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FACTORS CONTRIBUTING TO NEGLECT OF PATIENTS' SUICIDAL IDEATION, INTENT & ATTEMPTS BY GENERAL HEALTHCARE PROFESSIONALS

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Abstract:

Background: *The management of patients who have made suicide attempts is a responsibility that frequently falls to general healthcare professionals in the clinic, hospital, and emergency room. Management here holds a wide meaning. In the acute situation, the first step of management is to stabilize the patient and ensure his/her medical safety. Further steps include exploring the history and circumstances of the attempt, assessing persistent ideation and the likelihood of recurrence of the attempt and finally, referral to a psychiatrist.*

Objective: *This study hopes to unearth the factors contributing to neglect of patients' suicidal ideation, intent & attempts by general healthcare professionals.*

Methodology: *This cross-sectional analysis was conducted upon a total of 64 healthcare professionals. Data was collected using a self-administered, semi-quantitative questionnaire containing 12 close ended (quantitative) and 14 open-ended (qualitative) questions (in addition to basic demographic inquiries) after taking written informed consent. Both, acts of commission (of errors) and omission (of any of the steps of management, either acute or long-term) were considered as neglect. The data obtained was analyzed using MS. Excel 2017 and SPSS v. 21.0.*

Results: *All subjects effectively provided acute medical care to the patients that helped stabilize the patient's condition and successfully ameliorated all adverse symptoms, however, all but 12.5% of the subjects admitted to have omitted the crucial steps of referral to a psychiatrist. 15.6% of the subjects professed that the thought of referral never crossed their mind. 18.8% of the subjects admitted to have known the referral protocol but they never felt the need for referral. 53.1% of the subjects considered it to be not a part of their duty as a healthcare professional.*

Conclusion: *Most primary care physicians in our set-up, despite effectively ameliorating the patient's acute situation, do not bother to carry on and complete the management. They do not facilitate the coordination of care with appropriate psychiatric resources and are thus guilty of neglect by omission.*

Keywords: *Suicidal Ideation, Suicidal Intent, Suicide Attempt, Para-Suicide, Neglect & Psychiatric Referral.*

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INTRODUCTION:

The management of patients who have made suicide attempts is a responsibility that frequently falls to healthcare professionals. For this reason, it is important for healthcare professionals (physicians in particular) to have a clear strategy for management of the suicidal patient in the clinic, hospital, and emergency room. Management here holds a wide meaning. In the acute situation, the first step of management is to stabilize the patient and ensure his or her medical safety. Once this is accomplished, further steps can now be carried out, which include exploring the history and circumstances of the attempt and assessing the likelihood of recurrence of the attempt. This is followed by taking necessary actions, such as referral to a psychiatrist.

The primary care physicians in our set-up effectively deal with the acute emergency in nearly all the cases of patients presenting with both psuedo and actual attempts of suicide. Attention however, is seldom paid to the reasons behind the attempt. Furthermore, no consideration is given to the state of mental health of the patient, which is evident from the fact that physicians never bother to refer the patients to a mental health professional. It is much like taking steps to mask the symptoms but not really attempting to identify and treat the underlying disease. There is a dire need to realize that providing the patient with much needed support and guidance in the follow-up phase is just as important as meeting the immediate, potentially life-threatening challenges of caring for the patient. The need has become especially pressing since the incidence of suicide nowadays surpasses homicide. **[1]** It is the eighth leading cause of death in the developed world. About 1% of total deaths are a result of suicide. Unsuccessful attempts outnumber completed suicides by a multiple of 16 **[2]** while the level is expected to be even higher in the developing world.

It has been estimated that the average number of suicide attempts presenting before a physician is 10 to 15 yearly in the developed world **[3]** but it is reported that such a number is achieved here in our part of the world in less than a week. **[4]** Such is the burden of this problem in our set-up! Multiple attempts (in the adolescent and young adult age group) are more likely hike up the total incidence rate. Geriatric patient too comprise of a noteworthy percentage. **[5]**

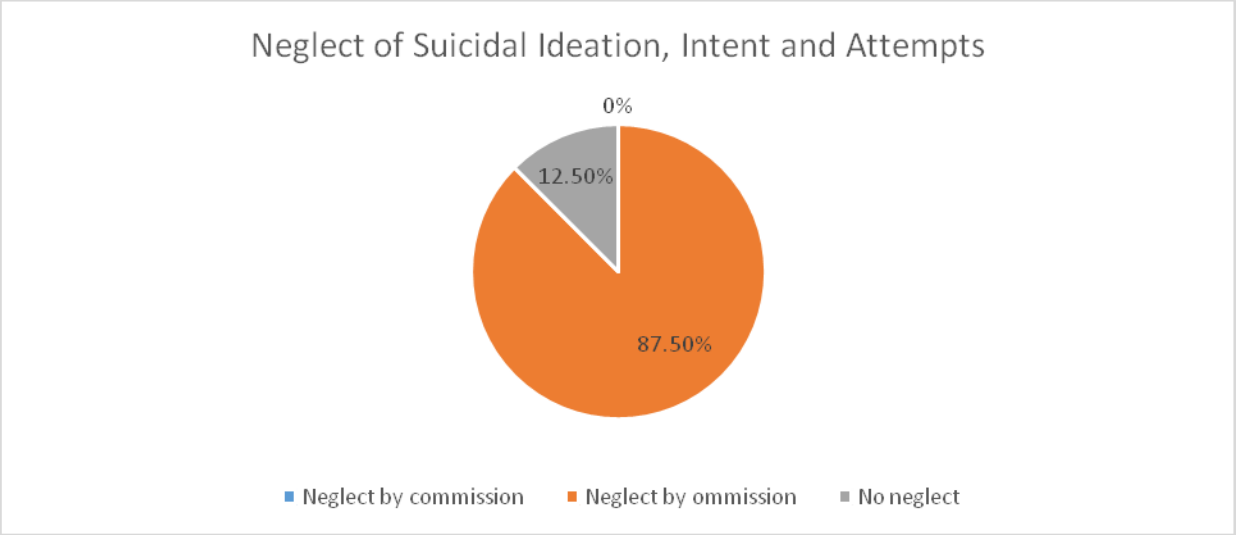
Even lesser importance is paid to para-suicide worldwide and similarly so, here in our set-up as well. Para-suicide refers to an act of self-harm without the realistic expectation of death. These behaviors/gestures can also lead to death when there are miscalculations or unexpected effects of the harmful behavior. **[6]** In addition, it is difficult and sometimes impossible to discern accurately the patient's intent. As a result, para-suicides or gestures should be taken seriously and deserve the same intensive intervention as unambiguous suicide attempts. This study thus hopes to unearth the factors contributing to neglect of patients' suicidal ideation, intent & attempts by general healthcare professionals.

METHODOLOGY:

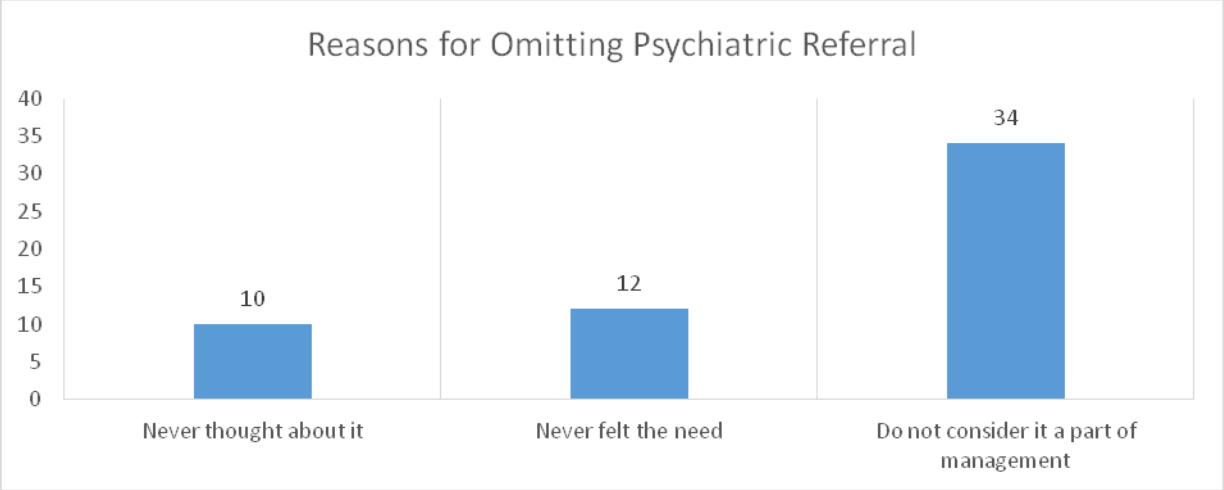
This cross-sectional analysis was conducted upon a total of 64 healthcare professionals. Data was collected using a self-administered, semi-quantitative questionnaire containing 12 close ended (quantitative) and 14 open-ended (qualitative) questions (in addition to basic demographic inquiries) after taking written informed consent. Both, acts of commission (of errors) and omission (of any of the steps of management, either acute or long-term) were considered as neglect. The data obtained was analyzed using MS. Excel 2017 and SPSS v. 21.0.
Only healthcare professionals that come in contact with attempted-suicide/para-suicide as part of their duty were enrolled in the study using non-probability, convenience sampling. Anonymity and confidentiality of the research subjects was protected by assigning codes to the data set, instead of names and keeping the data password protected. The data was discarded a set period of time after completion of the project.

RESULTS:

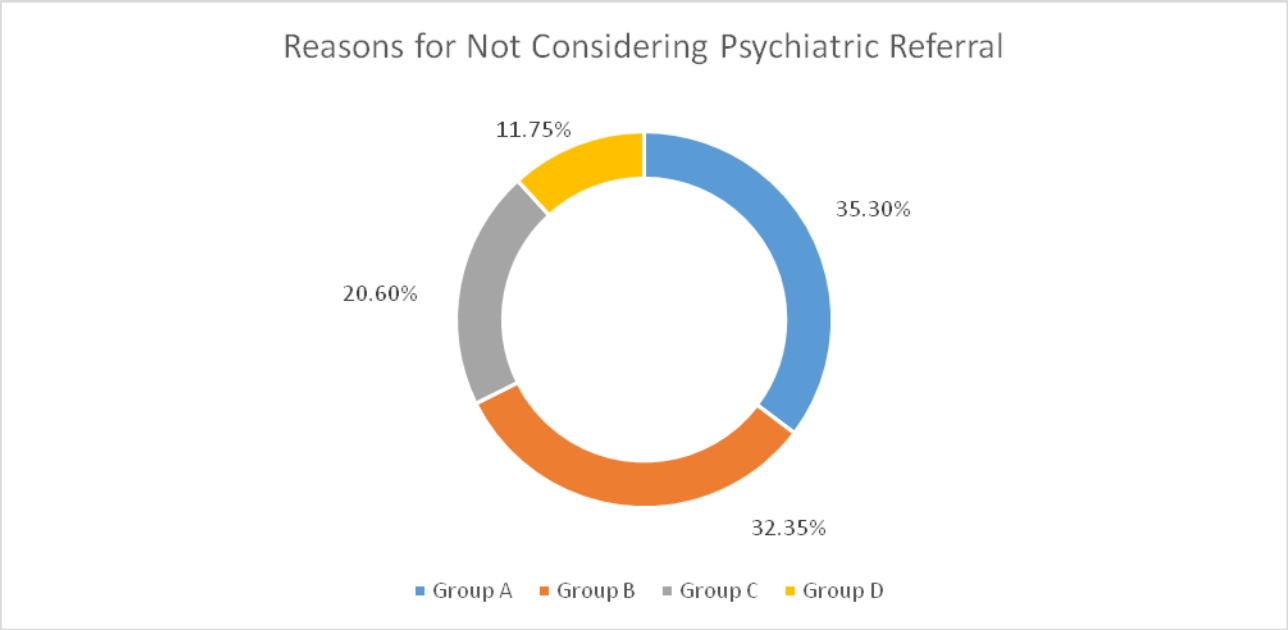
All subjects effectively provided acute medical care to the patients that helped stabilize the patient's condition and successfully ameliorated all adverse symptoms, however, all but 12.5% of the subjects admitted to have omitted the crucial steps of referral to a psychiatrist.



15.6% of the subjects professed that the thought of referral never crossed their mind. 18.8% of the subjects admitted to have known the referral protocol but they never felt the need for referral. 53.1% of the subjects considered it to be not a part of the management or a part of their duty as a healthcare professional.



Upon detailed inquiry, 12.5% of the subjects revealed that they had encountered the same patients presenting with a repeated suicidal attempt at least once during their medical career and still only 25% among them referred them to a psychiatrist. When questioned regarding their reasons for not considering psychiatric referral a necessary part of management, the subjects revealed different reasons. 12 subjects (Group A) believed the pain incurred during the attempt and treatment would deter any future misadventures by the patient. 11 subjects (Group B) did not consider psychiatric referral and consultation any useful and thus avoidable. 7 subjects (Group C) believed the patients attendants would learn to be more vigilant in preventing future events and solving underlying reasons personally with the patient. 4 subjects (Group D) considered all failed attempts of suicide as pseudo-suicide and hence not worth future (psychiatric) care and management.



DISCUSSION:

Globally, nearly one million people die from suicide every year and this is projected to increase to 1.53 million by the year 2020. **[7]** Depending on the location, suicide attempts can be up to 10 – 40 times more frequent than completed suicide and the rates for both continue to increase in many developing countries. **[8]** Data from developing countries have population counts that are unreliable, come from inefficient civil registration systems and often suffer from non-reporting of deaths due to the legal and social consequences of suicide. Hence, available suicide figures are considered gross underestimates of the true burden of the problem. **[8]**

Pakistan is a conservative, South Asian, low income country with a predominantly Muslim population. According to the latest Census of Pakistan the population of the country is 207.8 million. A 7-year (1995–2001) review of all autopsies for suicides in Karachi (the largest city) gave an average number of 199 suicides per year, which means at least 2000 to 4000 cases with suicidal intent, ideation and attempt every year in one city. **[9]** In Pakistan, it is estimated there would be between 30,000 and 60,000 suicidal intent, ideation and attempt events annually. **[10]**
However, there is no official data on suicide in Pakistan in the annual national mortality statistics. There is some academic evidence that suicidal behavior is on the increase in the country **[11]** and different psychological, social and biological factors have been reported to result in such self-destructive behavior. Our study however does not delve into the matter of investigating the frequency of reported events and instead, focusses on how individual doctors deal with the matter.

The role of a general healthcare professional (a physician in particular) in a clinic, hospital, and emergency room is to serve as a first point of contact for patients presenting with suicidal ideation, intent and attempt. **[12]** Thus, in such countries, such presentations are one of the main reasons for hospital emergency treatment of young people, putting a heavy burden on the health care professionals and the healthcare system as a whole. **[13]**

Patients presenting with the aforementioned conditions represent a major challenge for healthcare professionals, in terms of effective management of both medical and psychiatric factors in the clinical setting. Effective psychiatric management can have an impact in preventing the repeated presentation of the same patients, with more severe conditions each time. **[14]** Thus patients presented with suicidal attempts can only be only be recognized and handled appropriately when healthcare professionals handling them either in the clinical, hospital or emergency ward are trained in the recognition and management of common psychiatric idioms of distress and educated with knowledge apt to identify reasons behind suicidal ideation, intent and attempts and better still, educated to know the importance of psychiatric referrals for the patient and the healthcare set-up as a whole. **[15]**

CONCLUSION:

Most primary care physicians in our set-up, despite effectively ameliorating the patient's acute situation, do not bother to carry on and complete the management. They do not facilitate the coordination of care with appropriate psychiatric resources and are thus guilty of neglect of suicidal ideation, intent and attempts by omission.

RECOMMENDATION

When evaluating a suicidal patient, first and foremost, it is of prime importance to keep the patient safe. Stabilizing the presenting medical condition and treating any comorbid conditions. But it is equally important to ask for collateral information from the suicidal events. When the patient is able to participate in an interview, the physician should ask the question, "Why?" and listen intently for any clues to the patient's current situation. Perform a thorough and detailed physical examination and then refer the patient to a psychiatrist to obtain a psychiatric consultation and make sure a follow-up plan is in place. Thus, coordination with and support for specialized psychiatric care by the primary care physician is recommended.

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