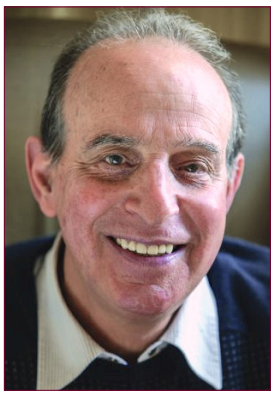
Suicide and Physicians – Why don't doctors in distress seek help?

NICHOLAS NISSEN, BA, MD '20; EDWARD FELLER, MD, FACP, FACG

- One in 9 medical students reports suicidal ideation during med school.
- Suicide – most common cause of death in male residents, second most common in women
- Study of 7905 surgeons – 1 in 16 reported suicidal ideation in the prior year.
- As many as 400 doctors die from suicide yearly.
- Yet, data indicate that as few as 1 in 4 at great risk sought help.



In an opinion piece in the April 29, 2019 *New York Times,* a professor of psychiatry stated, "We must address the root causes of suicide – poverty, homelessness…trauma, crime and drugs." But, that's not true for doctors. We have an abundance of accepted protective factors, including a high probability of being married, low divorce rate, advanced education, employment, likelihood of financial security and societal respect.[1] Yet, at every career stage, the rate of physician suicide is higher than that of the general population and other professionals – as much as 40% greater for males and a startling 140% higher for female doctors.[2]

An increased risk compared to age-matched controls is evident even in the first year of med school.[3] Shortly before med school graduation and beginning residency, the rates of burnout, depression and suicide ideation increase, while the mental quality of life declines without varying by specialty choice.[4] Resident suicides occur disproportionately (35%) in the first two months of residency. Post-holiday, midwinter and seasonal factors may also negatively affect some residents and later-career doctors, contributing to depression, isolation, and even suicide.

Why are doctors at increased risk?

The nature and culture of Medicine may exacerbate risk. Physicians work an average of 10 hours more weekly than the general population (50 vs 40 hours); one-third of physicians and as few as 11% of non-physician controls work 60 hours or more per week. As many as 4 in 10 physicians believe that their career does not allow adequate time for their personal life compared to 23% of controls without gender difference.[5]

Medicine has changed in recent decades with a widespread decline in job satisfaction. Financial issues associated with liability insurance costs, declining reimbursement and huge training

Table 1. Physician Risk Factors – Burnout, Depression, Suicide

Behavioral
- Imposter syndrome – unrelenting comparison with peers
- Sparse use of psychiatric referral
- Stigma of mental disorders as weakness, incompetence
- Degrading experiences, harassment, patient demands
- Poor coping skills, unfamiliarity with failure
- Microaggressions – stigmatized minorities (gender, race, ethnicity)
- Substance abuse

Academic
- Persistent work overload without personal control
- Unrealistic goals/demands
- Academic setback, failure
- Expectation of scholarly productivity
- Pressure to gain elite residency, promotion, job
- Research funding demands

Clinical/Cultural
- Culture of self-sacrifice, "work heroes"
- Perception – early success determines career path
- Unrelenting high-stakes assessments
- Inhospitable work environment, persistent work overload
- Patient suffering – grief
- Medical error – stigma, guilt

Social/Personal
- Death, illness of loved one
- Personal physical illness, divorce
- Inadequate protected time; poor work-life balance
- Isolation, lack of time to connect with peers
- Large personal debt; litigation-related stress
- Misalignment of career with family, childbearing
- Retirement – loss of self-identity

debts are debilitating. We now work in larger groups with less autonomy and more external restrictions, are subject to career-long evaluation of our record-keeping, competency and quality, quantity and cost of care. Positive, rewarding work relationships enhance career happiness. Only older doctors recall when hospitals had "Doctors-only" dining rooms filled with colleagues. Today lunch is typically eaten quickly, alone at one's desk while doing medical record chores or emailing.[6] Nursing stations in hospitals reveal everyone sitting – silent and alone – staring at a computer screen. A recent report indicates that interns spend 3 and one-half more time interacting with medical records than with direct patient care.[7] Unfortunately, too many of us confirm our angst on the UCLA loneliness scale, which asks: "How often do you feel you lack companionship?" and, "How often do you feel isolated from others?"

Depression is a reality at all career stages. Data from 1428 fourth-year medical students indicated that more than one-third reported depressive symptoms and poor mental quality of life.[8] Estimates of the prevalence of depression among resident physicians ranges from 21% to 43% depending on the survey instrument used.[4] Schwenk et al. noted that 81% of mid- and later-career physicians reported that depression had increased their professional stress level and 91% reported that depression had decreased work satisfaction. MDs in primary care fare worst.[9]

Burnout commonly afflicts caregivers, beset by stressful work amidst intense interactions with patients having pressing physical and emotional needs, frequently intractable. In a national survey, physicians had a greater rate of burnout – emotional exhaustion, cynicism, impaired or reduced sense of personal accomplishment and depersonalization – 38% vs 28% – relative to population controls. Data indicate that as many as 50% of medical students experience burnout at some point with 11% reporting suicidal ideation during medical school.[4] Those with burnout were three and one-half times more likely to report suicide ideation.[5]

Physician suicides differ from those in the general population

We seem less likely to experience personal trauma such as a recent death of someone close or other personal crisis as a suicide precipitant. Yet, we are more prone to work or career crises. Perhaps surprisingly, we don't have more documented antidepressant use, but do have higher rates of benzodiazepine or barbiturate intake.[10]

Compared to other professionals with doctoral degrees – PhD, JD – MDs have increased probability of burnout and poor work-life balance.[5] Physician self-identity seems to be more often dependent on satisfaction in their professional roles. Job unhappiness appears to be a major risk factor for suicide among physicians. We are exposed to a litany of workplace stressors – patient demands, conflicting roles, inadequate control over working conditions, time pressure, degrading experiences or harassment, patient death or poor outcomes, the trauma of medical errors, litigation-related stress and dissatisfaction with coworkers. Retirement has been incriminated as source of role loss and potential suicide risk.

Why don't doctors at high risk seek help?

At all career stages, a minority of physicians at risk seek psychologic support services.[11] In Medicine, seeking psychiatric help is viewed commonly as stigma, embarrassment, and loss of privacy. Other barriers are fear that public knowledge of receiving behavioral help confirms personal incompetence, weakness, lack of fitness, risk of discrimination in grades or clinical and research training, referrals, promotions and evaluations. As many as one-third cite lack of confidentiality and one-fourth report fear of documentation in their academic or employment record as impediments to seeking help. Some claim, "I don't have time!" Perceived career-long stress and competition for med school admission, residency positions or post-training jobs, research productivity and promotions also foster a hesitancy to disclose psychiatric problems. Doctors also describe fear of disclosure of a mental illness on state licensure, malpractice insurance and medical staff applications, reinforced by the reality that the vast majority of state medical boards inquire about mental illness on initial state medical licensure applications and half on renewal applications.[12]

A majority of doctors have not seen a physician in the previous twelve months.[12] Suicidal ideation and depression are commonly screened for at primary care visits; too many doctors are never screened. Many of us with behavioral health problems strive for anonymity, seeking care outside of our medical orbit or avoid therapy. Too commonly, at-risk physicians self-prescribe psychiatric medication or receive prescriptions from a colleague with whom they didn't

have a psychiatric treatment relationship. A unique suicide risk for physicians is medical knowledge. As Dyrbye notes, "We know how to kill ourselves."[13]

What is the natural and unnatural history of suicidality?

The National Comorbidity Survey indicated that about one-third of those with suicide ideation make a plan; three quarters with a plan make an attempt, and one quarter proceed directly to an unplanned attempt.[14] These findings suggests that as many as half of those with suicidality make a suicide attempt. The majority of attempts occur within 1 year of onset of suicide ideation. For many, progression from depression, suicidal ideation, and suicide attempt may be more rapid than believed. Impulsivity seems to play a major role – one in four suicide attempters make an attempt less than 5 minutes after deciding to commit suicide.[15]

Data on physician suicide is limited by poorly comparable study designs and screening methods, non-uniform assessment measures for depression, burnout and suicide ideation and different participant demographics. Speculation suggests that the magnitude of physician suicide is greater than reported because physician suicide may be consciously miscoded on death certificates as an unintentional overdose. Some med schools refuse to track suicides.

Conclusion

Suicide risk is a career-long reality for physicians**.** Medicine's pervasive, stressful demands help explain suicide's elevated risk compared to the general population. Depression and burnout are significant triggering factors. ❖

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URI Commencement 2019:
Kennedy asks grads to make U.S. safer, more supportive, and more loving for people with mental illness, addiction

PATRICK J. KENNEDY

URI PHOTO BY MICHAEL SALERNO

[Managing Editor's Note: Former U.S. Representative (D-RI) Patrick J. Kennedy, lead sponsor of the Mental Health Parity and Addiction Equity Act of 2008, and founder of The Kennedy Forum and of DontDenyMe.org, delivered the commencement address at the University of Rhode Island (URI) on May 19th, where he was awarded an honorary degree. The following excerpted remarks are reprinted with permission of URI.]

PRESIDENT DOOLEY, THANK YOU FOR THE honor and opportunity to be here today.

Thank you also for the honorary degree because that makes me one more member of the amazing class of 2019.

So, to the class of 2019, my fellow classmates, congratulations.

And to my fellow Rhode Islanders, it is great to be back home.

I've reflected a long time on what kind of message I wanted to offer this special group of students before me.

You know, I've given a lot of addresses over the years.

But as they say in the movies…this time, it's personal.

In an apartment not far from here I began the journey toward discovering the best version of myself, a journey which has lasted, and will continue to last, a lifetime.

A wise person once said the definition of hell is when, on the last day of your life, you meet the best version of yourself… and you discover that there is a huge gap between who you are and who you could have been.

Ouch.

That is not a good situation my friends. So, we all need to work every day to close that gap.

For me, part of this journey has also meant wrestling with the darkest version of myself. My "shadow self" as some call it.

And learning to understand, and embrace, and have compassion for that part of me.

Sometimes we treat ourselves much worse than we would ever treat a friend. We say things to ourselves we would never say to a loved one. That's been an important reflection for me.

I struggled through high school with what I now understand to be mental illness and addiction.

I have bipolar disorder, and to cope with that I have used both alcohol and prescription painkillers to self-medicate.

And for me this has been the central challenge of my life – amidst a great many blessings.

I am now 51. I recently celebrated with my family a profound and humbling victory: my eighth year of continuous sobriety.

So, this should give you an idea of how protracted this struggle can be.

'By the time I got to Rhode Island, I had already been to rehab and attempted the first of my many recoveries. I worked hard at it, and committed to seeing a psychiatrist, but I was so embarrassed that I used to park my car blocks away from his office.

But he helped me – and it was the first time I ever realized treatment with therapy and medication could work.'

Early years

Growing up, my problems were referred to, if at all, in whispers. And too much of the advice I got was judgmental rather than medically sound and supportive.

I'm very proud that my late father, Senator Edward Kennedy, was one of the nation's most important champions for healthcare. But he didn't really understand that what was going on with me was part of healthcare, too.

When it came to my asthma, or my brother's bone cancer, he was

all-supportive
all-loving
and
all-in
to fight the illness.

But when it came to my mental health challenges, and the vicious cycle of addiction that followed, he tended to lay that one on me – rather than viewing what I was experiencing through the prism of an illness.

This was a blind spot that a lot of people had in his generation. And too many people still have it in your generation.

More often than not, my father's diagnosis was that "Patrick just needs a good swift kick in the ass."

We now understand genetic predisposition to addiction and mental health much better. We have tools and therapies to intervene in, and prevent, devastating symptoms and behaviors.

And let me just say that if anyone within the sound of my voice is struggling with these issues, and this is statistically likely, I want you to know from my own experience that this is the most hopeful time in human history for a person to overcome mental health and addiction issues. There is a toolkit that a trained professional can give you to work on these issues. And with the right support, it works.

It's not easy and it's not magic but it's worth it – to live a full and free life. So, let this be the day you resolve to get the help you need and deserve.

Honestly, I was probably the biggest skeptic about these issues. I spent many years lost in the fog of shame…

I also believed I was suffering – not from diseases of the mind and body – but simply because of shameful personal failings. And many times in my life I lacked the faith I could prevail.

These days, I see it more clearly. No one wakes in the morning and chooses to alienate all their family, friends and risk losing their job and being arrested. Because they think that it will be a great plan for the day.

Long road to recovery

By the time I got to Rhode Island, I had already been to rehab and attempted the first of my many recoveries. I worked hard at it, and committed to seeing a psychiatrist, but I was so embarrassed that I used to park my car blocks away from his office.

But he helped me – and it was the first time I ever realized treatment with therapy and medication could work.

I struggled with these illnesses, just like everyone else. Being a Kennedy certainly has its benefits.

But I can assure you of this: mental illness and addiction are in no way impressed that I come from a famous family.

Untreated or unheeded, these illnesses are equal opportunity destroyers.

Still, through all of this, at the age of 21, I was elected to the RI House of Representatives. The press noted I was the youngest Kennedy to ever hold office. That was a nice factoid to talk about.

But the real achievement in my own eyes was doing a pretty good job in three terms in the State House – while at the same time dealing with my mental health challenges.

Fighting asthma was tough and it nearly killed me a few times. It was an excruciating painful physical challenge just to breathe during those attacks. But for me, at least, it was a walk in the park compared to maintaining sobriety and struggling with my mind.

This was when I started realizing that getting good care and good insight into your illness – even when you aren't always the best patient and despite some setbacks – can allow you to function and even thrive.

Again, these diseases are treatable. The challenge is that society discriminates against them and the people who have them.

And so does medical insurance, by not covering them properly and equally with other illnesses. So mental illness and addiction end up being the only diseases for which getting gold-standard treatment is questioned, and even sometimes discouraged.

When I was 27, I was elected to represent Rhode Island in the U.S. Congress. Believe me, I did not go to Washington to become the nation's voice for mental health and addiction care.

For several years, I tried to add mental health and addiction to my legislative agenda without calling any more attention to my own situation or providing any more personal information.

This was the mental health and addiction equivalent of "don't ask don't tell."

Darkest days

And then I blew it – and almost blew my entire career.

In the Spring of 2006, with my 40th birthday approaching, I was having problems keeping my illnesses under control. I had quietly gone to the Mayo Clinic for care over Christmas, and then when I returned to the House, I tried to balance my duties there with an outpatient day program – which allows you to go to work, but still get intensive therapy and support for recovery.

Then on May 6th, I woke up at 3 am in a panic thinking I was late for a vote. I drove under the influence to the House of Representatives and crashed my car into a security barrier.

On TV the next morning, I was forced to tell the truth.

And THAT is one of the biggest problems when you have a mental illness or struggle with an addiction. It's the secrecy, the lying, the self-delusion. Ultimately, the shame.

Our secrets are our most formidable adversaries: they are "the enemy within" that blocks our recovery…you become a con artist…only you are your own victim.

I knew this in my heart. So I went for it.

I went from living the big lie…to telling the big truth.

I admitted what had been really going on, in a way I couldn't take back or hide from. And I announced I was going to get care. This wasn't about politics. This was about saving my life.

…When I got back to work, I felt incredibly fortunate. Not only because I had survived such a dark chapter, but

also because had found my highest calling as a public servant: I prepared to devote myself, heart and soul, to making access to treatment for mental illness and addiction a reality for everyone.

Mental Health Parity Act

During the very next session of Congress, with the support of many like-minded colleagues, I got a bill passed and signed into law called the Mental Health Parity Act.

This basically put mental health and addiction on a par with other chronic illnesses for insurance purposes – as a matter of federal law.

…But we didn't stop there.

You know, we said:

"Not only is it wrong to charge higher premiums, higher copays or higher deductibles for mental illness and addiction.

…It's also against the law to have lower lifetime caps on coverage."

…And it's wrong to have more restrictive medical management decisions on whether or not approve care."

So, they can't wrap people up in red tape like they used to, with what they call pre-authorization, or concurrent review, or retroactive review to a greater extent than they apply to cancer cases, for example.

We need to make sure medical insurance treats these illnesses equally in relation to other dreaded diseases. And we must eliminate those blind spots in our society.

Too many of us still look upon these illnesses as merely shameful behaviors instead of complex, but highly treatable, conditions.

Taken to the extreme, we see these conditions criminalized in a manner that just throws a mountain of lives in the garbage. We don't rehabilitate, we incarcerate. And if you follow the money, you understand why.

…We now need to ensure we focus on this generation…your generation. I was looking at some of the most recent and most disturbing statistics about the changing causes of death for people your age.

You are the very first generation to be more at risk to die of suicide or overdose – or some other cause connected to mental illness or addiction – than any other cause of death.

But you're also the first generation to grow up under the protections of the Mental Health Parity Act, which we passed to prevent this from happening.

Still, we have a lot of work to do to enforce these laws, and these days that is one of the major areas of advocacy I'm involved in today…to finish the job.

Consider that the height of the HIV Aids crisis we were spending 24 billion dollars a year to combat it because it was killing 53,000 Americans a year. Thankfully, just like many forms of cancer, this has gone from a fatal illness to a mostly manageable chronic disease. This is wonderful news and our hearts soar to hear of these miraculous developments.

But against that backdrop, we had 72,000 fatal overdoses last year. We had 47,000 suicides. Why aren't 120,000 American lives lost last year to mental health and addiction…worth the same bold commitment our country is famous for making, to combat other health care challenges?

Why are we spending only 1/5 of the money on something that is killing twice as many people? The staggering rates of suicide and the overwhelming rates of overdoses among young people are literally lowering our life expectancy as a nation.

To make matters even worse, the opioid and methamphetamine epidemics have ripped a hole in our social fabric that across the entire country. No one is exempt from this. But somehow, we still don't have the sense of urgency required to reverse this appalling scourge.

…At the very least, I want that 24-year-old who overdoses or that thirty-year-old who contemplates suicide to be valued at least as much as a person like my Dad, who died in his 70s from brain cancer.

This is also an investment to counter income inequality. Consider that instead of making a few people at the top of the economic ladder richer, this money can allow all Americans to live a richer, healthier life.

Again, we benefit as a society when we treat mental illnesses and addiction as health issues instead of as criminal justice issues. There are proven, scalable programs that succeed at a community level. The Kennedy Forum is committed to promoting these solutions. We want to implement what works, over and over again.

This is the public health challenge of our time, and solving it will help reconnect our fractured nation.

Because, regardless of your age, your gender, your ethnicity, your politics or your socioeconomic class, we all have one thing in common – our brains are what allow us to function and be ourselves.

And if our brain diseases are not properly treated…we lose ourselves… and America loses what we could contribute.

It's a time of particular uncertainty for young people. I urge you to consider meeting that uncertainty with action. To dedicating some of your valuable time and youthful energy to a cause greater than yourself.

…And today, I have talked to you about the devastating mental health and addiction statistics threatening your own generation with epidemics that no other generation has endured.

We have a lot of overwhelming concerns in the world now. But please, don't let this issue get lost. That is my request to you as the future of this country and as voters who will shape the national dialogue for many decades.

As you go out into the world today, I ask you to do whatever it takes to make this country a safer, more supportive, and more loving place for people with mental illness and addiction. Do it for yourself. And do it for all the Rhode Island kids coming up behind you. ❖

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What Does It Mean to Heal?

JONATHAN STALOFF, MD, MSc

At the 45th ceremony for new graduates from Brown's Warren Alpert Medical School, 128 new doctors took the physician's oath. This year marked the first graduating class in the school's new Primary Care-Population Medicine (PC-PM) program. A member of that first PC-PM class, Jonathan Staloff, gave remarks at the ceremony, held in the First Unitarian Church on College Hill.

[*Editor's Note: The following are excerpted remarks from Jonathan Staloff's remarks at the Alpert Medical School Commencement Ceremony held on May 26th.*]

…I'D LIKE TO REFLECT ON A QUESTION I've grappled with since starting on this path of medicine. That is, what does it mean to heal?

When entering medical school, I thought I had a good understanding of this question. I was privileged that my experiences led me to believe that healing was a process with a clear, discernible beginning and end. In elementary school when I was sick with strep throat, the doctor healed me with an antibiotic. In high school when my friend was in end-stage kidney failure, the doctor healed him with a transplant. In college when my grandmother had a cancerous tumor on her eye, the doctor removed it, and healed her, too. I understood that not all that ails us could be healed, but for what modern medicine could provide, I found comfort and inspiration in this simple understanding of healing.

At the start of this journey, I thought that through learning the knowledge of medicine and mastering that wealth of tangible scientific facts, I, too, could become a healer. I, too, could be a physician.

I'm sure you won't be surprised to learn that these four years taught me that healing is not always so simple. For many of us, bearing witness to the more complex nature of our patients' suffering led us to struggle with our respective understandings of what it means to heal.

We wondered how are we healing patients hospitalized for chronic diseases like heart failure, knowing that despite our best efforts nothing will change the fact that their condition will slowly yet surely worsen? We asked do we owe more to our patients than prescription medicines and treatment plans when environmental and social systems so strongly influence their long-term health? Or what does it mean to heal patients at the end of their lives when so much of what lies ahead for them and their families is clouded in uncertainty?

These are just a few of the questions we've asked ourselves during the last four years as others have started to look towards us as healers for the first time.

Standing here today, I now appreciate that the uncertainty of illness does not challenge the notion that we as physicians can help our patients heal. Rather, we will heal by choosing to commit ourselves to our patients and joining them in the shadow of uncertainty. We heal by spending long tireless nights searching for answers to mysterious diagnoses so that morning might bring clarity. We heal through dedicating ourselves to years, decades of research so that the limits of medicine today are the foundations of medicine tomorrow. We heal by standing alongside our patients in each step of their journeys, whatever they may bring. We heal in celebrating moments of health, struggling in moments of illness, and mourning when life comes to an end. When under our care, our patients can say, "I have a partner, I am not alone;" that is what it means to heal.

I consider myself so fortunate to be your classmate, for over the last four years, your work, your advocacy, and our countless discussions in and out of the classroom have taught me that in our responsibility as physicians to

heal, we must also ask what in this world needs healing? You taught me that what impacts the health of our patients does not begin nor end in the walls of our hospitals and clinics, and neither should our roles as physicians. In the Brown tradition of questioning tradition and building new ones, together we are building a new understanding of what it means to heal.

We understand that when medical science produces groundbreaking treatments, but has not yet found a way to deliver them to the patients who need them the most, physicians must ask if our healthcare system needs healing. When communities are forced to ask if their water is safe to drink or if their air is clean to breathe, physicians must ask if our environment needs healing. When the zip code of someone's birth, their race, income, gender identity, immigration status, or who they love impacts their health as much as any medication we can provide, physicians must ask if what we consider just in our society needs healing. Even though the causes of social ills are as complex as the human body and their recovery equally uncertain, we must join our communities in this uncertainty and together work to make real a world that reflects our firm belief that health is a human right.

Beyond all of this, you have all taught me that what it means to heal and be a physician is always being re-written. I'm inspired to know that the future of medicine will be firmly written in the handwriting of the Warren Alpert Medical School Class of 2019. It is truly my honor to know you and to call myself a member of this extraordinary community of physicians, this community of healers. Thank you and congratulations! ❖