Physician Suicide

Overview

It has been reliably estimated that on average, the United States loses as many as 400 physicians to suicide each year (the equivalent of at least 1 entire medical school class).

Sadly, although physicians globally have a lower mortality risk from cancer and heart disease relative to the general population (presumably related to self-care and early diagnosis), they have a significantly higher risk of dying from suicide, the end stage of an eminently treatable disease process. Perhaps even more alarming is that, after accidents, suicide is the most common cause of death among medical students.

In all populations, suicide is usually the result of untreated or inadequately treated depression, coupled with knowledge of 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.

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.[1, 2, 3, 4, 5, 6, 7, 8, 9]

Perhaps in part because of their greater knowledge of knowledge of and better access to lethal means, physicians have a far higher suicide completion rate than the general public: the most reliable estimates range from 1.4 to 2.3 times the rate in the general population. 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).[10, 11]

A reasonable assumption is that underreporting of suicide as the cause of death by sympathetic colleagues might well skew these statistics; consequently, 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.

Go to Suicide and Depression and Suicide for complete information on these topics.

Depression in Physicians

Reluctance to recognize depression in a colleague is a tendency shared and imposed by other physicians, who may be well intentioned, chronically emotionally distanced, and/or feeling temporarily vulnerable themselves. Even when healthy, physicians find it difficult to ask for help of any kind. When they are depressed and feeling less than adequate, they find it even more difficult—and when they do bring themselves to ask, they sometimes find that the help they need is remarkably difficult to obtain.
Physicians are demonstrably poor at recognizing depression in patients, let alone themselves. Furthermore, they are notoriously reluctant to seek treatment for any personal illness. Research suggests that 1 in 3 physicians has no regular source of medical care.[12]

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).

To some extent, physicians' reluctance to reach out is self-imposed. They may 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, and 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, saying something like, "I never had any idea that he/she was suffering."[13] Of course, many physician obituaries omit the fact that the "sudden death" was a completed suicide.

Depressed physicians who do reach out may find that they receive only limited understanding or sympathy from colleagues. There is no specialized training for a physicians' physician, as there is for (for example) the pope's confessor. Most physicians either shrink from this 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 one's inability to diagnose oneself to another colleague is to admit failure. When this admission 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 that doing so 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 are surprisingly common among physicians.

Marriage is generally considered to be an effective buffer to emotional distress. Whether the incidence of divorce is higher among physicians than among the general population is not known, but marital problems are common, perhaps in part because of the tendency of physicians to postpone addressing marital problems and to avoid conflict in general.[14] Marital problems, separation, or divorce can certainly contribute to depressive symptoms, which can increase the likelihood of suicidality if unaddressed.

Litigation-related stress can precipitate depression and occasionally suicide.[15] The suicide note of a Texas emergency physician, written the day after he settled a malpractice case, read, "I hope that my death will shed light on the problem of dishonest expert testimony."[16] Some physicians have completed suicide upon first receipt of malpractice claims, after judgments against them in court, or after financially motivated but unjust settlements foisted upon them by malpractice insurers solely in order to cut the insurer's losses.

Other physicians have attempted or completed suicide in response to employment discrimination relating to judgments or settlements or upon the realization that they are no longer able to practice because of discrimination by liability insurers who refuse to insure them because of 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.[17] The "VIP syndrome," characterized by well-intentioned but superficial or inadequate treatment based on collegiality and concerns about confidentiality, can detract from the effectiveness of therapy.
Mental health experts who have studied physician depression and suicide stress that immediate treatment and confidential hospitalization of suicidal physicians can be lifesaving—more so than in other populations. Yet, the specters raised by this approach—the fear of temporary withdrawal from practice, of lack of confidentiality and privacy in treatment, or of loss of respect in the community—are often the major impediments that hinder physicians from reaching out in a time of crisis and 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.

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 Americans with Disabilities Act (ADA).

Most states have physician health programs that are 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. 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 repeated 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 them to adhere to the standard prescription, “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.

Too often, however, attempts at self-treatment are 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 to range from 15-30%. 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.[28] Other studies have confirmed the association of depression with self-perceived medication and other errors.[29]

Stressful aspects of physician training—such as long hours; having to make difficult decisions while being at risk 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.[30] 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 on the topic for physicians and other medical trainees.[31]

Education and Resources

Depression, like substance abuse, is not only more common in physicians than in the general public but also more readily treatable as a rule. This is because of physicians’ strong self-motivation to continue successful pursuit of a professional calling, which is an important source of their 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.[32] 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 attitudes of the general public, toward mental illness. Such changes 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 disclosing depression or other stable illnesses that do not interfere with ability to practice to licensing authorities.[33]

The American Medical Association 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.

For further information and resources related to physician depression and suicide, please consult the American Foundation for Suicide Prevention at www.afsp.org and www.physiciansuicide.com. Information on litigation-related stress, along with related materials and resources, can be found at www.mdmentor.com.

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