

Clinical Communiqué

VOLUME 5. ISSUE 3.
September 2018 Edition
ISSN 2204 - 0099

CONTENTS

Editorial	1
Case #1 OUT OF THE BLUE	2
Case #2 TO WHAT EXTENT?	3
Case #3 HARD TO BELIEVE	5
Expert Commentary #1 THE MENTAL HEALTH OF HEALTH PROFESSIONALS: SUICIDE AND SUBSTANCE ABUSE	6
Expert Commentary #2 SUICIDE PREVENTION IN HEALTHCARE WORKERS	8
Expert Commentary #3 CARING FOR THE CARERS: WHY STATUS QUO IS NOT ALRIGHT	10

PUBLICATION TEAM

Editor in Chief: Nicola Cunningham
Consultant Editor: Joseph E Ibrahim
Managing Editor: Alexander Gillard
Designer: Samuel Gillard

Address: Department of Forensic
Medicine, Monash University,
Victorian Institute of Forensic Medicine
65 Kavanagh St, Southbank VIC 3006
Honorary Advisory Board: Adam O'Brien,
Carmel Young, David Ranson

FREE SUBSCRIPTION

The Department of Forensic Medicine
Monash University and the Victorian
Institute of Forensic Medicine will publish
the CLINICAL COMMUNIQUÉ on a
quarterly basis. Subscription is free of
charge and will be sent electronically to
your preferred email address.

If you would like to subscribe to the
CLINICAL COMMUNIQUÉ, please go to:

<http://www.vifmcommuniques.org>

Next Edition: December 2018

EDITORIAL

The Clinical Communiqué exists to highlight the challenges that occur when looking after patients, so that clinicians may learn from the experiences of others, and to motivate readers to work together to improve patient safety. From the beginning, the Clinical Communiqué has tackled the difficult topics and challenging themes in health care with a professional, objective and dispassionate approach.

We have shared stories and reflected on the tragedy of patients' lives lost through sequences of events that would later be closely examined and held up as a lesson to change practice for the better. Often, there were defining points, actions or moments in time, where the precise nature of the adverse outcome was foreseeable with the benefit of hindsight.

This edition is unapologetically different. Looking after our patients and improving the ways in which we keep them safe is only one side of the story. The other side is looking after ourselves. As healthcare professionals, our behaviour is not infallible and our health is not immune to the physical and mental illnesses that afflict those we treat. At times, we are all patients as well.

Whether we are providing or in need of care, our health, and the health of our patients depends upon the prioritisation of our own well-being. That is why we felt it was important to step aside from our usual format for this edition and turn the lens back on ourselves. To focus the attention on suicide in healthcare professionals. It remains a disquieting entity that provokes mixed emotions and a sense of helplessness amongst peers. How do we talk about it? What are the lessons for us? Where are the identifiable defining moments that may have prevented the outcome? How do we manage if no matter how many times we reflect on the words and actions of our family, friend, or colleague we still cannot identify what we could have done differently?

I, like many others in our profession, have had experiences that make this subject all too personal. In the course of my career, I have seen two colleagues take their own lives as a result of mental health issues. For both, just as their families may have expressed following their loss, I did not see it coming. I treated one, only a few weeks before his death, following a fall from his bicycle. We bantered about him being a patient, the best way to manage gravel rash, and I discharged him from my care, making a mental note that I should ask him about his healing wounds the next time we crossed paths in the workplace. Except I never saw him alive again. I never saw a hint of his despair.

That was a long time ago, but my recollection of how we all dealt with the news is crystal clear. There was relative silence. It was as if we could not speak of it in the workplace. Hushed words in a corridor, then a funeral, then nothing. There was no communication from our managers, no changes or initiatives, no encouragement to speak out or consider counselling.

I am heartened to see that presently, a lot more is being said on the topic. There is still a long way to go, but there are a few brave and dedicated people who are making it happen, and the good work that they do is helping to progress the conversation around suicide of healthcare professionals. In this edition, we give our sincere thanks to the experts that have generously offered their time and knowledge. We especially thank the families who lost loved ones, who have put the well-being of our profession ahead of their own grief to allow us to bring these issues to light.

Thank you for reading. Now please start talking.

CASE #1 OUT OF THE BLUE

Case Number:
2017/1844 QLD

Case Précis Author:
Dr Nicola Cunningham
B.Med, MForensMed, FFCFM
(RCPA), FACEM

CLINICAL SUMMARY

Dr A was a medical specialist who worked in both public and private healthcare settings. The night before he died, Dr A left the bedroom he shared with his wife, explaining to her that he did not want to disturb her with his broken sleep. The next morning, he left early for work. Sometime later, staff arrived at the medical practice and noted that his office door was shut. When they tried to knock and enter Dr A's office to let him know that a student of his had arrived, they found him hanging by his tie. Despite the efforts of the staff, the student, and the ambulance officers who were called to the scene, Dr A could not be revived.

PATHOLOGY

A forensic pathologist conducted CT imaging and an external autopsy examination of Dr A. There were no significant pathological findings. Toxicological analysis showed only the presence of non-toxic levels of atenolol (a beta-blocker), and temazepam (a benzodiazepine). The pathologist concluded that cause of death was due to hanging.

The coroner noted that although there was a family history of depression, Dr A was not known to have a history of mental illness.

INVESTIGATION

The coroner heard from Dr A's family that he had been unduly concerned about financial matters. He had also been experiencing difficulty sleeping and feeling over-tired, which was compounded by the demands of on-call work.

Dr A was preoccupied with the recent death of a patient of his, and had begun to worry about his own health.

He prescribed his own treatment after discovering that his blood pressure was elevated. He was troubled even more after receiving abnormally high results on 'cardiac calcium testing' that he had organised for himself.

Not long before his death, Dr A was at a family gathering to celebrate a birthday. His family later reflected that his behaviour was withdrawn at the time, which was out of character. The coroner noted that although there was a family history of depression, Dr A was not known to have a history of mental illness.

The family hoped that their loss would highlight the sudden and potentially devastating consequences of depressive illness and the importance of seeking help.

CORONER'S FINDINGS

The coroner concluded that Dr A's death was unexpected and that it was likely he was experiencing major depression when he ended his life. The coroner described Dr A as a dedicated doctor, husband, and father, who had *'very rapidly become seriously unwell with respect to his mental health'*.

The coroner acknowledged the strength shown by Dr A's family in their resolve to increase awareness of depressive illness amongst healthcare professionals. The family hoped that their loss would highlight the sudden and potentially devastating consequences of depressive illness and the importance of seeking help.

KEYWORDS

Medical specialist, hanging, depression, mental health

ACKNOWLEDGEMENTS

This initiative has been made possible by collaboration with the Department of Forensic Medicine (DFM), Monash University, Victorian Institute of Forensic Medicine (VIFM) and Victorian Managed Insurance Authority (VMIA).

REPRODUCTION & COPYRIGHT

This document may be reproduced in its entirety for the purposes of research, teaching and education and may not be sold or used for profit in any way. You may create a web link to its electronic version.

Permission must be obtained for any modification or intended alternative uses of this document. If referring to this publication, the following citation should be used:

Clinical Communiqué [electronic resource]: Department of Forensic Medicine, Monash University, Victorian Institute of Forensic Medicine. Available at: www.vifmcommuniques.org

DISCLAIMER

All cases that are discussed in the Clinical Communiqué are public documents. A document becomes public once the coronial investigation process has been completed and the case is closed. We have made every attempt to ensure that individuals and organizations are de-identified. The views and conclusions are those of the authors and do not necessarily represent those of Victorian Managed Insurance Authority, the individual Coroner, the Coroners Court, Department of Health, Department of Forensic Medicine, Victorian Institute of Forensic Medicine or Monash University. If you would like to examine the case in greater detail, please contact us and we will provide the relevant website for the Coroners Court jurisdiction.

FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in clinical practice. Please email your comments, questions and suggestions to:

cc@vifmcommuniques.org

CASE #2 TO WHAT EXTENT?

Case Number:
COR 2013/1463 VIC

Case Précis Author:
Dr Don Buchanan
MBBS, FRACGP, FACLM, FACBS,
FFCFM (RCPA), MPH, JD, LLM
(Health Law)
Forensic Medical Officer,
Queensland

CLINICAL SUMMARY

Ms AM was a 49 year old woman who was employed as a paramedic. Past medical history included depression for which she was prescribed desvenlafaxine. Injury had caused her to work part-time for a number of years, however, her employer wanted her to return to work full-time. Ms AM admitted to her partner that the uncertainty around her work was making her unsettled. She also spoke of other issues including conflict with management, inadequate resources, and difficulties dealing with aggressive patients. When a work colleague suicided, Ms AM became increasingly withdrawn.

A month or so prior to Ms AM's death, her partner discussed a separation. Ms AM did not want the relationship to end and was noted to be increasingly reclusive and irritable. One evening, following an argument over this issue, Ms AM became extremely upset and left the house. At 8.30pm she attended her unmanned workplace. At 7.15am the next morning she was found deceased in the sleeping quarters, with an intravenous drip in-situ.

The coroner focussed primarily on the storage and management of medications in the workplace; and whether there was any causal connection between Ms AM's employment and her suicide.

PATHOLOGY

An autopsy found no evidence of natural disease causing or contributing to the death. There was also no evidence of trauma.

Toxicological blood examination demonstrated the presence of ethyl alcohol, fentanyl, midazolam, desvenlafaxine and paracetamol. The cause of death was determined to be multi-drug toxicity.

INVESTIGATION

An inquest was held into Ms AM's death to determine the circumstances in which her death occurred. Ms AM had gained entry to the drug safe, removed 10 vials of fentanyl and 13 vials of midazolam, and had administered these medications via an intravenous drip. The coroner focussed primarily on the storage and management of medications in the workplace; and whether there was any causal connection between Ms AM's employment and her suicide.

Ms AM's employer introduced a number of restrictions which included only allowing access to medication safes during a paramedic's rostered operational shift.

Storage and Management of Medications

The coroner heard that while the workplace computer system logged staff access to the safe, the monitoring was not in real time. Shortly after her death, Ms AM's employer introduced a number of restrictions which included only allowing access to medication safes during a paramedic's rostered operational shift.

Causal Connection Between her Employment and her Death

It was submitted to the coroner that there was a causal connection between Ms AM's employment and her suicide. This submission relied on the evidence of her partner and the opinion of a psychiatrist engaged by the family.

The psychiatrist believed Ms AM was suffering from a major depressive disorder with suicidal ideation, and the impending breakdown of her relationship was the primary cause in precipitating her suicide. The psychiatrist further opined that there was a causal connection between her psychiatric condition and her employment.

This opinion was based on four aspects: the impact of her work-related injuries; the suicide of a work colleague; negotiations over her working arrangements; and a workplace culture of unwillingness to seek psychological support for fear of impeding one's career prospects.

The coroner examined the initiatives put in place to prevent the misappropriation of medications and to promote paramedic mental health.

The employer gave evidence that since Ms AM's death, a mental health and well-being strategy had been introduced into the organisation. The strategy incorporated: suicide prevention training in partnership with beyondblue for all employees; a review of the available mental health services; extended access to counselling services; pre-employment psychological screening and mental health assessment of all new recruits; and upgrades to their leadership development programs, enabling managers and directors to better support employees with mental health issues. Additionally, greater flexibility around working arrangements would be promoted through more options for shorter shifts, part-time work, and equity in shift allocation across the workforce.

CORONER'S FINDINGS

The coroner determined Ms AM's cause of death to be multidrug toxicity due to intentional self-administration of intravenous fentanyl and midazolam, and that she intended the consequences of her actions. After examining each of the four aspects presented by counsel for the family, the coroner concluded they were not causative of her death. Moreover, to what extent they materially contributed could not be determined on the evidence before the court.

The coroner examined the initiatives put in place to prevent the misappropriation of medications and to promote paramedic mental health. The coroner was satisfied that the employer had acknowledged these issues and that the initiatives it had undertaken were reasonable in the circumstances.

AUTHOR'S COMMENTS

This case demonstrates that courts may not accept the evidence on which an expert opinion is based. A coroner's findings must be made on relevant facts proven on the balance of probabilities.¹ The basis of the psychiatric opinion that her employment was a cause of her psychiatric condition was not proven to the reasonable satisfaction of the coroner.

Nevertheless, the coroner acknowledged that paramedics generally may be at an increased risk of suicide due to occupation-specific reasons such as *'access to means, exposure to traumatic events, shift work, and a reluctance to seek help,'* and accepted that workplace initiatives were being put in place. Currently this issue is the subject of an inquiry by the Senate Education and Employment References Committee.²

KEYWORDS

Paramedic, mental health, suicide, employment, causation, multi-drug toxicity

FOOTNOTES

1. Assistance in determining the level of satisfaction required for relevant facts to be proven is found in the High Court decision of *Briginshaw v Briginshaw* (1938) 60 CLR 336, 362.
2. 'The role of Commonwealth, state and territory Governments in addressing the high rates of mental health conditions experienced by first responders, emergency service workers and volunteers.' Submissions have been requested, hearings have commenced, and the report is due by 5 December 2018.

RECOMMENDED LINKS

Australasian Doctors Health Network
www.adhn.org.au.

Nurses and Midwives Health Program
www.nmhp.org.au.

Turning Point (National Addiction Treatment Service)
<https://www.turningpoint.org.au>.

Beyondblue – The National Depression Initiative Workplace Online Programs.
<http://www.beyondblue.org.au/about-us/programs/workplace-and-workforce-program/programs-resources-and-tools/workplace-online>.
Beyondblue also has a range of information and resources to help staff and families talk about mental health issues and suicide:
<https://www.beyondblue.org.au/get-support/have-the-conversation>; <https://www.beyondblue.org.au/the-facts/suicide-prevention>.

Doctors Health Services Pty Ltd.
National forum on reducing risk of suicide in the medical professional final report: AMA; 2017. Available from: <https://ama.com.au/system/tdf/documents/DrHS%20national%20forum%20final%20report.pdf?file=1&type=node&id=47709>.

Black Dog Institute - focusses on translating the knowledge gained from research into better health outcomes for people with mental illness:
<https://www.blackdoginstitute.org.au>.

Mindframe – provides access to up-to-date, evidence-based information to support the reporting, portrayal and communication about suicide and mental illness: www.everymind.org.au.

Guide to staying alive: <https://www.sane.org/mental-health-and-illness/facts-and-guides/guide-to-staying-alive>.

Resources for starting conversations on suicide:
<http://www.conversationsmatter.com.au/> and
<https://www.ruok.org.au>.

CASE #3 HARD TO BELIEVE

Case Number:
COR 2012/1388 VIC

Case Précis Author:
Professor Joseph E Ibrahim
MBBS, PhD, FRACP
Head, Health Law and Ageing
Research Unit, Monash University

CLINICAL SUMMARY

Ms CW was a 53 year old woman who worked as a registered nurse, was a current cigarette smoker, and had a medical history of essential tremor and depression which included previous suicide attempts.

When Ms CW was in her early forties, she developed symptoms of anxiety and depression following the breakdown of a personal relationship with her partner. That same year Ms CW faced financial difficulties and was declared bankrupt. The following year Ms CW's general practitioner (GP) commenced treatment for anxiety, depression, and benzodiazepine dependency. Ms CW consulted a private psychiatrist (Dr LC), and then a second psychiatrist (Dr AS), a year later.

The next major life event occurred four years later when Ms CW's nursing registration was temporarily suspended. Two years after this occurred, Ms CW was treated for an attempted suicide through a medication overdose. Around this time Ms CW chose to see a new, third psychiatrist (Dr LB), who made a diagnosis of 'treatment resistant major depressive disorder with some anxiety' and prescribed a medication regimen of propranolol, lithium, escitalopram, lamotrigine, agomelatine, zolpidem, and quetiapine.

Two days later Ms CW was seen by the CAT team at home who noted her to have impaired judgement and difficulty with activities of daily living.

Over the next two years, Ms CW continued to work as a registered nurse in a public hospital and attended appointments with Dr LB.

Issues of insomnia, zolpidem dependency, an accidental propranolol overdose, and a decline in her ability to self-care were discussed during that time.

One day in autumn, a friend noted that Ms CW had burns to her face and arms, reportedly sustained from an oil fire in her kitchen two days earlier. The friend took her to see another GP, who asked Ms CW to attend a hospital and indicated that if this did not occur then a Crisis Assessment and Triage (CAT) Team would be contacted to conduct an assessment. Her friend was concerned that Ms CW was erratic, manipulative, and possibly doctor-shopping for medication. Around this time Ms CW's neighbours had also contacted police with concerns about her erratic behaviour.

Another three weeks passed by during which Ms CW failed to attend several scheduled appointments with her GPs and psychiatrists.

Ms CW was assessed in the emergency department for her burns and mental health issues, and was discharged with a plan to be reviewed by the plastic surgery team the following day, but she did not return. Two days later Ms CW was seen by the CAT team at home who noted her to have impaired judgement and difficulty with activities of daily living. She was not psychotic however, so they organised a plan for her to follow-up with a GP at one of the family medical centres she was known to attend. Five days later, a GP again contacted the CAT team to request a home visit when Ms CW had not kept her appointment and was not responding to telephone calls. When they arrived, Ms CW appeared confused and she attributed this to quetiapine which had been ceased some months earlier. She denied taking zolpidem and a number of other medications. The CAT team notified her GP and psychiatrist.

Another three weeks passed by during which Ms CW failed to attend a number of scheduled appointments with her GPs and psychiatrists. Several of her treating medical practitioners contacted each other to discuss the issues around Ms CW's doctor-shopping, the need to make another CAT team referral, and to also consider referring her to the driving authority and the Australian Practitioner Health Regulation Agency.

Meanwhile, Ms CW's friend received an express post letter from Ms CW stating that she had taken an overdose, and containing instructions about the care of her pets. The police were contacted, and they attended Ms CW's home to find her dead with two empty vials of insulin and mostly empty medication blister packs.

This review identified that Ms CW had obtained zolpidem from at least eight different prescribers and filled these scripts at three or more different pharmacies.

PATHOLOGY

A forensic pathologist completed a post mortem external and CT scan examination of the body which did not reveal any significant results. Toxicological analysis of the blood revealed the presence of propranolol and a markedly raised insulin level. The cause of death was combined drug toxicity (propranolol and insulin).

INVESTIGATION

Given the circumstances surrounding Ms CW's death, it was reported to the coroner, and following the coronial investigation, the case was closed without an inquest. The police obtained statements from Ms CW's friends and her GP. The Coroners Prevention Unit (CPU) was asked to assist with the investigation into issues of doctor shopping and drug abuse; communication between services; zolpidem dependency; propranolol access, and the use of insulin in suicide deaths.

This review identified that Ms CW had obtained zolpidem from at least eight different prescribers and filled these scripts at three or more different pharmacies. Ms CW had also obtained multiple scripts for nitrazepam and temazepam. These circumstances meant it was not possible for any of the medical practitioners to be certain of Ms CW's medication regimen. The overall communication between the different practitioners and services was deemed appropriate, responsive and timely.

From the available information, it became clear Ms CW had not been forthcoming with family and friends about her health and welfare, use of drugs and alcohol, and her capacity to work.

The review by the CPU identified that propranolol was involved in 53 medication overdose deaths over a 12-year period, and that 90% of these had combined drug toxicity (commonly involving antidepressants and benzodiazepines). Insulin had been implicated in six cases of intentional death, of which three were individuals who may have obtained insulin from their workplace.

The coroner also noted that Ms CW's friends and family were caring and proactive, and had provided encouragement to assist with her health and welfare.

CORONER'S FINDINGS

The coroner accepted that the medical cause of death was due to combined drug toxicity and that Ms CW had intended to suicide. The coroner further found that the suicide by overdose had a degree of planning and coordination. The access to propranolol was through prescriptions for treatment of Ms CW's essential tremor. The access to insulin was presumed to be from Ms CW's work place as there was no medical history of diabetes mellitus.

The coroner commented that the services had responded appropriately and there were no concerns about the clinical care provided by any of the health professionals. There were multiple stressors that may have contributed to Ms CW taking the course of action she did. Specifically, the prospect of a review of her nursing registration, financial strain, drug dependence, and fear of more intensive mental health care.

The coroner recommended that the Therapeutic Goods Administration consider issuing an alert to medical practitioners advising caution when prescribing propranolol to patients at risk of self-harm—specifically limiting the number of tablets available to the patient at any one time from 100 tablets with five repeats to 20-50 tablets per script and no repeats.

The coroner also repeated recommendations made in an earlier coronial case about the importance of a real-time prescription monitoring system to address the issues that arise from patients who are “doctor shopping”.

KEYWORDS

Nurse, suicide, insulin, propranolol, mental health, prescription, combined drug toxicity

EXPERT COMMENTARY #1: THE MENTAL HEALTH OF HEALTH PROFESSIONALS: SUICIDE AND SUBSTANCE ABUSE

Dr Kym Jenkins MB.ChB,
FRANZCP, MPM, MEd, GAICD
Consultant Psychiatrist,
Medical Educator
President, Royal Australian
and New Zealand College of
Psychiatrists (RANZCP)
Ex-Medical Director, Victorian
Doctors Health Program (VDHP)

The three cases discussed in this issue bring home in the most painful way that as health professionals we are not immune to mental health problems, including substance use disorders that can lead to suicide. In fact, there are multiple factors that make us more vulnerable.

Being a healthcare worker is inherently stressful: we cannot change that we look after sick people who don't always get better, that we see horrific sights and hear patients telling us unspeakable stories. We are constantly reminded of our own mortality. There are days when as health professionals we go home and cry that we have lost a patient, feeling that we have let them and their families down, and days when we feel supersaturated with other peoples' problems. Unless we lose our humanity, these moments are inevitable.

However, we can try to do whatever we can to modify the effect these sorts of events have on us and our colleagues: we can ensure there are enough other things in our lives to buffer these potential traumas and that we act collegially, looking after and supporting each other. We do ourselves a disservice if we continue to focus too strongly on the workplace and “how tough the job is” as a cause for ill health. It is vitally important to be mindful that as human beings we experience stressful major life events outside of our careers and can get the same (mental) illnesses as the general population.

We do ourselves (and any struggling colleagues) a disservice if we forget that none of us chose our own genetic inheritance, and we may have inherited biology that predisposes to mental illness that may manifest whatever career we had chosen. The three cases illustrate that not all mental illness in healthcare workers is because the job is tough or the workplace is toxic, but that there are many barriers to doctors and health professionals seeking and accessing help when they need it (Jenkins 2016, Kay et al 2008).

Suicide is the only cause of death where rates for doctors are higher than for the general population.

Physicians' health is a topic that has never before been so prominent in mainstream, social and medical media. There is evidence that physicians display elevated rates of common mental health disorders compared to the general population (Mata et al 2015). There is also increasing academic and clinical interest in the health and welfare of other health professionals particularly first responders (Harvey et al 2017).

Owing to factors such as shame, stigma, denial and lack of access to confidential services, the true rates of substance use disorders in health professionals are unknown. Lifetime prevalence of impairment from substance use for doctors has been estimated to be between 8-18% (Blondell 2005). However, it is known that when doctors enter treatment, recovery rates are greater than for the general population (McLellan et al 2008, Wile et al 2011).

Suicide is the only cause of death where rates for doctors are higher than for the general population (Torre et al 2011). Whether suicide is impulsive and reactive to an acute situation or crisis, something that has been contemplated for some time but ultimately opportunistic, or meticulously planned with “getting one's affairs in order”, disposal of assets and a suicide note can sometimes be inferred at the inquest. It is rare though, to be able to form a valid opinion about the factors that finally led to someone taking their own life. If we are truly to understand suicide there is as much need for a psychological autopsy as for a physical autopsy. We have information about the “how” and “when” but not the “why”.

Information from those who have survived a suicide attempt is a poor approximation here. It is contentious how much someone's profession or work stressors play in their suicidal ideation or final decision to take their life. The idea that it is a predominant factor has gained much traction in recent years and there is an unsubstantiated emphasis on, and a weak evidence base for, workplace stress and mandatory reporting as a reason for suicide in doctors.

It is suggested that whilst risk should not be ignored, there is more to be gained from focusing on the factors that drive the risk, on remedial factors and those amenable to treatment.

Undeniably, for health professionals, being reported to their regulatory body is extremely stressful and has been shown to be associated with high rates of suicide for doctors in the United Kingdom (Horsfall 2014). However, a study conducted at the Victorian Doctors Health Program (VDHP) failed to support that being under investigation was a direct causal link for suicide. Analysis of files of doctors who had attended VDHP and ultimately suicided, indicated that major mental illness particularly in combination with significant substance use were factors. Though all, except one, were recognised to be at high risk of suicide, time of suicide could not be predicted. Suicide was not temporally related to notification of the regulatory body, but more likely to be related to acute (real or perceived) separation from loved ones. Risk of suicide and risk of self-harm are notoriously difficult to predict. It is suggested that whilst risk should not be ignored (Large et al 2017), there is more to be gained from focusing on the factors that drive the risk, on remedial factors and those amenable to treatment.

Models of and access to mental health care varies across jurisdictions and between rural and metropolitan areas, as does stigma and discrimination. Some mental illnesses have very high mortality rates and there is no reason for these rates to be lower in the healthcare community. Health professionals have greater access to the means to commit suicide and greater knowledge of what is most likely to be effective.

In Australia, doctors can access help for mental illness and substance use through the Australian Doctors' Health Network, which links directly to State-based services. Nurses and midwives in Victoria can access help through the Nursing and Midwifery Health Program which works in association with Turning Point. Employee assistance programs are increasingly available for first responders and emergency workers. Globally, Doctors' health services are well established in the United States, Canada, United Kingdom and Scandinavia, and interest is growing in Asia.

GETTING HELP

If you or anyone you know needs help, these telephone support services are available:

- Lifeline Australia telephone counselling 131 114 (24 hours)
- Suicide Call Back Service 1300 659 467 (24 hours)
- SANE Helpline 1800 187 263 (10am-10pm AEST)
- beyondblue 1300 22 46 36
- Perinatal Anxiety & Depression Australia 1300 726 306
- Kids Helpline 1800 551 800
- MensLine Australia 1300 789 978
- Headspace 1800 650 890

RESOURCES

Blondell R. Taking a proactive approach to physician impairment. *Postgrad Med* 2005; 118: 16-18.

Harvey SB, Modini M, et al. Can work make you mentally ill? A systematic meta-review of work-related risk factors for common mental health problems. *Occup Environ Med* 2017; 74(4): 310-310. Available at: http://www.wmh.unsw.edu.au/sites/all/files/publication_related_files/can_work_make_you_mentally_ill_a_systematic_oem.pdf.

Horsfall S. Doctors Who Commit Suicide while Under GMC Fitness to Practise Investigation. Available at: https://www.gmc-uk.org/-/media/documents/Internal_review_into_suicide_in FTP_processes.pdf_59088696.pdf.

Jenkins K. Access to healthcare by psychiatrists, psychiatric trainees and overseas trained psychiatrists: findings from the RANZCP welfare study. *Australas Psychiatry* 2017; 25(2): 175-177.

Kay M, Mitchell G, Clavarino A, et al. Doctors as patients: a systematic review of doctors' health access and the barriers they experience. *Br J Gen Pract* 2008; 58(552): 501-508.

Large MM, Ryan CJ, Carter G, Kapur N. Can we usefully stratify patients according to suicide risk? *BMJ* 2017; 359: j4627.

Mata DA, Ramos MA, Bansal N, et al. Prevalence of depression and depressive symptoms among resident physicians: a systematic review and meta-analysis. *JAMA* 2015; 314(22): 2373-2383.

McLellan AT, Skipper GS, Campbell M, DuPont RL. Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. *BMJ* 2008; 337: a2038.

Torre DM, Wang NY, Meoni LA, Young JH, Klag MJ, Ford DE. Suicide compared to other causes of mortality in physicians. *Suicide Life Threat Behav* 2005; 35(2): 146-53.

Wile C, Frei M, Jenkins K. Doctors and medical students case managed by an Australian Doctors Health Program: characteristics and outcomes. *Australas Psychiatry* 2011; 19(3): 202-205.

EXPERT COMMENTARY #2: SUICIDE PREVENTION IN HEALTHCARE WORKERS

Scientia Professor Helen Christensen
BA (Hons)(Syd), MPsychol (Hons), PhD(UNSW), FASSA, FAHMS, MAICD NHMRC John Cade Fellow
Chief Scientist and Director, Black Dog Institute
Interim Joint Chief Executive Officer, Mindgardens Alliance

Additional input by
Joanna Crawford, M Psychol (Clin)
Research Project Manager, Black Dog Institute
Simon Baker, BPsychMgt/Mkt BSc(Hons) PhD
Research Program Manager, Black Dog Institute

Research shows that suicide rates in healthcare workers are higher compared to the general population (Clarke & McKee, 2017; Milner et al, 2016). Similarly, there is evidence that doctors have a higher risk of suicide than any other professional group (Agerbo et al 2007, Hawton et al 2011, Hem et al 2005).

Access to prescription medication is an important, contributing risk factor. Healthcare workers are more likely to use self-poisoning as the method of suicide than other professional groups, and health professionals with ready access to prescription medication have a higher rate of suicide than those who do not (Milner et al 2016).

Female doctors may be particularly vulnerable. The results of the 2013 National Mental Health Survey of Doctors and Medical Students, involving almost 43,000 doctors in Australia, found that female doctors not only have higher rates of depression, anxiety disorders, burnout, and suicidal thoughts than male doctors, but they also report higher rates of stressors such as conflict between study/career and personal/family responsibilities. These issues are not unique to female doctors (many women experience them), but in Australia, female doctors have been found to have a higher rate of suicide than women in other occupations, unlike male doctors (Milner et al 2016).

A range of individual, organisational, and systemic factors also contribute to mental health disorders in healthcare workers. These include long and irregular working hours, high workload and responsibility, sleep problems and fatigue, repeated exposure to trauma and suffering, bullying and harassment, and limited time for work-life balance and socialising.

There is debate about whether interventions to improve the mental health of healthcare workers should target individual workers directly, or focus on organisational and/or systemic factors such as rostering practices. Indeed, some doctors express frustration with being told to increase their “resilience” and instead attribute their poor mental health to workplace practices.

There is evidence that both individual-focused and structural/organisational strategies can reduce burnout in doctors (West et al 2016). For example, psychological interventions which have been found to reduce depression and anxiety in the general population, such as cognitive behaviour therapy and mindfulness, have also been shown to be effective in reducing symptoms of common mental disorders in doctors (when delivered in randomised controlled trials).

It is hoped that delivering mental health support directly to junior doctors via an app will overcome some of the barriers to help-seeking in this group, such as time constraints and concerns about confidentiality.

State and federal governments have funded the development of a range of new mental health initiatives for medical students and doctors. “Tackling Mental Ill-Health in Medical Students and Doctors” is a key collaborative translational research program, largely funded by the Australian Government Department of Health, and implemented through The Prevention Hub.

Led by researchers at the Black Dog Institute and partners including the Australian Medical Association, Australian Medical Students' Association, Everymind, Orygen (the National Centre of Excellence in Youth Mental Health), and United Synergies, the program will undertake translational research to better understand how to prevent the onset and reduce the severity of depression, anxiety, and suicidality in medical students and doctors.

Taking a multi-faceted approach, this evidence-based program focuses on five key activities:

1. the development of a best-practice framework to assist universities, colleges and hospitals to design safe and supportive environments for medical professionals;
2. the development and evaluation of a psychological intervention for medical students;
3. the development and evaluation of a smartphone app-based psychological intervention for junior doctors,
4. a detailed examination of Australian data on doctor deaths and associated risk factors; and
5. the development of a mental health and suicide prevention framework specifically for anaesthetists (with funding from the Australian Society of Anaesthetists).

The Black Dog Institute is leading the development and evaluation of a smartphone app to support the mental health of all Junior Medical Officers (JMOs) in NSW, largely funded by NSW Health.

In our view, reducing the suicide rate in doctors and other healthcare workers is both an urgent priority and an achievable goal.

This app will be developed in association with doctors and other health professionals and forms one of ten strategies in the NSW Health JMO Wellbeing and Support Plan. It will directly target individual JMOs. The remaining nine initiatives focus on systemic factors such as changes to mandatory reporting requirements and a review of rostering practices.

It is hoped that delivering mental health support directly to junior doctors via an app will overcome some of the barriers to help-seeking in this group, such as time constraints and concerns about confidentiality.

In our view, reducing the suicide rate in doctors and other healthcare workers is both an urgent priority and an achievable goal. We intend to demonstrate how much can be achieved by improving the work environments and reducing the stressors of doctors-in-training, reducing access to means of suicide, and promoting evidence-based therapeutic programs using technology.

RESOURCES

Agerbo E, Gunnell D, Bonde JP, Mortensen PB, Nordentoft M. Suicide and occupation: the impact of socio-economic, demographic and psychiatric differences. *Psychol Med* 2007; 37(8): 1131-1140.

Clarke R, McKee M. Suicides among junior doctors in the NHS. *BMJ* 2017; 357: j2527.

Hem E, Haldorsen T, Aasland OG, Tyssen R, Vaglum P, Ekeberg O. Suicide rates according to education with a particular focus on physicians in Norway 1960–2000. *Psychol Med* 2005; 35(6): 873-880.

Hawton K, Agerbo E, Simkin S, Platt B, Mellanby RJ. Risk of suicide in medical and related occupational groups: a national study based on Danish case population-based registers. *J Affect Disord* 2011; 134(1): 320-326.

Letvak S, Ruhm CJ, McCoy T. Depression in hospital-employed nurses. *Clin Nurse Spec* 2012; 26(3): 177–182.

Milner AJ, Maheen H, Bismark MM, Spittal MJ. Suicide by health professionals: a retrospective mortality study in Australia, 2001–2012. *Med J Aust* 2016; 205(6): 260–265.

Petrie K, Milligan-Saville J, Gayed A, et al. Prevalence of PTSD and common mental disorders amongst ambulance personnel: a systematic review and meta-analysis. *Soc Psychiatry Psychiatr Epidemiol* 2018; 53(9):897-909.

West CP, Dyrbye LN, Erwin PJ, Shanafelt TD. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. *Lancet* 2016; 388(10057): 2272–2281.

Zhou AY, Carder M, Gittins M, Agius R. Work-related ill health in doctors working in Great Britain: incidence rates and trends. *Br J Psychiatry*. 2017;211(5):310-315.

EXPERT COMMENTARY #3: CARING FOR THE CARERS: WHY STATUS QUO IS NOT ALRIGHT

Dr Mukesh Haikerwal AC
General Medical Practitioner
Board: beyondblue / Brain Injury
Australia
Past Chair World Medical
Association / Australian Institute of
Health and Welfare
Past President Australian Medical
Association / Australian Medical
Association Victoria

When I read the reports, they were chilling. The issue of suicide and access to medications being a factor in self-harm is one component to this statistic. Attendant on each case are questions about why?

'Why Physicians Die by Suicide: Lessons Learned from Their Families and Others Who Cared' by Michael F Myers MD is a widely cited source. Could anything different have been done to prevent these events? Why are so many doctors in the figures? Is there a role of the systems, the regulators, the administrators in this environment? Are mental health responses available and safe? Are other issues beyond mental illness involved here?

How much is there a ["cultural" issue](#) between colleagues at all levels? [Many of these dimensions](#) have been [exposed in articles](#) in the media. The World Medical Association has noted the need for physicians to care for their health, and the modern Hippocratic Oath – the [Declaration of Geneva](#) reflects that.

In early 2015 in Victoria there were four suicides amongst doctors in a few days. These were not deemed a 'cluster'.

In 2008 I chaired the beyondblue doctors' mental health program. This included the publication of the beyondblue [doctors' mental health study](#). It gleaned information and provided data to support the medical profession. We hoped that perhaps learning from this group could help reduce morbidity and mortality. Further, we would highlight that these issues were not isolated to doctors alone.

We expected to learn about better ways of dealing with mental illness across the health sector and the community.

The program was successful in that the findings were unequivocal. The sample size was large and Australian-based. Unfortunately translating these findings into a better scheme is still emerging.

In early 2015 in Victoria there were [four suicides amongst doctors](#) in a few days. These were not deemed a 'cluster'. Colleagues and I worked with groups including beyondblue and AMA Victoria. There was a debriefing session with psychiatry trainees and a general meeting of doctors-in-training. beyondblue Chairman the Hon. Jeff Kennett AC organised a meeting of all hospital services in Victoria at CEO and medical director level which was attended by the Victorian Minister for Health Hon. Jill Hennessy. There was an undertaking that the health and working conditions of doctors-in-training, the medical profession in general, and the wider health sector needed to be a matter of priority.

There was also activity to advocate for more thoughtful regime from the regulator - the Australian Health Practitioners Regulation Agency (AHPRA). This now includes [ambulance paramedics who are registered](#) under the [Paramedicine Board of Australia](#). The notion that a practitioner who had an illness had to be ["mandatory reported" continues to be a concern amongst the medical profession](#). The conjoining ill-health in a list of reportable misdemeanours is absurd. Add to that the findings of the beyondblue study where medical professionals believe that they were failures when sick, weak for seemingly not coping. Further, the stigma associated with illness - in particular mental illness - and the perception of their colleagues and administrators around inability to cope with their normal workload and who then saw them as a liability are troubling traits. A report commissioned by the Council of Australian Governments has been completed and [recommends adopting the WA mandatory reporting regime](#) for ill health professionals. It is shameful that this "reform process" has been in play for over four years.

A further group of suicides were reported in [New South Wales](#) and [Queensland](#) which focused minds on our mortality in the medical profession early in 2017.

Very remarkably, the families of the deceased have been very vocal, highlighting attendant circumstances and rightfully the [sense of outrage](#). They are speaking out openly and seeking changes including speaking at public [conferences](#).

Alongside the recent campaigns to be more open about suicidality, this has been a 'game-changer'. This saw others emerge to describe the [previously hidden situation](#) of suicide in the medical profession with a [drive for change from within](#).

After over 30 years advocating for my profession, the notion of suicidality as an occupational hazard is both abhorrent and unacceptable.

There is a sense of urgency and optimism in health. This whole agenda of health and mental health has hit a raw nerve in our sector. The extraordinary success of ["Crazy Socks 4 Docs"](#) in May 2018 had over 37 Million Twitter impressions. It was supported globally and across the health professions. The care in Victoria of "first responders" is being catered for by a more aware respectful management, beyondblue's [Police and Emergency Services Program](#) and the Victorian Government. Across the health sector, the emphasis has been to provide guidance to attain a safe mental health environment with the [Health Services Program](#). Change needs advocacy, change champions and the brave who will stand up for high standards and safety, and not be detracted by obfuscation and bullying. This is sadly often hard to achieve. A recent piece asked: ["What's the best way to fight high suicide rates among doctors?"](#) While in the very recent past we get jolted by news of other medical suicides in Tasmania and the NSW / Victoria border. Addressing suicide must be informed by journals such as this and a [more informed way to approach suicide](#).

After over 30 years advocating for my profession, the notion of suicidality as an occupational hazard is both abhorrent and unacceptable. The cultural, organisational, political and regulatory confounders of professionals' care must be addressed. A humane, fair, acceptable and respected system must be put in place. Failure to address each of these is not an option.