**Physician Suicide**

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**Introduction**

On average, the United States loses the equivalent of at least one entire medical school class each year to suicide (reliable estimates are as many as 400 physicians).

Sadly, physicians globally have a lower mortality risk from cancer and heart disease relative to the general population, presumably relating to self-care and early diagnosis; however, physicians have a significantly higher risk of dying from suicide, the end stage of an eminently treatable disease process. Depression is a leading risk factor for myocardial infarction in male physicians. Although, as a profession, physicians seem to have heeded their own advice about avoiding smoking and other common risk factors for early mortality, they are decidedly reluctant to address a significant risk of both morbidity and mortality that disproportionately affects them.

In all populations, suicide is usually the result of untreated or inadequately treated depression coupled with knowledge and access to lethal means. Depression is at least as common in the medical profession as in the general population, affecting an estimated 12% of males and 18% of females. Depression is even more common in medical students and residents, with 15-30% screening positive for depressive symptoms. Because of stigma, self-reporting likely underestimates the prevalence of the disease in both populations.

Perhaps due in part to knowledge of and ready access to lethal means, completed suicide is far more prevalent among physicians than the public, with the most reliable estimates ranging from 1.4-2.3 times the rate in the general population. More alarming is that, after accidents, suicide is the most common cause of death among medical students. Although female physicians attempt suicide far less often than their counterparts in the general population, completion rates equal those of male physicians and, thus, far exceed that of the general population (2.5-4 times the rate by some estimates). A reasonable assumption is that underreporting of suicide as the cause of death by sympathetic colleagues might well skew these statistics, so the real incidence of physician suicide is probably somewhat higher.

The most common psychiatric diagnoses among physicians who complete suicide are affective disorders (eg, depression and bipolar disease), alcoholism, and substance abuse. The most common means of suicide by physicians are lethal medication overdoses and firearms.

**Depression in Physicians**

Reticence to recognize depression in a colleague is imposed by other physicians, who may be well intentioned, chronically emotionally distanced, and/or feeling temporarily vulnerable themselves. Physicians are notoriously reluctant to ask for help of any kind. When a physician is depressed and feeling less than adequate, asking for help is even more difficult, and sadly, sometimes remarkably difficult to actually obtain.

Physicians are demonstrably poor at recognizing depression in patients, let alone themselves. Furthermore, physicians are notoriously reluctant to seek treatment for any personal illness. Research suggests that 1 in 3 physicians has no regular source of medical care.[1 ]Although everyone knows that "a doctor who treats (himself or) herself has a fool for a patient," we also know that most physicians treat themselves anyway, at least on occasion. This is especially likely when the physician believes that the consequences of seeking treatment might subject him or her to shame or worse (see Problems With Treatment in Physicians).

Some physician reluctance to reach out is self-imposed. Physicians feel an obligation to appear healthy, perhaps as evidence of their ability to heal others. Inquiring about another physician's health can shatter this mutual myth of invulnerability. Volunteering assistance may seem like an affront to a colleague's self-sufficiency. Thus, the concerned partner may say nothing, while wondering privately if the colleague has become impaired. Unconsciously defending against this painful vulnerability, colleagues or significant others may fail to notice significant depression or withdrawal, attributing behavioral changes instead to stress or overwork. Nearly every article about a physician's suicide contains a quotation from some close contact, occasionally a spouse, similar to "I never had any idea that he/she was suffering."[2 ]Of course, many physician obituaries omit the fact that the "sudden death" was a completed suicide.

Depressed physicians who do reach out may find limited understanding or sympathy demonstrated by colleagues. There is no specialized training for a physicians' physician (there is, for example, for the pope's confessor). Most physicians shrink from the role, or perform it poorly. For many experiencing depression, the early symptoms are physical. A physician unable to diagnose his or her own symptoms commonly feels incompetent. To admit inability to diagnose oneself to another colleague is an admission of failure. When such tacit confession is met with avoidance, disbelief, or derision by a reluctant treating physician, it can only reinforce a depressed physician's feelings of worthlessness and hopelessness.

Physicians find it painful to share their experience of mental illness with others and know it is somewhat risky (see Problems with Treatment in Physicians); therefore, published accounts of physician depression are nearly impossible to find. However, in the author's experience, private consultations with a trusted counselor reveal that symptoms of depression among physicians are surprisingly common.

Marriage is generally considered to be an effective buffer to emotional distress. Whether the incidence of divorce among physicians is higher than that in the general population is not known, but marital problems are common, perhaps in part due to the tendency of physicians to postpone addressing marital problems and a general conflict avoidance.[3 ]Marital problems, separation, or divorce can certainly contribute to depressive symptoms, which can increase the likelihood of suicidality if unaddressed.

Litigation stress can precipitate depression and occasionally suicide. The suicide note of one Texas emergency physician the day after he settled a malpractice case read, "I hope that my death will shed light on the problem of dishonest expert testimony."[4 ]Physicians have completed suicide upon first receipt of malpractice claims, after judgments against them in court, or following financially motivated but unjust settlements foisted upon them by malpractice insurers solely in order to cut the insurer's losses. Others have attempted or completed suicide due to employment discrimination relating to judgments or settlements and/or upon the realization that they are no longer able to practice because of discrimination by liability insurers who refuse to insure them due to past judgments or settlements, or because of licensure limitations.

**Problems With Treatment in Physicians**

Many clinicians are uncomfortable treating fellow physicians, especially in the realm of mental health.[ 5 ]The "VIP syndrome" of well-intentioned but superficial or inadequate treatment based on collegiality and concerns about confidentiality can detract from the effectiveness of therapy.

Mental health experts studying physician depression and suicide have stressed that immediate treatment and confidential hospitalization of suicidal physicians can be lifesaving more so than in other populations.[6 ]Yet, this very specter is often the major impediment to a physician's reaching out in time of crisis. The fear of temporary withdrawal from practice, of lack of confidentiality and privacy in treatment, or the loss of respect in the community hampers physicians from seeking effective treatment.

Physicians who have reported depressive symptoms (even those for which they are receiving effective treatment) to their licensing boards, potential employers, hospitals, and other credentialing agencies have experienced a range of negative consequences, including repetitive and intrusive examinations, licensure restrictions, discriminatory employment decisions, practice restrictions, hospital privilege limitations, and increased supervision.[7,8 ]Such discrimination can immediately and severely limit physicians' livelihoods as well as the financial stability of their families. For this reason, well-meaning colleagues or family members who are aware of the depression sometimes discourage physicians from seeking help.

Medical licensure applications and renewal applications frequently require answers to overly intrusive questions regarding the physician's mental health history and are probably out of compliance with the provisions of the ADA.[9,10,11 ]Most states have physician health programs not associated with the medical licensing authority, and more enlightened states have regulations governing some state physician health programs that allow a physician enrolled in a physician health program who is compliant with treatment to check "no" on the mental health questions on licensure applications. However, physicians who are contemplating or in need of treatment are almost universally unaware of such provisions.

Most physicians assume that any state agency or treating physician will share confidential information about them to the licensing authority.[12 ]Additionally, any lack of disclosure on an employment or credentialing application can be cited as grounds for termination or decredentialing.

Discrimination in obtaining insurance coverage is a common but little publicized problem for physicians with mental illness. Health, disability, and liability insurance may all be denied to a physician who admits to depression. Even if disability insurance has previously been procured, its use may subject physicians to repetitive humiliating and invasive examinations by detached and dubious "independent medical examiners" for the insurer, whose motivation is to cut company losses. Many physicians affected by mental illness feel that insurers expect adherence by them to the standard prescription of "physician, heal thyself."

Despite the protections afforded by law to citizens and other professionals who have disabilities, the potentially devastating effects triggered by a physician's self-reporting of depression may delay or in effect preclude appropriate treatment. A depressed physician, whose thought processes are clouded because of the illness and the anticipated consequences of seeking treatment, may honestly believe that self-treatment is the only safe option. However, attempts at self-treatment are often unsuccessful. Failure to obtain consultation and treatment for depression needlessly and significantly increases the risk of physician suicide.

**Depression in Medical Trainees**

Prospective medical students and residents are extremely unlikely to report a history of depression during highly competitive selection interviews. The prevalence of depression in these populations and in medical student and postgraduate trainees is unknown, but it is estimated in the range of 15-30%.[13 ]After accidents, suicide is the most common cause of death among medical students. One report has suggested that depression is not uncommon in pediatric residents (up to 20% self-reported in 3 programs). This preliminary study found that residents who experienced depression may be as much as 6 times more likely than nonaffected controls to make medication errors.[14 ]Other studies have confirmed the association of depression with self-perceived medication and other errors.[15 ]

Stressful aspects of physician training, such as long hours, difficult decisions with the potential for errors due to inexperience, learning to deal with death and dying, frequent shifts in workplace and estrangement from supportive networks such as family could add to the tendency toward depressive symptoms in trainees. Harassment and belittlement by professors, higher level trainees, and even nurses contribute to mental distress of students and development of depression in some. Even positive workplace changes such as translocations to secure further training or job advancement could contribute to job-related stress.

A few schools are implementing programs to recognize and deal with depression and other stresses in medical trainees. The American Foundation for Suicide Prevention has created a video for physicians and other medical trainees on the topic.[16 ]

**Education and Resources**

Depression, like substance abuse in physicians, is not only more common than in the general public, but it usually is more readily treatable. This is because of the strong self-motivation to continue successful pursuit of a professional calling, which is an important source of a physician's self-esteem.

More education is needed regarding this disease and its disproportionate and needless toll on the profession of medicine, beginning in the earliest stages of physician training. In addition, there is an urgent need to change the attitudes of those in health care, including those in the regulatory system, as well as the general public, toward mental illness. This might encourage physicians to be more receptive to a diagnosis of depression and enable them to feel free to seek treatment without the fear of repercussion. Physicians themselves need to be aware of the existence of Physician Health Programs in nearly every state and province, which allow a physician who is compliant with treatment to avoid disclosure of depression or other stable illness that does not interfere with ability to practice, to licensing authorities.

The AMA has a 2009 directive from its House of Delegates to work with the Federation of State Medical Boards and Federation of State Physician Health Programs to study barriers to effective utilization of physician health programs, including confidentiality safeguards, and to educate members and others regarding the relationships between state licensing authorities and physician health programs.

Please consult the American Foundation for Suicide Prevention available at www.afsp.org and www.physiciansuicide.com for further information and resources about physician depression and suicide. Litigation stress and related materials and resources can be found at www.mdmentor.com.

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