"Physician Suicide - A Problem for Our Time" | Written by Gary Carr, MD

Statistically, it happens somewhere in America about once a day. Suddenly, someone's mother or father, a spouse, a friend, a colleague – a fellow physician – ends his or her own life. Those close to the physician, family and coworkers, are devastated. The physician's patients are confused and sad as well. We, the fellow physicians, are surprised, shocked, saddened, confused, and frustrated at being faced with such a horrible occurrence and angry at our absolute powerlessness to have it be anything other than what it is. We, each of us, mourn the loss in our own way and quickly move on as if looking away from a sight too awful to contemplate. There is no sense dwelling on it. Or is there? What do we know about physician suicide? What are its underpinnings? Are there warning signs? And most important, what do we all need to know in order to help prevent such tragedies?

When I met Jim, he was a 40-year-old anesthesiologist with a suspended medical license in treatment for opioid dependency. A personal friend of mine, Darren, was in treatment and Jim was his roommate. Jim seemed optimistic, hopeful and met me with a ready smile. I liked him immediately. Darren had a terrible time in treatment, and Jim looked after him like an older brother. He encouraged and supported him, made him laugh during the tough times, and cared enough to speak the hard truth to him when Darren threatened to leave. They became close – not unlike soldiers who have shared combat. Darren finished his treatment and returned home. Jim finished his treatment soon thereafter and quickly relapsed. His chances of recovering his family and medical career, he feared, were not good. The next day he ran a hose from his car exhaust into his vehicle and took some sleeping tablets. A neighbor found him the next day.

Why could Jim not realize that relapse is a part of the illness of addiction and know that his setback was temporary? Why did Jim not understand he was more than a medical license? Did he not know that his children and people like Darren loved him – that he mattered?

Frank was on the fast track in his medical corporation. His outgoing personality, willingness to work, skills, and talent brought rapid promotions. He was headed to the top. Then the depression came. Eventually he sought out help, and his colleagues believed he was getting better. His smile came more easily. He told a colleague things were turning around for him. A week later he wrote a note, took all those pills, and didn't wake up again.

Why could Frank not say how much he hurt? Why could he not say what was on his mind? How could he leave such a loving family that way? Could we have seen this coming? Could this have been prevented?

INCIDENCE AND RISK FACTORS

These are but two of last years estimated 300 – 400 U.S. physicians whose lives were cut short by suicide.(2) They are our brothers and sisters who, like us, devoted themselves to respecting, promoting, and preserving human life. They, more than anyone, would have known of the array of health services available to them since they had used those very services for their own patients. Why were they unable to take advantage of the help available for themselves? Suicide does not occur in the absence of underlying causal or contributory factors. Most notably, suicide is strongly associated with psychiatric illness, including mood disorders (i.e. depression) and addictive illnesses. This is equally true for all our patients.

Table 1. Profile of Physicians at High Risk for Suicide (2)

Sex: Male or Female

Age: 45+ (women); 50+ (Men)

Race: Caucasian

Marital Status: Divorced, separated, single, or currently experiencing marital strife

Risk factors: Depression, alcohol or other drug abuse, workaholism, excessive risk-taking

Medical status: Psychiatric symptoms (depression) or anxiety or physical symptoms (chronic pain, chronic debilitating illness)

Professional: Change in status or threats to status, autonomy, security, financial stability, recent losses, increased work demands

When these significant risk factors are further inflamed by significant loss such as failed relationships, loss of loved ones, financial setbacks, revocation or suspension of license, or real or perceived loss of reputation, the risk increases. What variables might contribute to physicians having a higher suicide rate than the general population (about 1.4 X greater risk for all physicians and 2.3 X greater for female physicians)? The chances of a male physician dying of suicide are 70% higher than men in the general population and between 250% and 400% higher for female physicians than women in the general population.3,4 Why do female physicians suicide at a rate equal or greater than male physicians when the general population sees 4 male suicides for every 1 female suicide? (See Table 1)

PHYSICIAN ISSUES AND THE CULTURE OF MEDICINE

Unfortunately, we have more questions than answers at this stage. Yet there are some things we do know, and there are some reasonable avenues that deserve further exploration.

First, it is clear the personalities of those choosing a career in medicine are somewhat unique. Typically such individuals are perfectionistic, compulsive, driven, motivated, and highly self-reliant. By nature, such individuals are not prone to admit any weakness or to ask for help.

Second, in our physician culture we have placed a low priority on physician health; particularly mental health. We are "care givers," not "care receivers." We are taught from medical school to put the patient first and ourselves and our families last. A large part of our training is self-denial: sleep, time with family and friends, meals, recreation become secondary. Our selfcare instincts or skills tend to be trained out of us. We learn to "suck it up," to "play with pain," to "get the job done." Sometimes we work exhausted or, perhaps, more ill than our patients. Covertly, we get the message. We are to rise above any human frailty. It isn't a conscious process; it is, rather, who we have become. Resilience isn't taught but is expected, and we come to expect it of ourselves and each other. Therefore, to admit a problem is to admit that we are, somehow, less than and not equal to our peers. We feel shame and we fear being judged and stigmatized so we tend to suffer in silence and carry on in a profession that prides itself on stoicism and bravado. "How are you?" "Just great! How are you?" We physicians rarely think about physician health unless a physician's ability to treat patients or work with colleagues is called into question. The majority of physicians who commit suicide are not in treatment or under psychiatric care.(5)

One study looking at depression in medical school and residency found that among 200 medical students only 22% of those who had screened positive for depression sought out mental health services. Reasons offered for avoiding help included lack of time, lack of confidentiality, stigma, cost, fear of documentation on the academic record, and fear of unwanted intervention.(6)

Third, we tend to believe that a) "I can't have a problem; I'm a doctor" and b) "if I do have a problem, I can handle it myself – I'm a doctor." This is an example of omnipotence on the one hand and omnipotence on the other. We often don't have our own doctor other than, perhaps, a brief sidewalk consult. When we do see a physician, we prefer to have a "real illness." Lymphoma is legitimate - we can see it on laboratory tests or X-ray, and we can all gather round and palpate it. We hesitate to admit depression or substance use disorder. Some physicians succumb to the temptation of prescribing for themselves – never a good idea.

Fourth, we fear, and often with good reason, that acknowledging a substance use disorder or a psychiatric illness will adversely impact our practice, our career, and perhaps our medical license.(5,6) While many states such as Mississippi have a proactive Medical Board and state medical association that work closely with the state physician health program by encouraging ill physicians to seek help, others do not. In fact, 13 of 35 state medical boards responding to a survey instrument reported that a diagnosis of addictive illness or mental illness in and of itself was sufficient grounds for adverse disciplinary action. Thirty-seven percent (37%) of responding boards admit they deal with physicians seeking psychiatric care differently from those receiving medical care.4 Understandably, even in more enlightened states, this sends a strong, clear, unambiguous and shaming message which has a chilling effect on the ill physician.

Finally, mental illness and substance use disorders are stigmatized illness. Ironically, this is especially true within the medical community itself. This stigmatization reinforces the inherent denial of these illnesses and certainly contributes to delays in seeking care, a tendency toward self-medication, and unnecessary suffering with the attendant risk of overt impairment. The increasingly ill physician may become isolated from colleagues, friends, and family. At times, inappropriate outbursts which are out of character can occur and overt disruptive behavior can be seen. The abuse of alcohol or other drugs can begin.

DEPRESSION, SUBSTANCE USE DISORDERS - STIGMA AND FEAR

How common is Substance Use Disorder and Depression among physicians? It is estimated that 2% of physicians have a current Substance Use Disorder and that 8 – 18% will have one at some point in their lives. Cross-sectional rates of depression in medical students and residents range from 15% - 30%.2 The AMA has stated that 30% of physicians may have an impairing illness at some point in their career and has called physician suicide "an endemic catastrophe." (See Table 2)

Overcoming the stigma of addictive and psychiatric illness within the medical profession is a complex and difficult process which will require a change in the medical culture itself coupled with the ongoing education of our colleagues. Additionally, far too many regulatory agencies unwittingly contribute to the problem when they mistakenly equate "illness" with "impairment." In reality, illness and impairment typically exist on a continuum with the former preceding the later, often by many years. When any Board reflexively disciplines physicians only on the basis of a diagnosis of addictive or mental illness, the unintended and counterproductive backlash is profound. Other affected physicians with these illnesses suffer in fear and silence.

Table 2. Suicides Among Professionals Recovering From Addictive Illness(9)

Study by LeCair Bissell, MD, et. al.

Method: Survey Instrument to Treatment Facilities

Cohort: 942 pharmacists and 1,164 physicians treated for SUDs (N = 2,106)

Number of reported deaths: 24 *Deaths from suicide:* 15 (62.5%)

In relapse – 8 (53%)

Abstinent - 5 (33%)

Unknown - 2 (13%)

Primary Method: Overdose

Recently I attended an out of state meeting with a Medical Board and its Medical Association on the topic of physician health and impairment. This board has a reputation for high numbers of adverse disciplinary actions against physicians with diagnoses of addictive or psychiatric illness. This is an example of what Public Citizen (Dr Sidney Wolfe) terms a "good board." At that meeting I heard one of the Board members, a forensic psychiatrist, speak. He told of a female physician who was depressed and had a serious suicide attempt. He explained that "had the physician made arrangements for coverage for her practice" before the attempt the board would have "just given her a five year disciplinary order." Since she hadn't thought to do that she received a "fifteen year disciplinary order." This disciplinary action makes it impossible for her to sit on many provider panels or to sit for recertification in her specialty and more. I had an opportunity to speak to this doctor who had, by that time, been in remission from her depression for 3 years and finds herself unemployable. This, of course, is a rather extreme – but astounding - case of regulatory abuse.

QUESTIONS, ANSWERS, AND POSSIBILITIES

One solution to physician fear of the regulatory process adopted in many states is a change in Board licensure and renewal questions from the typical, *Have you ever been diagnosed with…"* to language geared toward effective intervention. An example of such a question would be some variation of, *"Have you been advised or required by the state medical board or any other licensing or privileging body to seek treatment for a physical or mental health problem unknown to this state's physician health program?"* The Consensus Statement issued by the American Medical Association and theAmerican Foundation for Suicide Prevention strongly recommended that licensure regulations, policies, and practices be nondiscriminatory. They should require disclosure of misconduct, malpractice, or impaired professional abilities and NOT a psychiatric or medical diagnosis.(2,5)

The role of the Boards to protect the public is critically important and should remain the focus of state Boards. Yet Boards would be protecting the public and improving their relationship with physicians if they initiated programs aimed at physician health, wellness and impairment prevention. Many Boards around the country are doing this work through close professional relationships with their state PHP.

State Physician Health Programs (PHPs) have been a valuable asset to the physician in need of help with psychiatric illness or substance use disorders. The membership organization of the state PHPs is the Federation of State Physician Health Programs (FSPHP). Forty-eight states now report having a PHP. Nationally, state PHPs continue to expand their services. Unfortunately, many physicians view their state PHP as an extension of the Board and are fearful of Board entanglement. Others view state PHP involved physicians as "those doctors with problems" or as "impaired doctors" and do not wish to be identified with that group. These barriers require clearer use of "ill" and "impaired" language, a shift of focus to illness prevention and medical community education if they are to be overcome.

The culture of medical school and residency must be willing to examine open and honestly their impact on the student with an eye toward change. Medical students and residents must be able to recognize signs of distress in themselves and each other and feel safe and supported in seeking out help. They must guard against the tendency to self-medicate or use alcohol or other drugs for relief of stress. Education about the diseases of depression and more especially addictive illness is woefully inadequate and must be enhanced. Personal "wellness" must become part of the culture and be recognized, modeled and encouraged at each level of training. The residency that boasts about the high rate of divorce among their residents should be avoided.

The AMA and state medical associations, the Federation of State Medical Boards (FSMB) and state medical boards, along with the Federation of State Physician Health Programs (FSPHP) and state PHPs should find ways to partner. More research is needed. Proactive screening should be considered. We should develop anonymous self-evaluation screens for physicians aimed at issues such as stress, burnout, anxiety, depression, and substance use disorders – even if only physicians themselves know the result. Such a periodic screening effort should be accompanied by clear and supportive messages that there is a confidential avenue available for assistance. A proactive approach such as this might help the ill physician recognize a need for help before overt impairment or – worse yet – another physician suicide is manifest.

Is it possible that we could glean valuable preventive information through some process to "autopsy" physician suicides? While such an undertaking would require significant forethought in terms of the worthwhile data we would hope to capture, it seems prudent to consider. One designated group of researchers working through the state medical associations should be able to accomplish this task. Certainly, such an undertaking would be labor intensive and require great sensitivity on the part of the research team.

CONCLUSION

We physicians who devote our lives to caring for others have a long way to go toward caring for ourselves and each other. Our medical culture is in need of an honest and thorough inventory. Antiquated laws and institutional policies must be challenged. The critically important difference between "illness" and "impairment" must be understood and taught. The stigma of needing help must be supplanted by our support and encouragement of a physician willing to face courageously his/her own human condition. Our compassion for the ill must extend to our fellow physicians. The medical community must learn to better support our recovering colleagues. As Dr. Lowell once cautioned us, "Whatever you may be sure of be sure of this, that you are dreadfully like other people."

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