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

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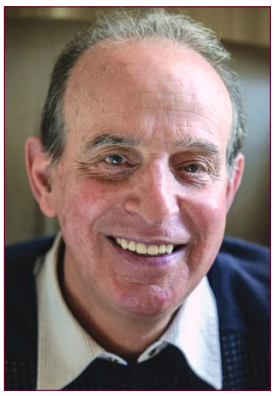
- One in 9 medical students reports suicidal ideation during med school.
- Suicide – most common cause of death in male residents, second most common in women
- Study of 7905 surgeons – 1 in 16 reported suicidal ideation in the prior year.
- As many as 400 doctors die from suicide yearly.
- Yet, data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