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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Suicide in doctors and their wives

SIR,—Why is the medical profession at such high risk for suicide? In male doctors this is thrice that in the general public, ten times that in members of Parliament and senior civil servants, and six times that in university teachers and the clergy. In unmarried women doctors the frequency is more than twice that in unmarried women in general, but is comparable to that in selected groups of professional women.[1] The data for married women doctors are, unfortunately, unreliable.

The special knowledge that doctors have of toxicology and surface anatomy may mean that impulsive suicide attempts are usually fatal, whereas many more are survived in the general public. The very high risk of suicide in pharmacists (who share some of this knowledge) supports this view. What is controversial is whether stresses related to the practice of medicine, possibly interacting with personality flaws in vulnerable doctors, play a part.

The finding of a standardised mortality ratio (SMR) for suicide of 458 in doctors' wives arouses concern that the families of doctors are also drawn into the net. This figure (based on 31 deaths during 1970-2) exceeds by far that found in the wives of other professionals including pharmacists. (There are no comparable figures at present for suicides in the children of doctors.) Searching for aetiological factors, the popular belief that some doctors attempt to cope with their frustrations by recourse to alcohol and other drugs is supported by the SMR of 311 in male doctors aged 15-64 dying of cirrhosis. (In addition to the 59 male doctors in England and Wales who took their lives during 1970-2 a further 18 died of cirrhosis.) Unmarried women doctors do not share this latter risk, but doctors' wives do so to a certain extent.

In order to elucidate the role of marital strain in the suicides of doctors and their wives I have looked at data[2] on the civil states of the 55 male doctors aged 25-64 who committed suicide during 1970-2 (see table). There is an excess of unmarried and of divorced doctors, which, on further analysis, is concentrated in the age group 35-54. Twice as many doctors among the suicides have remained unmarried later than among their living colleagues, and there are also disproportionately more divorces. The numbers, however, are small. The majority were married at the time of their deaths, and some of these marriages may have been under strain, but it is obviously impossible to determine the extent on these data. Among male doctors as a whole the distribution of civil states was identical to that seen in social class I, which does not support either the notion that marital strain is more common in the medical profession or that male doctors as a group tend either to delay marriage or not to marry at all. Nevertheless, one wonders about the 12 bachelor suicides and whether, exclusively dedicated to their careers, they met with ultimate disappointment in their professional aspirations only to find a cushion of family support absent during their hour of need. Equally, they may have failed to marry on account of those very idiosyncracies which led eventually to their suicides. It is quite likely that a number of the total group were psychiatrically ill and suffered from depression, complicated or otherwise.

However we may speculate, there is clear evidence of an occupational hazard of suicide in doctors and their wives. The envisaged health committee of the General Medical Council is a step taken at the tertiary level. Primary prevention should begin with career counselling prior to medical school so as to ensure congruency between the expectations of the aspirant medical student and the realities of life in the profession. Admission procedures

Marital states of 55 suicides among male doctors aged 25-64 (England and Wales, 1970-2)

	Single	Married	Widowed	Divorced
Suicides	12 (21·8%)	40 (72·7%)	1 (1·8%)	2 (3·6%)
Living doctors*	476 (11·2%)	3708 (87.3%)	29 (0·7%)	36 (0·9%)
Social Class I*	7332 (11·6%)	53 778 (86·7%)	454 (0·7%)	467 (0·8%)

$\chi^2 = 14{\cdot}84$, df 6; $p = 0{\cdot}02$.
*Ten per cent samples.