The Physician and the Older Suicidal Patient

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Although they represent only ten percent of the population, persons 65 years and older commit 25 percent of all the suicides that occur in the United States each year.[1-5] However, many physicians are apparently unaware of the seriousness of the problem or of the vital role they might perform in its amelioration.[6]

Scope of Problem

Several studies have shown that the majority of people who kill themselves (regardless of age) consult a physician shortly before their fatal acts.[3,7-9] As many as 75 percent of the suicidal people studied followed that pattern.[10]

Suicide attempters also appear to visit physicians shortly before their suicidal episodes. For example, Buckle et al[11] reported that 74 percent of a group of attempters in Melbourne, Australia had been recently treated by a physician. In the United States, Motto and Greene[8] found that 60 percent of their subjects had been under medical care at the time of their attempts.

Rockwell and O'Brien[12] have also suggested that as many as ten percent of all persons who commit suicide see a physician on the day of or immediately prior to their self-inflicted deaths. It therefore seems reasonable to conclude, as Litman[10] has, that "suicidal people seek out physicians as potential rescuers." Thus physicians are clearly in an ideal position to recognize and respond to a potentially suicidal patient.

In a recent study of men 60 years and older who committed suicide in Maricopa County, Arizona,[13] another dramatic pattern was observed. More than 76 percent of the older men who killed themselves had been seen by a physician within one month of their deaths, and a third of the men had seen a physician within a week before the suicides (Table 1). Why then weren't the suicidal motivations of the older patients detected by their physicians? Perhaps the answer may be found among the observations of Richman and Rosenbaum,[14] who have stated:

1. Suicide is a taboo subject which most people try to avoid.
2. Suicide arouses much anxiety in physicians.
3. Medical personnel rarely receive adequate training in the recognition and management of the suicidal patient.
4. Physicians usually do not have the social-psychological knowledge needed to deal with the familial aspects of suicide.

Comment

There is no question that suicide is a taboo subject[15] or that several studies have indicated a particularly high suicide rate among physicians.[16-19] Therefore it seems likely that a face-to-face encounter with a suicidal patient would be a stressful event for even the most competent of physicians. Perhaps this anxiety factor in itself tends to dull the physician's sensitivity to the suicidal clues which are often presented by older patients.

Also, a lack of formal training in suicidology further decreases most physicians' chances of detecting clues which indicate that suicide may be imminent. Nowhere throughout their extensive formal educations do physicians traditionally receive training in suicide prevention, detection, or intervention. These are subjects that have basically been overlooked by medical schools and continuing education programs for physicians.

Assuming that the physician does suspect that an older patient is suicidal, even a referral to a psychiatrist may not resolve the problem because many psychiatrists will not knowingly accept a suicidal or an older patient for treatment.[20] Some practitioners have a disinclination to treat such patients because they are deemed to have low status and to represent a poor investment of time.[21,22] Also, being under psychiatric care certainly does not preclude the possibility that

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Table 1. Final Visits to Physicians by White Males 60 Years and Older Who Committed Suicide in Maricopa County, Arizona During the Period of January 1, 1971 Through June 30, 1975 (N = 30)

Last Seen by a Physician	Number of Men
Same day as the suicide	1
One week or less before the suicide	9
One month or less before the suicide	13
One year or less before the suicide	3
More than a year before the suicide	4

suicide may occur.[23]

As if this quandary were not problematic enough, the physician may also face the frustrations often associated with treating an older patient and/or deciding which medications in what dosages to prescribe to a suspected suicidal person. The fear that the older patient may use the medication as the means of suicide may indeed be justified, particularly when the patient is a woman.

Because of societal proscriptions against the admission of any sign of weakness, older suicidal men often feel constrained from seeking or accepting psychiatric assistance. Instead they are likely to visit a physician and complain of a somatic or depressive symptom.[13] It has also been shown that although older patients will discuss depressed feelings with their physicians, very few if any will voluntarily talk about their suicidal ideations. It was the impression of at least one group of researchers that the patient's reticence concerning suicide results mainly from the physician not asking direct questions about the possibility of self-destruction.[24]

When questioned about their suicidal feelings, most patients will readily discuss them.[25] However, if the physician does not probe deeper than the patient's superficial complaints, he may not see the suicidal scenario unfolding before him.

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