



Experts Address Risk of Physician Suicide

Tracy Hampton, PhD

STUDIES OVER THE PAST 4 DECADES have shown that physicians die by suicide more frequently than non-physicians. Because of this striking finding, experts with knowledge and experience in areas including medicine, health insurance, and physician licensing recently convened to address factors in the profession that can discourage physicians experiencing depression and other psychiatric conditions from seeking treatment.

“The object of getting all of these people together is to see if we can change the culture of medicine,” said cochair Herbert Hendin, MD, medical director of the American Foundation for Suicide Prevention (AFSP) and professor of psychiatry at New York Medical College, in New York City.

Sponsored by the Milbank Memorial Fund and the AFSP, the meeting included 35 experts who had spent 9 months working in small groups to study key aspects of the problem (including factors in medical student and resident education and health, hospital support for depression treatment for physicians, insurance, and physician licensing) and to identify priorities for further research. The impetus for the effort was publication of a consensus statement from a 2002 AFSP-hosted workshop on depression and suicide in physicians, which emphasized the need to change professional attitudes and institutional policies to encourage physicians to seek help when needed (Center et al. *JAMA*. 2003;289:3161-3166).

Participants from organizations, including the American Psychiatric Association, the American Medical Association, the Accreditation Council for

Graduate Medical Education, the Federation of State Medical Boards, the Joint Commission on the Accreditation of Healthcare Organizations, and a variety of insurance organizations, hospitals, and medical schools were in attendance to review the collected data and come up with ways to take action.

PHYSICIANS' PSYCHIATRIC HEALTH

The chances of dying by suicide are substantially higher for physicians than non-physicians, about 70% higher for male



Because physicians have a heightened risk of suicide, efforts are under way to address factors that can deter those with psychiatric conditions from seeking treatment.

physicians than for men in the general population (including other professionals) and between 250% and 400% higher for female physicians than other women. (Although the suicide rates for male and female physicians are about equal, in the general population the suicide rate for men is higher than for women.)

“There is really a dramatic elevation in the rate of suicide generally but much more dramatic when you’re dealing with female physicians,” said Hendin. “We don’t know why.”

A heightened rate of suicide is seen as early as medical school. Although various studies have analyzed such stressors as excessive professional demands, long working hours, little vacation time, and conflicts between work and personal life, no solid evidence has been found to link these stressors to the elevated suicide rate among physicians.

The two greatest risk factors for suicide are having a mental disorder or substance abuse disorder. Both biological and psychosocial factors may play a role in physician suicides because there is a higher prevalence of psychiatric disorders among physicians than in the general population.

In addition, physicians who attempt suicide (usually with drugs) are more likely than nonphysicians to succeed in killing themselves, which may partly account for the increased rate of death by suicide. Among US physicians, there are more completed suicides than unsuccessful attempts, while for US women in general, unsuccessful attempts outnumber completed suicides by 10:1 to 15:1 (Schernhammer. *N Engl J Med*. 2005;352:2473-2476). Men in the general population have fewer unsuccessful attempts than women: while more than 4 times as many men die by suicide, women report attempting suicide during their lifetime about 3 times as often (Weissman et al. *Psychol Med*. 1999;29:9-17).

The expert group first turned to the topic of medical education as an avenue to address ways to lower the numbers of physician suicides. Physicians often do not diagnose depression in themselves and do not seek treatment as they do for other conditions, noted Hendin. Few physicians who have died by suicide were receiving psychiatric



Mental Illness and Suicide Resources

Information about mental illness, suicide, and suicide prevention is available from a number of organizations.

- The National Mental Health Association (<http://www.nmha.org/index.cfm>). This nonprofit organization addresses all aspects of mental health and mental illness, including advocacy, education, research and service.
- The National Institute of Mental Health (<http://www.nimh.nih.gov/>). The mission of this government agency for research on mental and behavioral disorders, part of the National Institutes of Health, is to reduce the burden of mental illness and behavioral disorders through research on mind, brain, and behavior.
- The American Psychiatric Association (<http://www.psych.org/>). This a medical specialty society that works to ensure humane care and effective treatment for all persons with mental disorders. Links to topics relating to physician suicide are provided.
- The American Foundation for Suicide Prevention (<http://www.afsp.org/>). This nonprofit organization funds research, develops prevention initiatives, and offers educational programs and conferences for friends and family of individuals who died by suicide, mental health professionals, physicians, and the public.
- The American Association of Suicidology (<http://www.suicidology.org/>). This nonprofit organization promotes research, public awareness programs, and education about suicide.
- The Bazelon Center for Mental Health Law (<http://www.bazelon.org/>). This national legal advocate for individuals with mental disabilities works to advance and preserve the rights of individuals with mental illnesses and developmental disabilities.

treatment just prior to their death. In addition, studies have found that physicians do not adequately detect or treat 40% to 60% of patients with depression. Therefore, physicians may need to do a better job of knowing and looking for the signs of depression in their patients and in themselves.

Recommendations by the group included providing material on physician depression and suicide in medical school lectures and integrating education about depression and its impact on other medical conditions into the medical school curriculum. Focusing on medical students and residents makes sense, explained Hendin, because "it's easier to change people's habits while they're still learning."

Another factor the group addressed is the mental health care that physicians receive, beginning in medical school and residency. In a study of nearly 200 medical students, only 22% of those who had screened positive for depression used mental health services (Givens and Tjia. *Acad Med.* 2002;77:918-921). The most frequently cited barriers

to treatment were lack of time (48%), lack of confidentiality (37%), stigma (30%), cost (28%), fear of documentation on academic record (24%), and fear of unwanted intervention (26%). Some medical centers have made arrangements with insurance companies so that medical students can receive psychiatric care with a copay, but that is the exception rather than the rule, said Hendin. Once out of medical school, many physicians also lack adequate health care. In a cohort study of more than 900 physicians, 35% had no regular source of health care, a situation which is associated with less use of preventive medical services (Gross et al. *Arch Intern Med.* 2000;160:3209-3214).

OTHER BARRIERS

Other factors considered by the group, including practices by state licensing boards, insurance concerns, and hospital policies toward physicians, can create additional barriers to better mental health for physicians. In some states, for example, licensing boards conduct investigations if physicians seek psychi-

atric treatment, a process that can lead to sanctioning regardless of whether there is any evidence of impaired functioning. In addition, although the extent of the problem is not known, physicians with depression must deal with insurance concerns, including issues of malpractice and disability insurance, if a history of depression is revealed.

"Physicians don't go for treatment because they're afraid of all kinds of consequences, even if they're aware that they're depressed," said Hendin.

Hospital policies to protect patients also may discourage physicians from seeking help by inappropriately identifying impaired physicians, focusing on psychiatric diagnoses and not capability. Thus, physicians may try to hide their condition to protect their careers.

"But physicians who are depressed who are functioning fine with their patients are going to be a danger if somebody *doesn't* help them get treatment," said Hendin.

Deficiencies in research on physician suicide also should be addressed, the group said, including a paucity of data on depression and suicide rates, such as incidence among physicians and other professionals. Unlike some European countries, the United States does not compile current statistics on the number of individuals in various professions who had particular medical conditions in any given year. Such data would be extremely valuable, said Hendin.

"You need to know about peoples' occupation in terms of disease, not just for suicide but for a lot of other things," he noted. The mental and physical aspects of an individual's work environment can have an impact on health and play a role in the development of a variety of medical conditions.

STEPS TO PREVENTION

In moving forward, the group identified several important measures to address the issue of physician suicide:

- Hospitals and medical centers should be convinced to do yearly anonymous screenings. "Even if nobody knows the result but the physician, it creates a



climate that says we think this is something you should do," said Hendin.

- Hospitals should implement programs that train medical students and physicians to recognize depression in themselves, colleagues, and patients.

- Medical schools and hospitals should work with insurance companies to develop in-house consultation, referral, and treatment services for students and residents with mental health problems.

- Data on treatment services offered to medical students and residents with mental health problems should be collected.

- Decisions about physician licensing and credentials should be based on professional performance, not psychiatric treatment or diagnosis.

- State wellness programs should address the needs of physicians who are depressed, but not necessarily abusing substances.

- Physicians applying for insurance should be informed of their rights, privileges, and obligations regarding disclosure of a psychiatric diagnosis and/or treatment.

The group said that for all of these recommended measures, model programs at hospitals and medical schools should be identified and publicized, and noted that much more research is needed concerning the scope of the problem on all levels. □

Rehabilitation Medicine Welcomes a Robotic Revolution

Rebecca Voelker

CHICAGO—Physical therapist Ela Lewis, MSPT, is about to do something that would be considered a grave error in any other setting. Her patient, a 65-year-old man, was left with impaired balance and walking ability after a stroke 10 years ago. To challenge his sense of balance Lewis throws a ball toward her patient, just outside his reach.

Many similarly impaired individuals would fall if they tried to catch the ball; others wouldn't attempt to catch it for fear of falling. And no responsible therapist would ever risk injuring a patient. But Lewis and her patient are demonstrating a novel robotic device that keeps him upright and allows his therapist to use exercises that otherwise would be unthinkable.

The 500-pound device, called the KineAssist, is a motorized platform, or "buggy," with a "smart brace" that supports the trunk and pelvis to help patients recovering from a stroke or other neurological conditions learn to walk and balance their weight again. It is part of an evolution in robotic devices intended to ease and speed patients' recovery and, at the same time, push rehabilitation medicine toward the ultimate question of how far machines can go in reproducing human abilities.

USER-FRIENDLY ROBOTS

Dozens of devices, including the KineAssist, a thought-controlled myoelectric prosthetic arm, and a robotic



The KineAssist, a novel robotic device, challenges patients who are recovering from stroke or other neurological conditions while reducing the risk of injuries.

nurses' aid that helps patients perform breathing exercises after cardiac surgery, were described or demonstrated during the International Conference on Rehabilitation Robotics (ICORR),

hosted in June by the Sensory Motor Performance Program of the Rehabilitation Institute of Chicago (RIC). The demonstrations showed that robots have been transformed from workhorses in the assembly of large, heavy industrial machines to precision tools tailored for use with patients undergoing rehabilitation.

"The field of robotics has changed," said William Z. Rymer, MD, PhD, the John G. Searle chair and director of research at RIC. "We now have a generation of smaller, portable, more human-friendly devices."

Going beyond the marvel of "bionic" limbs and microelectrodes implanted in the brain's primary motor cortex that allow a patient with tetraplegia to move a computer cursor by imagining the movement, many of the new devices have more practical, therapeutic applications. They are aimed at getting patients who are recovering from a stroke, spinal cord injury, or other neurological disorder back on their feet or able to perform activities of daily living more easily and quickly.

Recovery from stroke is a particular focus in therapeutic robotics research. The number of noninstitutionalized US stroke survivors increased by more than 50% from the 1970s to the 1990s (<http://www.americanheart.org/downloadable>