the patient's death have any impact on your medical practice?) and personal lives (Did the patient's death have any impact on your personal life?), and whether they needed and/or received support after the

suicide (Did you get enough support and/or counseling after the patient's death?). The type of impact was not specified; however, HCPs were able to provide a description of the types of impacts they had experienced and additional support required through an open-ended query. These latter responses were written or verbal and could not be systematically assessed or accurately quantified. They were also asked about previous encounters with suicide in their professional and personal lives. Demographic data obtained included age (under/over 50), sex, state, type of health profession, private or public setting and years in practice.

2.1. Statistics

To analyze and compare different groups, odds ratios (ORs) with a 95% confidence interval (CI) were calculated. When calculating ORs in subgroups with small numbers (fewer than 4), Fisher's Exact Test was used. Multinomial logistic regression was applied to estimate the independent contribution of significant predictors from the analyses. Variables with a significant association with serious suicidal ideation were entered into a forward stepwise logistic regression analysis. Final models were assessed using the Hosmer–Lemeshow goodness-of-fit test to evaluate the calibration (a small χ^2 value and a *P* greater than .05 would show an acceptable adaptation), and the Nagelkerke *R*² to present the proportion of explained variance [29]. A probability level of .05 was employed for all statistical tests. IBM SPSS version 20.0 was used for data analyses.

The Griffith University Human Research Ethics Committee and the South Eastern Sydney Human Research Ethics Committee approved the study.

3. Results

There were 303 HCPs interviewed, 211 following a patient suicide and 92 after a sudden death. The majority were interviewed by phone (*n* = 277), with the rest either face to face (*n* = 4) or by e-mail (*n* = 21) (1 with missing data). The HCPs were identified by the next of kin (*n* = 216), coroner's files (*n* = 58), medical records (*n* = 17) or another HCP (*n* = 10). Interviews occurred approximately a year after death. Demographic and professional details of the HCPs are listed in Table 1. HCPs of suicide deaths were significantly more likely to be psychiatrists (OR = 7.68, 95% CI 2.65–22.30) or other mental health professionals (OR 7.41, 95% CI 2.19–25.08) than HCPs of sudden deaths.

Table 1
Demography and professional profile

	Suicide, <i>n</i> (%)	Sudden death, <i>n</i> (%)
Age <50 y	101 (50.5) ^a	37 (40.7) ^a
Male	154 (73.0)	66 (71.7)
State		
– Queensland	152 (72.0)	67 (72.8)
– NSW	59 (28.0)	25 (27.2)
Type of HCP		
– GP	104 (49.3)	68 (73.9)
– Psychiatrist	47 (22.3)	4 (4.3)
– Psychologist	15 (7.1)	2 (2.2)
– Mental health nurse	12 (5.7)	1 (1.1)
– Medical specialist	13 (6.2)	14 (15.2)
– Other	20 (9.5)	4 (4.3)
Practice setting		
– Private	147 (70.0)	77 (84.6)
– Public	45 (21.3)	8 (8.8)
– Community	13 (3.9)	2 (2.2)
– Other	6 (2.8)	4 (4.4)
Years of practice (mean)	20.17	22.87

^a One missing.

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