

Depression and suicide among physicians



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Stigma, licensing concerns, other barriers to treatment can be overcome

Dr. G, a second-year surgical resident, becomes depressed when his girlfriend abruptly ends their relationship. His phone calls and e-mails seeking an explanation go unanswered. Having long struggled with his self-esteem, Dr. G interprets this rejection as confirmation of his self-criticism.

Because of his work schedule, Dr. G feels that there is no way to see a therapist or psychiatrist and believes that asking for time off to do so would adversely affect his evaluations. He feels too embarrassed and “weak” to disclose his breakup and depression to his colleagues and attending physicians and senses that fellow residents would resent having to “carry his load.” Dr. G has spent the past 2 years moonlighting at the local emergency room and thinks it would be humiliating to go there for psychiatric help. His work performance and attendance decline until eventually his residency director forces him to take a medical leave of absence.

Dr. G feels that his pain will never end. He writes goodbye letters to his family, makes arrangements for his possessions and funeral, and hangs himself from the balcony outside his apartment.

Although the rate of depression among physicians is comparable to that of the general population, physicians’ risk of suicide is markedly higher.¹ Depression and other mood disorders may be under-recognized and inadequately treated in physicians because physicians might:

- be reluctant to seek treatment
- attempt to diagnose and treat themselves

- seek and receive “VIP treatment” from other health care providers.

This article examines physicians’ risk for depression and suicide, licensing concerns and other barriers to effective treatment, and what can be done to overcome such obstacles.

Not immune to depression

Rates of depression are higher in medical students and residents (15% to 30%) than in the general population.^{2,4} A longitudinal study of medical students at the University of California, San Francisco showed that students’ rates of depression when they enter medical school are similar to those of the general population, but students’ depression scores rise over time; approximately one-fourth of first- and second-year students were depressed.³ Fahrenkopf et al⁵ reported that 20% of 123 pediatric residents at 3 U.S. children’s hospitals were depressed. These depressed residents made 6.2 times more medication errors than did their non-depressed peers.⁵ For more information on physicians-in-training, see “Treating depression in medical residents,” page 96.

After completing residency, the risk of depression persists. The lifetime prevalence of depression among physicians is 13% in men and 20% in women⁶; these rates are comparable to those of the general population. Firth-Cozens⁷ found a range of factors that predict depression among general practitioners; relationships with senior doctors and patients were the main stressors (*Table 1*).⁷ Although these stressors increase depression risk, Vaillant et al⁸ showed that they did not increase suicide risk in physicians who did not have underlying psychological difficulties when they entered college. Certain personality traits common among physicians, such as self-criticism and perfectionism, may increase risk for depression and substance abuse.⁸

A depressed physician might enter a downward spiral. Feelings of hopelessness and worthlessness frequently lead to declining professional performance. Professional and personal relationships are strained as internal dysphoria mani-

Table 1

Predictors of depression in physicians

Difficult relationships with senior doctors, staff, and/or patients
Lack of sleep
Dealing with death
Making mistakes
Loneliness
24-hour responsibility
Self-criticism
Source: Reference 7

fest as irritability and anger. Spouses and partners can feel overwhelmed and bewildered by changes in the depressed person’s behavior, which may lead to separation or divorce. Patient care and the physician’s professional standing can be endangered. Signs that suggest a physician may be suffering from depression or another mental illness appear in *Table 2* (page 25).⁹

Increased suicide risk

A review of 14 studies found that the relative risk of suicide in physicians compared with the general population is between 1.1 and 3.4 for men and 2.5 to 5.7 for women.¹ A retrospective study of English and Welsh doctors showed elevated suicide rates in female but not male physicians compared with the general population.¹⁰ There are no recent studies of suicide rates among U.S. physicians. A 1984-1995 study showed that white male physicians have a higher risk for suicide than other white male professionals.¹¹ A survey of 4,500 women physicians found that female doctors are less likely to attempt suicide than the general female population⁶; however, their attempts more often are lethal, perhaps because they have greater knowledge of toxicology and access to lethal drugs.¹²

The relative rate of suicide among medical specialties is unknown. Studies had indicated higher rates of suicide among psychiatrists and anesthesiologists, but these trials were methodologically flawed.¹²

Silverman¹² developed a profile of the

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Personality traits common among physicians—such as perfectionism and self-criticism—may increase depression risk

▶ For more information see “Treating depression in medical residents,” pages 96-97

be considered in elderly patients for whom orthostatic hypotension is of concern [see Warnings and Precautions (5.7) in full PI]. Concomitant use with Furosemide in Elderly Patients with Dementia-Related Psychosis In two of four placebo-controlled trials in elderly patients with dementia-related psychosis, a higher incidence of mortality was observed in patients treated with furosemide plus oral risperidone when compared to patients treated with oral risperidone alone or with oral placebo plus furosemide. No pathological mechanism has been identified to explain this finding, and no consistent pattern for cause of death was observed. An increase of mortality in elderly patients with dementia-related psychosis was seen with the use of oral risperidone regardless of concomitant use with furosemide. RISPERDAL® CONSTA® is not approved for the treatment of patients with dementia-related psychosis. [See Boxed Warning and Warnings and Precautions]

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Management of Overdosage: In case of acute overdose, establish and maintain an airway and ensure adequate oxygenation and ventilation. Cardiovascular monitoring should commence immediately and should include continuous electrocardiographic monitoring to detect possible arrhythmias. If antiarrhythmic therapy is administered, disopyramide, procainamide, and quinidine carry a theoretical hazard of QT prolonging effects that might be additive to those of risperidone. Similarly, it is reasonable to expect that the alpha-blocking properties of bretylium might be additive to those of risperidone, resulting in problematic hypotension. There is no specific antidote to risperidone. Therefore, appropriate supportive measures should be instituted. The possibility of multiple drug involvement should be considered. Hypotension and circulatory collapse should be treated with appropriate measures, such as intravenous fluids and/or sympathomimetic agents (epinephrine and dopamine should not be used, since beta stimulation may worsen hypotension in the setting of risperidone-induced alpha blockade). In cases of severe extrapyramidal symptoms, anticholinergic medication should be administered. Close medical supervision and monitoring should continue until the patient recovers.

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physician at high risk for suicide: a workaholic white male age ≥ 50 or female age ≥ 45 who is divorced, single, or currently experiencing marital disruption and is suffering from depression. He or she has a substance abuse problem and a history of risk-taking (high-stakes gambling, etc.). Physicians with chronic pain or illness or with a recent change in occupational or financial status also are at risk. Recent increased work demands, personal losses, diminished autonomy, and access to lethal means (medications, firearms) complete the profile.

Protective factors that lower the risk of completed suicide include effective treatment, social and family support, resilience and coping skills, religious faith, and restricted access to lethal means.^{13,14}

Barriers to treatment

Physicians often are hesitant to seek mental health treatment.¹⁵ They may fear social stigma and could have trouble finding a local provider who they trust but is not a colleague. Physicians might be concerned about confidentiality and fear recrimination by colleagues, facilities where they work, or licensing boards.¹⁶ Givens and Tjia³ found that only 22% of medical students who screened positive for depression sought help and only 42% of students with suicidal ideation received treatment. These students reported that time constraints, confidentiality concerns, stigma, cost, and fear that their illness will be documented on their academic record were major barriers to seeking mental health care.

Licensing concerns. Physicians may be required to disclose a mental health diagnosis or treatment history when applying for or renewing their medical license. Increasingly, medical boards are asking applicants if they have been treated for bipolar disorder, schizophrenia, paranoia, or other disorders.¹⁷ Credentialing bodies, clinics, and hospitals may make similar queries.

In an analysis of 51 medical licensing applications (50 states and the District of Columbia), Schroeder et al¹⁷ determined that 69% contained at least 1 question that

was “likely impermissible” or “impermissible” in terms of compliance with the Americans with Disabilities Act (ADA). In 1993, a U.S. District Court found that the New Jersey State Board of Medical Examiners was in violation of the ADA because licensure application questions did not focus on current fitness to practice medicine but rather on information about a candidate’s status as a person with a disability (illness or diagnosis).¹⁸

In *Alexander v Margolis*,¹⁹ however, the court found that because patient safety is in question, medical licensing boards and credentialing bodies can solicit information about serious mental illness that could lead to impaired performance. Courts have ruled that questions regarding a history of treatment or hospitalization for bipolar disorder or schizophrenia and other psychotic disorders are permissible because they are considered “serious disorders” likely to interfere with a physician’s current ability to practice.²⁰ In a 2008 review of all U.S.-affiliated medical licensing boards (N = 54), Polfliet²¹ found that 7 specifically asked applicants about a history of bipolar disorder or schizophrenia, paranoia, and other psychotic disorders. Polfliet²¹ also found that state medical boards’ compliance with ADA guidelines was not uniform and some questions were “just as broad, and potentially discriminatory, as they were before enactment of the ADA.”

Worley²² reported a successful appeal to the Arkansas State Medical Board to revise its licensure questions following a cluster of medical student and physician suicides. The Board changed the question “Have you ever, or are you presently, being treated for a mental health condition?” to “Have you ever been advised or required by any licensing or privileging body to seek treatment for a physical or mental health condition?”

Providing inaccurate information on a medical licensure application may result in denial or revocation,²³ but acknowledging a history of mental health or substance abuse treatment triggers a more in-depth inquiry by the medical board. The lack of distinction between diagnosis and impairment further stigmatizes physicians who seek care and impedes treatment.

Table 2
Manifestations of mental illness in physicians

Severe irritability and anger, resulting in interpersonal conflict
Marked vacillations in energy, creativity, enthusiasm, confidence, and productivity
Erratic behavior at the office or hospital (ie, performing rounds at 3 AM or not showing up until noon)
Inappropriate boundaries with patients, staff, or peers
Isolation and withdrawal
Increased errors in or inattention to chart work and patient calls
Personality change, mood swings
Impulsivity or irrationality in decision making or action
Inappropriate dress, change in hygiene
Sexually inappropriate comments or behavior
Diminished or heightened need for sleep
Frequent job changes and/or moves
Inconsistency in performance, absenteeism
Source: Adapted from reference 9

Bipolar disorder. The trend in psychiatry toward diagnosing bipolar II disorder and “soft bipolarity” in patients previously diagnosed with and treated for major depression presents a new challenge. Despite no change in their history or functioning, a physician whose diagnosis is changed from depression to bipolar II disorder might be moved from a non-reportable to a board-reportable diagnostic category. With the evolving understanding of bipolar spectrum disorders, medical boards may need to revise their screening questions to ensure that they are seeking information about impairment, not simply the presence of a medical disorder.

Seeking special treatment

Self-treatment. Physicians may attempt to treat their mood disorder with self-prescribed medications before seeking consultation from a psychiatrist. Others use alcohol or illicit drugs to try to alleviate mood disorder symptoms. Self-diagnosis

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The lack of distinction between a psychiatric diagnosis and impairment stigmatizes physicians and impedes treatment



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Clinicians who treat physician patients may underestimate the severity of the illness and the patient's suicide risk



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Table 3

Risks of caring for 'VIP' patients

Caregivers, family, and the patient may deny the possibility of alcohol or substance abuse
Caregivers may avoid or poorly handle discussions of death and 'do not resuscitate' orders
The patient may suffer from emotional isolation when protected from the normal hospital culture
The patient's feelings of shame and fear in the sick role can go uncomforted
Caregivers may overlook neuropsychiatric symptoms because they do not wish to 'insult' the patient
Staff may neglect or poorly handle the patient's toileting and hygiene
Ordinary clinical routine may be short-circuited
Caregivers may avoid discussing issues related to the patient's sexuality

Source: Reference 26

and treatment are not advisable because it is impossible to be objective. Professional boards and state medical boards discourage or prohibit self-prescribing because of the need for ongoing evaluation and monitoring for adverse reactions.

'VIP' treatment. When a physician comes to a colleague for help with a mental health issue, both parties might underestimate the severity of the crisis.²⁴ Weintraub²⁵ reported a case series of 12 "VIP" psychiatric inpatients, 10 of whom he described as "therapeutic failures," including 2 who committed suicide and 3 who left the hospital against medical advice. He observed that improvement occurred only after patients lost their VIP status/treatment.

In a literature review, Groves et al²⁶ found delays in pursuing diagnostic evaluation and treatment for physician patients. He described risks of VIP treatment (Table 3),²⁶ including the physician's ability to circumscribe the care regimen to obtain "special treatment," which can create conflict among care providers and other patients. The ailing physician might have trouble relinquishing control. Care providers might not give physician patients necessary information about the illness or treatment because they make assumptions about the physician's knowledge or fear causing narcissistic injury. Providers' identification with their peers, deference to their background, and desire to preserve these patients' autonomy may lead to interventions that are different from those they would provide to other patients.

Treating physicians might underestimate the patient's suicide risk and tend to not hospitalize a physician patient who faces an imminent risk of self-harm. Similarly, a physician patient might know what key words to use to deny suicidal ideation or avoid hospitalization. Providers assessing physician patients should provide the same interventions they would give to nonphysician patients with the same history and suicide risk factors. To do otherwise is to risk a fatal outcome.

Physician health programs provide confidential treatment and assistance to physicians with mental illness and/or substance abuse problems. Some programs are affiliated with licensing boards, some are branches of the state medical societies, and others are independent of the licensing agencies. Directories of these programs are available from the Federation of State Physician Health Programs and the Federation of State Medical Boards (see *Related Resources, page 30*). Physician health programs aim to help impaired physicians receive treatment and rehabilitation without censure or licensure revocation, provided they comply with treatment and monitoring requirements.

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Physician health programs can help physicians find treatment without censure or licensure revocation

Related Resources

- American Foundation for Suicide Prevention. www.afsp.org. 24-hour crisis line: 1-800-273-TALK (8255).
- Center for Patient and Professional Advocacy. www.mc.vanderbilt.edu/root/vumc.php?site=CPPA.
- Depression and Bipolar Support Alliance. www.dbsalliance.org.
- Federation of State Physician Health Programs, Inc. www.fsphp.org.
- National Alliance on Mental Illness. www.nami.org.
- Vanderbilt Center for Professional Health. www.mc.vanderbilt.edu/cph.
- Vanderbilt Comprehensive Assessment Program. www.mc.vanderbilt.edu/root/vcap.

Disclosure

The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

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Bottom Line

Physicians with depression may go undiagnosed or be inadequately treated because of obstacles to seeking and receiving care. Medical boards should focus licensure questions on impairment rather than diagnosis. Psychiatrists should advocate for their physician peers to seek and receive treatment and (if needed) monitoring to enable symptom remission and safe clinical practice.