history of a severe depressive episode, much the same as medical disorders such as heart failure. While this attitude may lead to a more objective outlook and less of a sense of personal responsibility over patients' lives, Alexander et al[1] caution against it fostering a sense of nihilism. Conversely if preventing suicide is seen as the responsibility of mental health professionals it may further exacerbate feelings of guilt if a patient commits suicide. It is difficult to find a balanced response.

Consultants invariably have to return to work immediately and be expected to show leadership. However, it is important to accept that a certain amount of grieving in the immediate time period after the patient's suicide is appropriate and to at least acknowledge what one consultant described as the 'personal sadness' that is felt following the death of a patient by suicide.

Peer support was the largest source of support after the consultant's own family. Speaking to colleagues, particularly those who have previously had patients die by suicide, may help to reduce feelings of isolation. Considering that the majority of those psychiatrists whose lives were affected by the suicide were newly appointed consultants in the previous three years, it also lends support for a system of mentoring outlined by Dean[20] in 2003. This is where all newly appointed consultants might have access to a designated senior colleague who could offer guidance and advice. Such a system already appears to be operating, on an informal basis at least.

The majority of psychiatrists found both the team and team meetings in the time after the suicide to be 'very helpful' or 'helpful'. The approach of group self-examination in team meetings may reduce feelings of isolation and result in a greater willingness to treat future suicidal patients.[21] Bartels[22] describes a 'suicide review conference' to consider the factors surrounding the suicide and to review it in context, ideally reducing feelings of guilt. In any meeting such as this, as it is difficult to act in the dual roles of investigator and counsellor, it is advisable to have an outside clinician as the chairperson. As highlighted by respondents in this study, there should be an awareness of 'scapegoating' within the group as team members have considered leaving psychiatry altogether in this time period.[23]

In 2007, Foley and Kelly[24] described a pilot scheme of 'patient suicide meetings' which was set up in their service to highlight the effect of patient suicide on the team. It used a 'journal club' format whereby relevant papers such as that by Alexander et al[1] were presented. Ideally this will improve a team's preparedness for the event. Information may also be found from the National Suicide Research Foundation,[25] the National Suicide Bereavement Support Network[26] and the College of Psychiatrists'[27] websites.

The patient's family was felt to be 'helpful' or 'very helpful' by 47.5% of consultants. But 27.5% found them to be 'unhelpful' or 'very unhelpful' while the remaining 25% described them as 'neutral'. Alexander et al[1] observed similar results in their study in this regard. It is advisable to make contact with the family as early as possible and to encourage them to meet with the team in person.[4] A review of the patient's history and treatment with the family may be beneficial[28] and provide an opportunity for the consultant to acknowledge their own personal grief. This is a difficult time for the family and they have much to deal with on a practical and emotional level. They should be allowed to ask questions and ventilate distress. This may help dissipate some of the hostility that could be generated towards the psychiatrist.[9] Families may not remember all the questions they have and a further meeting should be offered. Such a meeting could be helpful for all involved. It is notable that psychiatrists expressed a willingness to foster greater links with other patient's families in their future management.

Conclusion

Most psychiatrists will experience a patient's suicide and when it does occur, it has an impact on a proportion of consultants, particularly those new to the grade. As highlighted, peer support, team support and team meetings were identified as important modulating factors. Early liaising with the family should be considered. These steps may help to reduce distress in the aftermath of a patient's suicide.

Declaration of Interest: None.

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Erratum: The editorial in our December 2010 issue incorrectly stated that the John Dunne Medal was first awarded in 1992. We apologise to earlier winners.

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