

PERSPECTIVE: PART II

PHYSICIAN SUICIDE IS A PUBLIC HEALTH IMPERATIVE

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"Dr. Henry Andrews, a physician...committed suicide about 2 o'clock yesterday morning...

*Despondency was the only cause that could be assigned...He was very dejected but never hinted at suicide."*¹

—An 1886 obituary published in *The New York Times*, the day after Christmas.

*The body of Andrea Liu was found...[she] did not show any signs she was stressed when they last saw one another at a fundraiser for the school's free clinic last month."*²

—A short article published online in *New York Post* in May 2018.

Physician suicide is a public health imperative. After 130 years, physicians, residents, and medical students are still dying by suicide, traumatizing families, friends, patients and medical communities. Since the 1960s, more studies of physician suicide and possible risk factors have been published. Some, for example, indicate physician suicide disproportionately affects women physicians. Also, the phenomenon is global. In more recent years and with social media, unverified speculation is growing that physician, medical student, and resident suicides are increasing in incidence. It seems that a physician's death by suicide is first noted on social media or online newswires by a member of their community, a form of backchannel communication in the absence of official or standard platforms for dialogue.

Suicide carries negative stigma, especially among physicians. Generally, mental health and substance use disorders are risk factors for suicide; however, 54% of people who die by suicide do not have known diagnoses, according to a June 2018 CDC report. Physicians are no exception. Social or institutional stigma, a culture of silence, and a false culture of strength prohibit at-risk physicians from accessing timely, non-judgmental and confidential treatment. Stigma and its consequences can also interfere with investigations of the root cause.

To map existing knowledge from peer-reviewed

literature, we received a grant from the Arnold P. Gold Foundation to perform a scoping review about physician suicide. We also aim to highlight opportunities for further research, education, and advocacy with the specific goal of preventing suicide among physicians. We presented preliminary findings at the Gold Foundation's Mapping the Landscape Symposium in May 2018.

We performed an iterative search of two electronic databases in Fall 2017, re-run in April 2018, for relevant English-language publications. The approach was inclusive, including publications on suicidal ideation, behavior, or completion, among physicians, residents, and medical students.

Initial findings indicate that the epidemiology of physician suicide has been studied predominantly in the United States, Norway, Sweden, and the United Kingdom. Most studies are observational studies based on vital statistics, membership registries, obituaries, and/or death certificate ascertainment. Suicidal ideation and attempts have been assessed via cross-sectional surveys of subpopulations, often medical students and residents, in countries on every continent except Antarctica. Beyond gender, no data is published on other minority group subpopulations.

Hypotheses about unique suicide risks for physicians have been proposed dating to 1922. However, causal re-

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relationships remain difficult to prove. For example, proposed risks for suicide among physicians include: access to and increased medical knowledge about lethal methods among physicians; personality traits, such as tendency towards perfectionism; and adverse childhood experiences or dysfunctional parental relationships. Yet, only observational studies and case reports may support the access and knowledge hypothesis; few studies examine association of personality with suicidal ideation or attempts; and no published studies support adverse childhood experience or parental relationships as unique risks for physician suicide.

In an effort to explain physicians' increased vulnerability to death by suicide, one investigator applied the interpersonal psychological theory of suicidal behavior (IPTS).³ The IPTS posits three necessary and sufficient precursors to death by suicide: (1) *thwarted belongingness*, a feeling of disconnection with others, (2) *perceived burdensomeness*, a miscalculation that one's death would relieve burdens on others, and (3) *acquired capability*, habituation to previously provoked fear responses, including losing the fear of pain involved in taking one's life. This can stem from repeated exposure to painful or provocative stimuli, including events triggering second victimization, such as patients' poor outcomes, death, and suffering.

Role strain, another theory to describe physician risks in their work environment, is a mismatch between social and institutional norms and the physician's roles. In other words, institutions and policies might not adequately support physicians' performance of their roles as a committed healer. This is problematic when physicians are expected to always function at a maximum level of competence.⁴ Further, physicians are at high risk of burnout, although no direct causal relationship between burnout and suicide has been

established. Naturally, the relationship between burnout, mental health disorders, substance use disorders, and suicide is complex.

Finally, suicide contagion or clusters, in which suicides may occur in close chronologic or geographic proximity, is also an important concept in dialogue about physician suicide. Best practices on communication and reporting about suicide could be better disseminated to potentially mitigate such concerns. Unfortunately, a fear about such clusters may paradoxically fuel censorship and lack of support for open, non-judgemental dialogue about physician suicide risks, prevention, and deaths: that fear has not triggered an accompanying public health response.

From our preliminary findings and conversations with experts in humanism research, education, and advocacy at the Gold Foundation MTL Symposium, the following are a few actionable opportunities to potentially address the public health imperative of physician suicide:

- **Explore cross-disciplinary learning and program development towards alternative problem-solving for populations exposed to similar pressures.** Suicide rates for physicians are higher than some non-healthcare professions, but other healthcare professions, such as nursing, pharmacy, dentistry, and veterinary medicine are also affected by suicide rates higher than that of the general population.
- **Lead and foster environments of collegiality and mutual respect.** Much like we aim to be self-compassionate and minimize self-criticism, treating colleagues, affiliates and other members of the healthcare team compassionately could help reduce workplace bullying and violence and other counterproductive aspects of the work envi-

ronment. This also may help to increase responsiveness to cues of physician distress, improve working conditions overall, and reduce role strain.

- **Advocate for compassionate, confidential treatment of mental health and substance use disorders in physicians.** Cultures of fear and silence contribute to delayed use of supportive and rehabilitative services. Physician health programs (PHP) exist in all but four states and offer such services, but there is no standard on components and timing of the programs. This can lead to unnecessarily invasive and potentially non-evidence-based surveillance and punishment if non-adherence is reported to a medical board by a PHP.
- **Advocate for sensible policies that reduce stigma for physicians and trainees.** For example, only one-third of state licensing boards comply with ADA requirements on their applications when they inquire about mental health disorders and substance use disorders.⁵ Licensing applications should focus on current physician impairment, not on past treatment for such disorders, and should not be singled out from other chronic medical illnesses.
- **Evolve the landscape towards better understanding the unique cultural, organizational, and social factors that contribute to physician suicides.** Few published investigations reflect on physician suicide, for example, through qualitative interviews of peers' experiences after a colleague's death by suicide, or psychological autopsies to collect a comprehensive behavioral analysis after a physician's death.

Physician suicide cannot remain stigmatized and in the shadows.

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Honest and transparent dialogue is vital. Interventions specifically targeted towards suicide prevention among physicians should be discussed openly, frequently, and internationally.

While we highlighted opportunities for further work, some of which are being explored, more deaths of physicians, residents and students by suicide are happening in the interim. Aligned and co-occurring interdisciplinary efforts across advocacy, education, and research can continue to address high physician suicide rates. And collaborative and community-oriented behaviors can support a healthier, more transparent and supportive culture of medicine.

A physician's life may depend on it.

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