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Doctor Suicide: The Elephant in the Examining Room

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Short Communication

Figure 1:

(Figure 1) Louise Stanger is a speaker, educator, social worker, clinician, and interventionist who uses an invitational intervention approach to work with complicated mental health, substance abuse, chronic pain and process addiction clients. When you plan a visit to your doctor, the topic of conversation almost always centers around you. The doctor checks your vitals, may take a sample of blood, discusses ways to improve your health, etc. You may feel relief as you believe the doctor is here to help navigate you through whatever ails you. But have you ever wondered what goes on in the mind of that highly educated person wearing a white lab coat and stethoscope?

In Abraham Verghese's New York Times bestseller, The Tennis Partner, Verghese weaves a story that shows us how doctors are more than their persona. In the book, Verghese, a physician, becomes friends and tennis partners with David, a talented resident with a dark past of drug abuse and addiction. When the beast of addiction returns to haunt David, Verghese witnesses a complex human, resplendent with varying shades of emotions, emerge. "There I thought are so many David's: the retiring Aussie, the stylish tennis player, the downcast lover, the thoughtful friend, the mischievous Lothario, the recovering addict, the plodding medical student."

Although Verghese came to see David as much more than his depression and addictions, his insecurities and self-effacement, in the end David overdoses and dies. Verghese reflects back on his friendship with David, and realizes it was a slow build, a toxic suicide manifested by the congruence of multiple mental health issues and addiction in which he attempted to manage all on his own. As such, there are documented accounts of interns, residents and doctors who find their lives unbearable and in that final moment of despair take their own lives, leaving patients, family, loved ones, friends, co-workers, hospitals and practices bewildered.

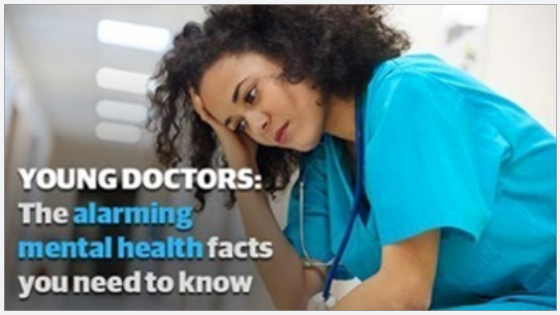

Figure 2:

In fact, "more than 920,000 Americans lose their doctors to suicide each year," writes Neil Ungerleider for Fast Company. And according to a recent New York Times article, "approximately 400 doctors commit suicide yearly," and "physicians are more than twice as likely to kill themselves as non-physicians (and female physicians three times more likely than their male counterparts.)" Where do these alarming statistics come from? It's a confluence of issues. The educational demands, extended workdays, the demands of patient care which are both rewarding and exacerbating, chronic stress, lack of institutional emotional support, and the availability of addictive substances coupled with a "conspiracy of silence" which leads to underreporting or failure to report when a doctor is in trouble. This spider web of silence may be inadvertently perpetuated by families and co-workers, who fear that addressing the problem head-on or doing a compassionate loving invitational intervention may cause their loved one financial harm or increased work stress (Figure 2).

Perhaps it begins in medical school. Long grueling hours of study and work, the 86-hour workweek, stress and anxiety take a toll. In her Ted Talk titled "Why Doctors Kill Themselves," Pamela Wible, MD, denounces the medical school culture of "hazing and bullying and name calling" that continues into residency that results in "occupational-induced depression, poorer health care for patients, and a professional culture that dissuades doctors from seeking health care." Furthermore, the American Foundation for Suicide Prevention indicates that "drivers of burnout include workload inefficiency, lack of autonomy and meaning in work and work-home conflict."

This culture continues through residency and culminates into a frame of mind that pits doctors at odds with reality. Pranay Sinha, a physician in his first year at Yale-New Haven Hospital, points out the mind-set. He writes in a New York Times op-ed there is a "strange machismo that pervades medicine. Doctors, especially fledgling doctors like me, feel pressure to project intellectual emotional prowess beyond what we truly possess. Our expectations skyrocket as if the conferral of a degree (MD) were an enchantment of infallibility in fact very little changes, apart from our legal ability to prescribe medications. "

In addition to rising pressures and a hubris culture, depression, as Dr. Robert Bright explains in his report published at Current Psychiatry, may be one of the leading contributors. Although the rate of depression amongst physicians is comparable to the general population, the risk of doctor suicide is higher. And the prevalence of depression among residents is higher than similarly aged individuals in the general US population. Finally, depression and other mood disorders amongst doctors may be under-recognized and inadequately treated due to:

a) Doctors may be reluctant to seek treatment

b) Residents and interns may have no time to seek treatment because of grueling work weeks

c) Doctors may attempt to be their own doctor - they will diagnose and treat themselves (i.e. self medicate)

d) Doctors have easy access to prescription drugs

e) May be fearful of stigma attached to mental health disorders

f) Doctors if they do seek treatment may get VIP Treatment

Additionally, in their research, Bright and Kahn of the Mayo Clinic have discovered that rates of depression are higher in medical students and residents (15 to 30 percent) than in the general population. Some of the predictors of depression in doctors are:

i. Difficult relationships with senior doctors, staff and or patients

ii. Lack of sleep

iii. Dealing with death

iv. Making mistakes

v. Loneliness

vi. 24-hour responsibility

vii. Self-Criticism

As such, there are manifestations of mental illness in doctors according to Bright and Kahn that can create a negative impact on the health of our doctors. As a therapist, clinician and addiction/mental health interventionist, when assessing risk for doctors in particular and the population in general it is important to do a robust bio-psycho–social history and take a look at past family history and past history of the doctor in question as well as viewpoints on the work culture. Here are some questions to ask:

i. Is there a family history of mental illness?

ii. Is there a family history of suicide?

iii. Has the doctor previously experienced a depressive episode?

iv. Has there been previous suicidal thoughts and/or attempts?

v. Is there a family history of addiction and or process disorders?

vi. What are families' religious and cultural beliefs about mental health, substance abuse and suicide?

vii. Has the doctor had a history of addiction?

viii. What is the doctor's past experience with prescribed and non-prescribed mind-altering drugs?

ix. Has the doctor been treated for any addicted disease per ASAM's definition of addiction?

x. Has the doctor been treated previously for anxiety or insomnia?

xi. Has the doctor had any learning disabilities that affect their learning style?

xii. What are his/her current relationships? How, if at all, are professional requirements affecting those?

xiii. What are one's views on getting and seeking help (current and past family views)?

xiv. What are one's personal and family religious or cultural views on mental illness, suicide, and substance misuse, drug addiction or process disorders, sex, shopping, gambling?

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So what is being done to help the situation?

To help prevent what others have labeled the "Silent Epidemic," Pranay Sinha, the first year resident mentioned above, passionately says, "we must be able to voice [our] doubts and fears. We must be able to talk about the sadness of the first death certificate we signed, the mortification of the first incorrect prescription we ordered, the embarrassment of not knowing an answer on rounds that a medical student knew." And if a fellow physician does commit suicide there must be protocols in place that allow for discussion, crisis intervention, and management of the situation.

As such, the first suicide prevention and depression awareness program was established at the University of California, San Diego in 2009 to destigmatize help-seeking and prevent suicide among medical student, residents and faculty physicians. The approach of the program consisted of screening, assessment, referral and education. The screening practice was trustworthy. The educational part consisted of grand rounds (a teaching tool whereby doctors, residents and medical students evaluate the medical problems and treatment for patients) on students' and physicians' exhaustion, depression, and suicide (Figure 3).

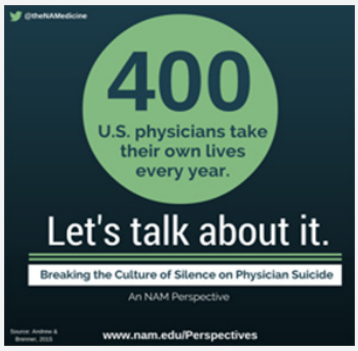

Figure 3:

Today the American Foundation for Suicide Prevention (AFSP) has a robust list of resources on its website including videos, articles, interactive screening programs, etc. In addition, Pamela Wible, a physician in Eugene Oregon mentioned in the Ted Talk above, who was "plagued" with both doctors she dated in medical school killing them, her own previous thoughts of suicide, and the reality that 10 local Oregon doctors killed themselves, became a self-proclaimed advocate of this silent epidemic. She wrote a book about the topic of doctor suicide called Physician Suicide Letters in which she sheds light on the issue lurking in the shadows. Wible's goal is to make sure these facts get out into the public arena, and urges an examination of causation factors and preventative measures to be put in place.

Why is reading about Suicide and Doctors so important? aka The July Effect

Every summer a new cohort of medical graduates enters hospital wards. To be exact, 36,000 students applied for residency this year. There is a perceived increase in the risk of medical errors and complications that occurs in July and August because the new medical graduates don't talk about the pressures and climate of culture in residency. This has been labeled the July Effect. While not statistically proven, one surely can argue with the influx of a new generation of doctors comes an increase of stress, anxiety and suicide ideation. Recent medical school graduates step foot in teaching hospitals as residents for the first time, as the class above them takes on new duties. As such, this year hospitals offered a record number of residency positions and more doctors will start their career than ever in the summer months. Overall, the number of residency positions offered hit a record high of 31,757, up more than a thousand from 2016, according to a report in Stat News.

Just ask Anupam Jena, an internist and assistant professor of health care policy at Harvard medical school, who was interviewed for U.S. News & World Report. "The interns know less than the physicians who were there two or three months before." That is simultaneously scary and anxiety inducing! As a licensed clinician and interventionist, I believe it is imperative for hospital systems on a macro level to have policies in place and to be trained on how to intervene with compassion and grace when one is experiencing mental health and substance abuse distress.

It is important to keep the doors of communication open and have policies and protocols that support wellness with respect to work hours, random drug testing, etc. and provide opportunities for treatment that is confidential, ethical and respectable. Our medical schools and teaching hospitals must learn the warning signs and take heed of them and must become well versed on treatment options available. Our doctors must enjoy the same confidentiality, respect, treatment that one would provide for a loved one. I for one am well-suited to work in tandem to provide tools and strategies for such discourses to take place and strategies to be implemented.

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