

'The Health of the Nation', suicide and the general hospital doctor

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Records were obtained of all suicide and open verdicts in York ($n=127$) between 1990–1994 inclusive. Those with no past or current contact with psychiatric services were identified ($n=67$). The extent and nature of this group's general (i.e. non-psychiatric) hospital contact in the months prior to death was established. Thirteen per cent (9/67) of these received general hospital input in the month before death with eight out of the nine aged over 65. Five of the 67 suicides showed evidence of depression. General hospital practitioners are in a position to make a small but important contribution in reducing the suicide rate.

The Government White Paper *The Health of the Nation* (Department of Health, 1992) placed an onus on doctors to reduce the suicide rate in both the general population and in those with severe mental illness. The paper makes the assumption that doctors have the ability to prevent suicide. While this may be open to debate, it is undoubtedly the case that doctors can do little to prevent suicide unless they have contact with the victims prior to the act.

Barracough *et al* (1974) demonstrated high rates of medical contact by suicides in the period immediately preceding death. In his series of 100 suicides, two-thirds visited their general practitioner (GP) in the month prior to death and 40% in the week before. In addition, one-quarter of the sample were currently under the care of a psychiatrist and of these about half had visited him in the week prior to death. Barracough *et al* argue that doctors are in a position to and have an obligation to prevent suicide. They were critical of the "fatalism" that has "characterised their (i.e. doctors') attitude to prevention".

Recent studies suggest such high rates of medical contact are no longer the case. Matthews *et al* (1994), in a study of all Scottish suicides during 1988 and 1989, showed that only 38% of suicides contacted their GP in the month before death, and 16% in the week before. Patients with a known psychiatric history and women were more likely to consult their GP. In the month prior to death 21% saw either a psychiatrist or another hospital practitioner.

Meats & Solomka (1995) reviewed 112 suicide and self-harm open verdicts in Nottinghamshire

between 1987 and 1991, obtaining figures remarkably similar to those of Matthews *et al*. While suicides made increasing use of their GP in the year prior to death compared to a control group, only 41% saw him in the month prior to death. Twelve per cent saw a psychiatrist or other hospital practitioner in this time.

A large proportion of suicides therefore do not make use of their GP prior to death. The general (i.e. non-psychiatric) hospital is a further setting in which suicidal intent may present. The aims of this study are twofold. First, to quantify the amount of general hospital contact by suicides unknown to the psychiatric services. Second, for suicides receiving general hospital care, to establish whether suicidal intent and/or mental illness was identified and if so, appropriately managed.

The study

We obtained the coroner's records from 1990–1994 inclusive on all suicide and open verdicts (henceforth referred to as 'suicides') for York and the surrounding area (population=280 000). Suicides currently or previously under the care of psychiatric services were excluded from the study, on the assumption that such people are already in receipt of or have available specialist services with a role in suicide prevention. The general hospital records (medical and nursing notes) of the remainder of the population were reviewed independently by the two authors. The following data were collected:

- (a) timing of last hospital contact prior to death
- (b) nature of last hospital contact, i.e. in-patient, out-patient, hospital department
- (c) for those suicides who had received hospital care within six months of death:
 - (i) evidence from the notes of suicidal intent and/or mental illness
 - (ii) resulting management strategy

Concerning (c), only those cases in which both authors agreed there was evidence of suicidal intent and/or mental illness are discussed in the

results. In cases resulting in disagreement, the presentation was considered to be unclear.

Findings

Over the five-year period there were 70 suicide (49 men, 21 women) and 57 open (41 men, 16 women) verdicts. Sixty out of the total 127 had past or current involvement with the psychiatric services and so were excluded from the study.

General hospital contact

Of the 67 suicides (38 suicide, 29 open verdicts) with no involvement with psychiatric services, 19 received general hospital care in the six months prior to death and 9/19 within one month of death. Six suicides received in-patient care in the month prior to death (Table 1).

Departments represented

Suicides received care from a wide range of specialities prior to death, including surgery, general medicine, orthopaedics, gynaecology, ophthalmology and accident and emergency (A&E). Only 2/67 suicides attended A&E departments in the six months prior to death. Of the six suicides who received in-patient care in the month prior to death, four were admitted to surgical or orthopaedic wards.

Patient characteristics

In this series, male suicides outnumbered female suicides 2:1. Suicides in contact with the hospital before death were commonly elderly, with eight of the nine suicides receiving hospital input within one month of death aged over 65 (Table 2).

Cases for concern

In five cases both authors agreed that there was evidence of suicidal intent and/or mental illness from the hospital notes (e.g. depressive cognitions, biological features of depression, etc.), and that psychiatric referral was warranted. Four out of five received a coroner's verdict of suicide. Three had in-patient episodes within one month of death and one within three months. The fifth was seen as an out-patient five months prior to death. Four hospital departments were represented.

In all five cases depressive symptomatology was evident from the notes with suicidal ideation documented in one case. One suicide was diagnosed as depressed during her admission but subsequent treatment and follow-up were inadequate. A second case was on antidepressant medication prescribed by her GP, but persistent fears about her future were not acted upon. None of the remaining four cases were on psychotropic medication at the final hospital contact or at death. Three cases were male. The age range was 29–85 years, with three cases aged over 65.

Table 1. General hospital contact of suicides unknown to psychiatric services ($n=67$)

Nature of general hospital contact	Hospital contact within 0–6 months of death n (%)	Hospital contact within 0–1 month of death n (%)
Out-patient episode	14 (21)	6 (9)
In-patient episode	9 (13)	6 (9)
Both out-patient and in-patient episode	4 (6)	3 (5)
Total in-patient and/or out-patient episode	19 (28)	9 (13)

Table 2. Age and gender of suicides by levels of hospital contact

Patient characteristic	All suicides with no psychiatric contact ($n=67$)	Suicides receiving hospital care within	
		0–6 months of death ($n=19$)	0–1 month of death ($n=9$)
Gender			
Male	47	13	6
Female	20	6	3
Age			
Range	17–93	21–93	21–93
Mean	56	61	71
Number aged > 65	26	11	8

Comment

In this series 13% of suicides unknown to the psychiatric services received input from the general hospital within one month of death from a wide range of departments. The numbers are too small for any meaningful analysis of differences in rates of contact between departments. Suicides made little use of A&E departments in the six months prior to death (2/67). The finding that 8/9 of the suicides receiving hospital care in the month prior to death were elderly is perhaps predictable since suicide in the setting of physical illness is more common in this age group.

Despite this low level of hospital contact, general hospital practitioners are in a position to contribute to a reduction in the suicide rate. Five suicides showed evidence of depression and in the authors' opinion may have benefited from immediate psychiatric referral. Although all five suicides might not have been prevented by such referral since about one-fifth of depressives do not respond to treatment, this represents one potentially preventable suicide per year over the study period. Out of approximately 25 suicides per year in York this equates to a possible 4% reduction in the suicide rate.

Of practical importance is the need for psychiatrists to encourage other hospital practitioners to observe the mental state of patients and to advise on identification and treatment of depression. Rutz (1989) has suggested that educating GPs in the diagnosis and treatment

of depression may reduce the suicide rate. A similar outcome may be attainable in the general hospital by training from liaison psychiatric services. Although the numbers in this series are small, there is a suggestion that elderly in-patients are most at risk and should be targeted – an area future studies might address.

References

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