Toward Preventing Physician Suicide: It Takes a Village

(International Practitioner Health Summit: The Wounded Healer)

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Disclosure Slide

- Medical Education Speakers Network – Two grand rounds presentations in 2017
- Book royalties – American Psychiatric Association Publishing, Inc., Sage, Penguin Gotham, Amazon

Learning Objectives

- Discuss the biopsychosocial risk factors for mental illness and suicide in physicians
- Grasp how stigma works against recognition of illness in physicians themselves and confounds help-seeking and adherence to life-saving treatments
- List the systemic, institutional, intercollegial, familial and individual changes that must occur to stop physicians from killing themselves

Brief Overview

- The magnitude of physician suicide and its wake
- What we know (and don't know) about the "why"
- Stigma – it is ubiquitous and is killing our doctors
- Our collective response to this worldwide tragedy is beginning to work

The magnitude: physicians

- In the US, it is estimated that 300-400 physicians take their own lives every year
- Put another way, we lose a doctor a day to suicide
- In male physicians, the suicide rate ratio is 1.41 compared to the general population and in female physicians it is 2.27 (Schernhammer and Colditz 2004)

The magnitude: physicians

- Between 2000 and 2014, 324 residents died (220 men and 104 women)
- Suicide was 2nd most prevalent cause: 51 men and 15 women
- 74% of the suicide deaths were PGY I and II
- 64% of the suicides were 1st and 3rd quarters of the academic years
  - Yaghmour NA, Brigham TP, Richter T et al. Causes of death of residents in ACGME-Accredited programs 2000-2014: implications for the learning environment. Acad Med 2017;92(7):976-983

The magnitude: the aftermath

- Survivors are those bereaved by suicide
- For each death by suicide 147 people are exposed
- Among those, more than 6 experience major life disruption
- This means that more than 1800 – 2400 individuals are deeply affected each year in the US when a doctor dies by suicide

The why

- It is generally believed that 85-90 percent of people who kill themselves have been living with some form of mental illness
- And these mental illnesses are often unrecognized and undiagnosed
- Even if diagnosed, they may be untreated or commonly undertreated
- BUT THIS IS ALL UNDER STUDY

"Suicide is Not Just about Mental Illness" CDC Vital Signs Report June 7, 2018

- There are a range of factors – beyond mental health conditions alone – including relationship, substance use, physical health, job, financial, isolation and legal problems.
- Focusing suicide prevention efforts solely in health care settings is insufficient – must involve schools, workplaces, faith communities, neighborhoods

The Suicidal MD: Psychiatric Disorders

- Major depressive disorder
- Bipolar disorder
- Alcohol use and substance use disorder
- Anxiety disorders
- Borderline personality disorder

  - Silverman MM. Physicians and suicide. In: Goldman LS, Myers MF and Dickstein LJ. *The Handbook of Physician Health: The Essential Guide to Understanding the Health Care Needs of Physicians*. Chicago, IL: American Medical Association; 2000.

The Suicidal MD: Additional Psychiatric Disorders

- Burnout
- Substance/medication induced depressive disorder (especially in clinicians who have been self-medicating)
- Posttraumatic stress disorder
- Other personality disorders
- “Double depression”

The Suicidal MD: Additional Psychiatric Disorders

- Comorbid conditions: MDD and substance use disorder, anxiety disorder and unrelenting and progressive medical disorder, bipolar disorder and narcissistic personality disorder, MDD and traumatic brain injury
- Adjustment disorders with overwhelming stress, loss, threat, public humiliation
    - Myers MF. Suicidal behaviors in physicians. In Brower K and Riba M *Physician Mental Health and Well-Being: Research and Practice.* Springer. New York 2017

The Suicidal MD: Risk Considerations

- Previous history of a depressive episode
- Previous suicide attempt
- Family history of mood disorders, including suicide
- Professional isolation
- Lawsuits and medical license investigations
- Poor treatment adherence
- Treatment refractory psychiatric illness
  - Myers MF. Physician suicide and resilience: diagnostic, therapeutic and moral imperatives. *World Medical Journal*. 2011;57(3):90-97.

The Suicidal MD: Risk Considerations Updated

- Undiagnosed and untreated bipolar I or II disorder
- Rapid cycling bipolar disorder, mixed affective states
- Comorbid conditions
- Impulsivity
- Unrecognized emergent psychosis
- Severe sleep deprivation and circadian rhythm disruption
- Acute suicidal affective disturbance (Stanley et al 2016)

Additional risk considerations

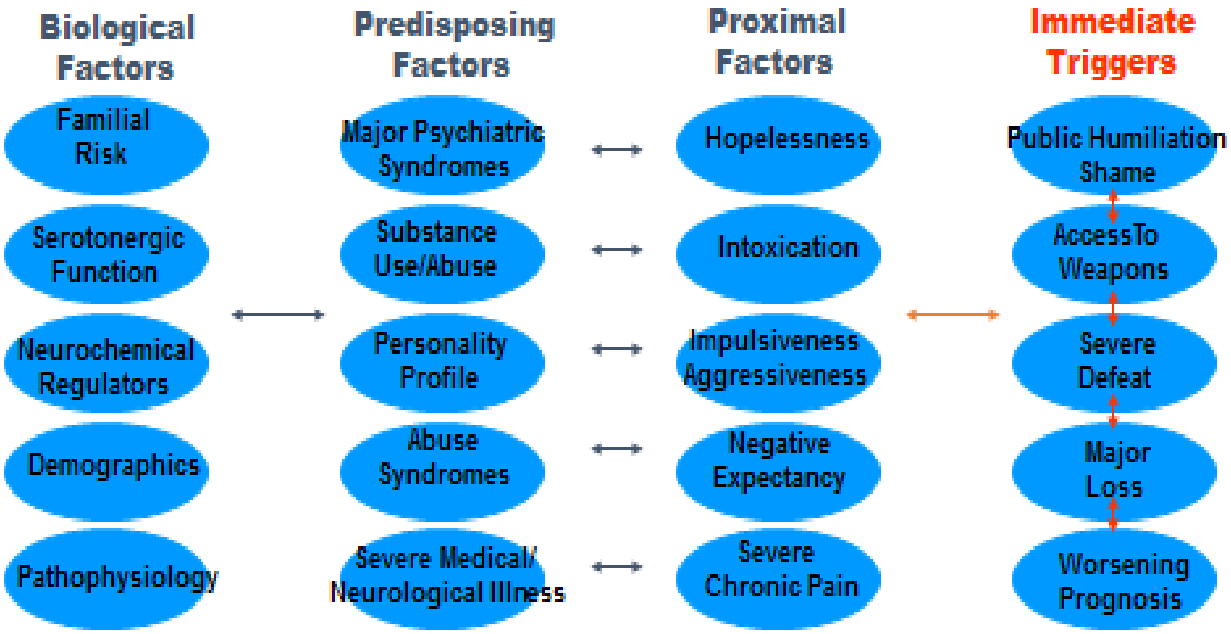
- We know how to kill ourselves
- Access to means
- Self-prescribing (or fraudulent prescribing) of potentially lethal meds
- Inadequate treatment due to transference and countertransference dynamics that muddle the treatment dyad

The final frenzy

- Suicide is believed to occur when several factors come together all at once in a perfect “horrific” storm that is painful and overwhelming, causing the sufferer to seek relief as quickly as possible
- The “psychic pain” is terrifying and relentless
- There is cognitive narrowing or restriction (tunnel vision) and the person can see no other option but ending his/her life
- Severe insomnia and alcohol/other drugs are dangerous bedfellows

Suicide is an outcome that requires several things to go wrong all at once.

-- There is no one cause of suicide and no single type of suicidal person. (AAS 2009)



The reality

- “For many of the deceased, it was the receipt of a complaint (even a trivial one) that had led to rumination, shame, and depression. Often unsupported, young and older doctors alike had to face the impact of the complaint alone.”
  - Clare Gerada: In memoriam – doctors who have died by suicide or accidental death. BMJ blogs. August 9, 2018

The words of the older sister of a 33 year old Fellow in a surgical subspeciality who took his life (Myers MF 2016)

- *“He was very special, happy (usually), thoughtful and very giving*
- *He was kind of a renaissance man, touched by a light, brilliant, creative, gifted*
- *He was so accomplished, he won so many awards, a medical rock star*
- *He worked very hard…but he played hard too…he was quite driven*
- *But he was highly sensitive, he took things very personally… a case went badly, his judgment was criticized – and there was no support, no safety net, no cohort, just a feeling of alienation”*

Anna Rosen, MD who lost her brother, a medical student, to suicide

“Anthony didn’t realize he was in such a severe depression; he didn’t have the experience that I have as a psychiatrist. No one could understand why he’d be depressed. And I think that this inhibited him from getting treatment. He was gifted, he was super-smart, his work ethic was profound. I said ‘Anthony, please see someone’ [meaning a psychiatrist]. But he was super-averse to seeking treatment. He was too ill to think it through.”

Stigma in the house of medicine is pernicious

- Two types:
  1. Felt stigma aka self-stigma and internal stigma
  2. Enacted stigma aka public and external stigma - it is judgment and discrimination against people with a psychiatric illness because of their perceived unacceptability or inferiority
- Both types of stigma threaten your self-esteem, security, identity and life chances

How stigma hampers illness recognition

- Who wants to recognize the signs and symptoms of an anxiety disorder or mood disorder or a substance use problem in oneself if its acceptance is terrifying and shameful?
- Who wouldn’t want to just bury their head in the sand? Throw themselves into their work?
- Who wouldn’t use magical thinking? (“if I help others who are sick I’ll be ok myself”)

How stigma hampers illness recognition

- And if it doesn't go away, who wouldn't want to wait just a little bit (or a lot) longer?
- Or who wouldn't think that he/she just needs to, in today's vernacular, "suck it up"?
- Is it any wonder then that when ill MDs finally do seek professional help, they feel defeated and diminished?
- How sad that they do not view this as the smart thing to do

Stigma has many variables

- Cultural studies have confirmed that the stigma associated with psychiatric illness varies significantly with one's race, ethnicity, country of origin, religious beliefs, age, gender, sexual orientation, gender identity and upbringing
- Also, stigma may be on a continuum so that it increases and decreases during the course of illness and its treatment

Stigma, procrastination and worsening

- The process of delaying and avoiding treatment can have untoward consequences
- Increasing the magnitude of symptoms or developing additional symptoms leads to more suffering
- This can result in an obsessive state of rumination and morbid egocentricity, including isolation and withdrawal from supportive others

Adverse Consequence #1

- The original illness becomes more entrenched, tough to treat or refractory to treatment altogether = poorer prognosis
- The individual becomes more resistant to spontaneous recovery, single drug pharmacotherapy and simpler forms of psychotherapy
- Treatment protocols become more complex, more costly and multidisciplinary

Adverse Consequence #2

- Work performance is at risk
- Errors of commission or omission
- Cognitive slowing and/or distorted thinking
- Multitasking, an essential skill, becomes impossible
- Memory impairment occurs
- Self doubts encroach and accurate decision making is harder

Adverse Consequence #3

- Comorbidity risk accelerates
- Other DSM-5 disorders
- Medical disorders – coronary artery disease, hypertension, diabetes, flu, etc
- Substance use disorders – increase use of alcohol, self-prescribing, diversion of drugs in the workplace, use of street drugs, etc
- Non chemical addictions – porn, gambling

Adverse Consequence #4

- Self-medicating of tranquilizers, antidepressants, sleeping medication, and stimulants
- Other MDs who don't self-prescribe may convince their general practitioner to write prescriptions for them that may not be treating the original problem so they become dependent on these meds and the GP becomes an enabler

How does stigma affect treatment adherence?

- Just because a MD has now ‘sort of’ accepted that he/she has a psychiatric illness and has consented to go to see someone does not mean that he/she will accept becoming a patient (‘the patient role’) and cooperate with the prescribed treatment
- Becoming a patient is a process

How does stigma affect treatment adherence?

- If you feel ashamed of your symptoms you may be less forthcoming with your doctor
- You may be embarrassed to disclose key pieces of your situation that will help your doctor make the correct diagnosis
- You are well intentioned but yet are late for appointments (so you don't need to endure the full 50 minutes) or 'forget' or 'miss' or 'cancel'

How does stigma affect treatment adherence?

- You ‘forget’ to take your medication as prescribed
- Or stop it because of side-effects without calling your doctor
- Or you stop it the minute you begin to feel better
- Or forget to refill it

How does stigma affect treatment adherence?

- You assume a passive role in treatment – as opposed to a collaborative one
- You resist any/all forms of important psychotherapy except supportive psychotherapy
- You demean or challenge your treating professionals
- You associate being a patient with dependency and loss of power

How does stigma affect treatment adherence?

- Pills and appointments are symbolic of illness and you don’t want to be reminded of that
- You may seduce (or try to seduce) your treating professional into believing that you are much more improved than you really are
- If you leave and then relapse or develop a recurrence later, you delay or avoid calling because you feel you’ve failed or you’re ashamed for ‘acting out’ earlier

How does stigma affect treatment adherence?

- Types of treatment may carry less/more stigma for some physicians
- Medication – use of mood stabilizers and neuroleptics frighten many patients, higher doses equate with “I must be really screwed up”
- Psychotherapy – psychodynamic psychotherapy may be resisted more than CBT or motivational interviewing

Stigma can be lethal

- *"A good friend told me about her death. We didn't know right away that it was suicide. It was horrible to hear the truth. It came out that she had been struggling. Why is there so much stigma? Why is there that message of 'don't show any weakness' in the everyday world of medicine?"*
  - The words of Pam Swift, MD, author of "Doctor's Orders. One Physician's Journey Back to Self" interviewed about the loss of a doctor colleague to suicide.

Stigma can be lethal

- *"My dad never really stuck to the treatment you provided for him, Dr. Myers. He just hated being a patient. He felt so ashamed. I tried hard too, but even my support wasn't enough"*
  - Words spoken to me by the medical student son of my patient, a psychiatrist, at the memorial service after his death by suicide

Collectively we are making a difference!

- The meaning of this conference “The Wounded Healer”
- National Physician Suicide Awareness Day was launched on Monday September 17, 2018
- Doctors Support Network (DSN) – Vice-Chair Louise Freeman
- NHS Practitioner Health Programme – Clare Gerada
- Geoff Toogood – campaign #CrazySocks4Docs

Collectively we are making a difference!

- In the US, the AMA, the ACGME and the National Academy of Medicine Action Collaborative on Clinician Well-Being and Resilience are taking MD suicide very seriously and working on changes at a national, state, organizational and leadership level
- The FSMB is developing a national template to eliminate questions about past mental health issues from licensure applications

Unpublished research

- Qualitative study of “survivors” of 39 decedents
- Survivors = family members, medical colleagues, employers, training directors, therapists and patients of decedents
- 65 interviews (19 in person, 46 by telephone) to date
- 10-15% of MDs killed themselves without receiving an assessment or Rx by a health professional

Unpublished research

- Their families are calling for increased education about common psychiatric illnesses in doctors:
  - Basic education for families i.e. what to watch for
  - Education for physicians themselves

  – Myers MF. Toward Preventing Physician Suicide: Enlisting Decedents' Families and Colleagues in Driving Meaningful Change. To be presented International Conference on Physician Health. Toronto Canada. October 11, 2018

Collectively we are making a difference!

- There are an increasing number of medical student and physician authored first person accounts of living with a psychiatric illness in our medical journals, lay press and online sites
- Anecdotally, I receive unsolicited emails from medical students and physicians about how their reading of doctors' personal narratives eased their path to reaching out for help themselves

An example

- “What I had was the good old fashioned face to face psychotherapy. The talking therapy was a godsend….The pills probably helped biochemically….they represented the fact that this was an illness and it wasn’t my fault.”
  - Dr Mike Shooter. Past president of the Royal College of Psychiatrists. Doctors’ diagnosis. Depression. BMJ 326;June 14, 2003

Some intercollegial resources

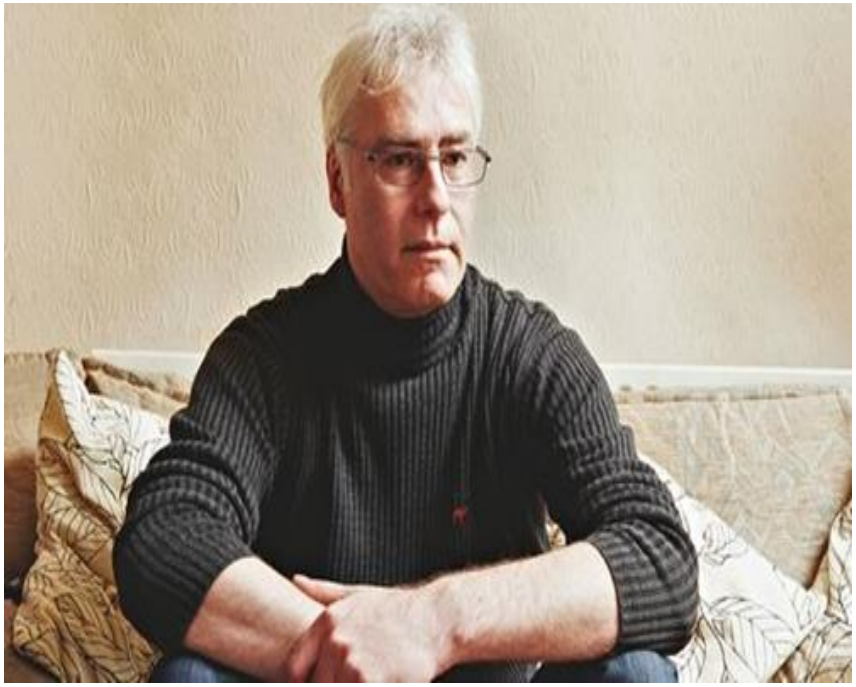
- Australian Drs Anne Malatt and Jane Barker co-creators of the website “To Medicine with Love”
- Students, residents and faculty at University of Michigan “Physicians Connected”
- “Make the Difference: Preventing Medical Trainee Suicide” Mayo Clinic and AFSP
- “Unspoken: Doctor Depression and Suicide” Newsy featuring University of Michigan

Survivors making a difference

Wise words

- *"Spouses should be included as far as practically possible in the care of their partner, they should be acknowledged as their 'unofficial carer' and not viewed as an appendage or positioned on the periphery of any planned care and treatment programmes; spouses should be seen as another resource in monitoring the health of their partner, to be primed in recognizing signs of a relapse of their partner's illness, and in effect be the eyes and ears of the responsible medical officer in the interim period between regular and planned appointments."*
  - Dave Emson who lost his wife Dr Daksha Emson and daughter Freya to 'extended suicide' in London October 9, 2000

The Emson Family



More wise words

- *“Naz and Matt Foundation is keeping me very busy and we are making good progress. With each new opportunity there comes more work to do. We must support everyone who contacts us and continue on the path to bring change to families and communities that don't want to listen.”*
  - Matthew Ogston who lost his physician partner and fiance Dr Nazim Mahmood to suicide in 2014

And…

- *“I do not have Louise’s professional skills, knowledge and experience to make a difference in this world. But I do have the power of our story and I will use it here and wherever I can to enable Louise to continue, indirectly, to reach out to help people even now, just as she would want.”*
  - Gary Marson who lost his wife Dr Louise Tebboth to suicide in 2015. He has established a foundation in her name and penned ‘Just Carry on Breathing: A Year Surviving Suicide and Widowhood’

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In appreciation

- To all the individuals who have been interviewed for their generosity and commitment to prevention
- To all my colleagues and friends in the physician health movement and the field of suicidology
- To all of you for coming. Please share your insights with your colleagues who can't be here today.
- To the many physicians whose tragically interrupted lives have informed this work

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