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Doctors have an elevated suicide rate, but it is most likely moving in the right direction

## Suicide among doctors

Recently in New York City, two first-year residents jumped to their deaths within a few days of each other. These suicides aroused horror, drawing renewed attention to suicides among doctors (1, 2).

Suicides in the medical profession have been studied and debated for decades (3). The results have been surprisingly consistent. In fact, doctors *do have* an elevated suicide rate, over time as well as across many countries. We have good-quality data from Norway as well. In a study comprising the period 1960–2000, a total of 111 suicides among Norwegian doctors were recorded (4). During this forty-year period, the suicide rate increased from the 1960s to the 1980s before falling in the 1990s. Although this was a positive trend, the suicide rate among women doctors in the 1990s remained twice as high as among women in general (4). This high suicide rate is striking, since doctors have a lower mortality than other groups for all other causes (5). Only their suicide rate stands out negatively.

In recent years we have acquired much knowledge of significance. The particular use of drugs by doctors to commit suicide is a recurring feature (6). This is unsurprising, since doctors are well aware of the effects of drugs and their toxicity. Moreover, their suicide rate increases with age (4). Why is it difficult to be an old doctor? We do not know the answer to this question. Perhaps the identity and self-esteem of doctors are more closely connected to their profession than is the case for other groups, and for some, the transition from a busy working life to retirement may be insuperable (7). Common risk factors for suicide have been shown to be the same for doctors as for others: depression, personality disorders and substance abuse (3). However, although such risk factors also occur in doctors, more profession-specific factors are likely to provide an explanation for the elevated suicide rate, especially the knowledge and availability of the means of suicide.

Certain issues may render suicide prevention in doctors even more of a challenge than in others. We doctors have traditionally been reluctant to ask for help (6). When we run into problems we try to solve them ourselves, for example by self-prescribing and self-medication. In addition, the prevalence of attempted suicide is relatively low (3). In light of the elevated suicide rate, this may indicate that doctors rarely “cry for help», but act on their suicidal thoughts (3). Thus, there is good reason for particular alertness if we discover or suspect that any of our colleagues are struggling.

Recent studies indicate that the suicide mortality among doctors is declining (4, 8). The prevalence of suicidal thoughts also seems to be on the wane (9). One explanation could be that being a doctor has become rather common. Now, we have one doctor for every 222 inhabitants in Norway. In 1970 the corresponding figure amounted to 700, and in 1950 to 1 000 (10). We may therefore hope that time

is on our side. In coming years, we may perhaps see the suicide rate among doctors normalise.

I believe that we can help reduce the suicide risk among doctors in two areas in particular. It is essential to ensure that doctors can more appropriately seek help. This might be a particular challenge in the human service professions, where it is an inherent feature of the occupation to provide help – not receive it. In this respect, much has occurred of a positive nature over the last couple of decades. Two low-threshold options are available where doctors who are exposed to stress may seek advice and guidance. In all counties, doctors have access to especially appointed support colleagues who are accessible for calls. Moreover, doctors from all over the country can seek help from the Resource Centre Villa Sana funded by the Norwegian Medical Association, and run in cooperation with a local psychiatric facility, Modum Bad. Most doctors will also have their own regular GP, and some counties still maintain the doctor-for-doctor scheme, in which those involved have experience as treatment providers for colleagues. However, each and every one of us has a responsibility. It is especially crucial to be aware of colleagues who have mental health issues, including substance abuse, and do our part to ensure that they enter treatment and are shielded from performing tasks that could make a bad situation worse, if need be. It is essential to catch those who are struggling at an early stage, to ensure that they receive help before their problems assume such proportions that a suicide risk arises.

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