

Why Do Physicians Kill Themselves

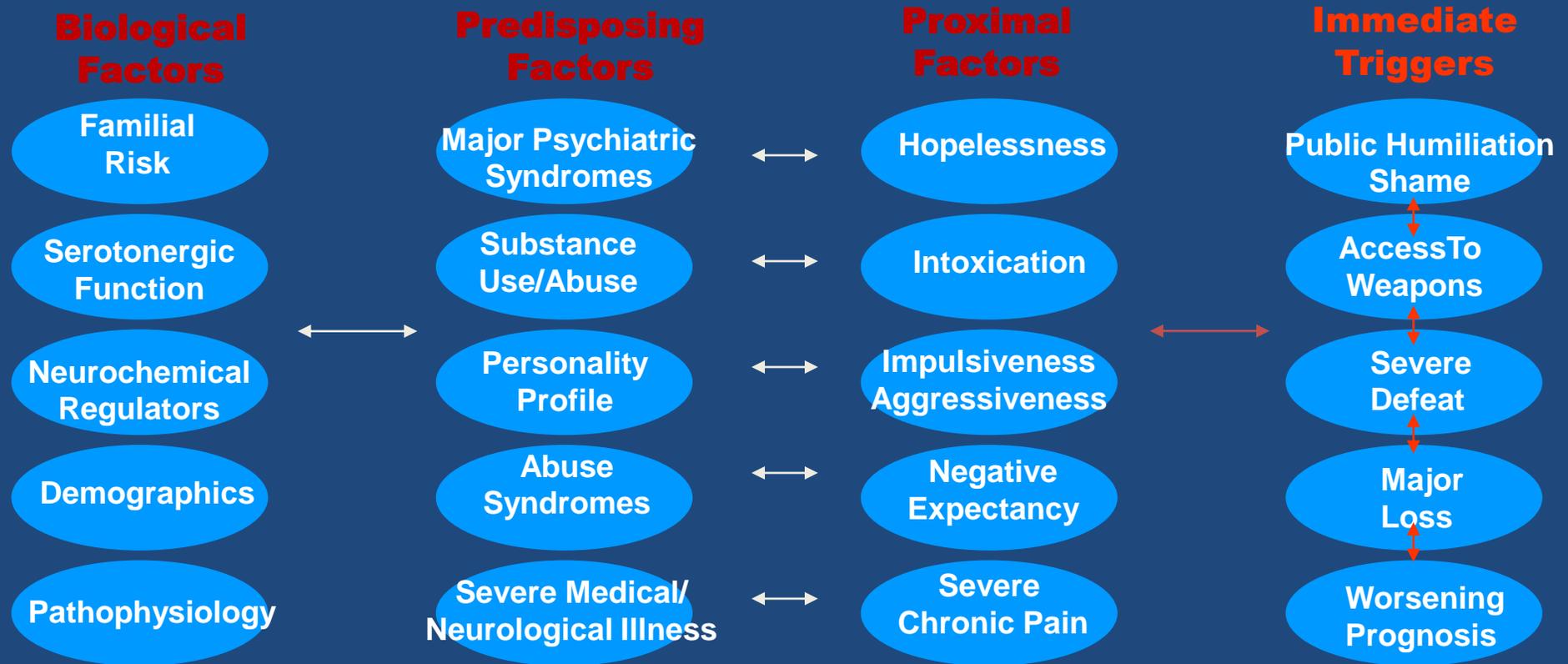
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Disclosure Statement

- Dr Myers serves on the board of directors (emeritus) of the New York City Chapter of the American Foundation for Suicide Prevention without compensation

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)



Background: what do we know?

- 42,773 people died by suicide in 2014 (CDC 2015)
- 85-90% of people who kill themselves have a psychiatric illness
- Every year, three to four hundred physicians take their own lives — the equivalent of two to three medical school classes (Struggling in Silence AFSP)
- Put another way, we lose a doctor a day to suicide in this country
- 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)

Most common illnesses in suicidal MDs

1. Depression and bipolar illness
2. Substance use disorder
3. Anxiety disorder
4. PTSD
5. Severe and unrelenting burnout
6. Underlying personality disorder – borderline, narcissistic, antisocial
7. Chronic, worsening, painful and debilitating medical illness
8. COMORBIDITY!!!!

The culture of medicine

- Demanding without adequate praise
- Overworked and sometimes burned out attending physicians lack humanistic communication skills
- Bullying and abusive teaching in some settings and specialties
- Some sadistic physicians in power can sink the career of a resident, fellow or early career physician
- The 'hidden curriculum' – indifference, cynicism, loss of idealism, ethical breaches, etc
- Trainees with normal or good resilience can survive this – but symptomatic doctors or individuals with 'sensitive' personalities become hurt, self-deprecating and depressed
- **Resilience is not a static monolithic state**

Significant personality traits

- Narcissism – inner sense of self-loathing, severe core anxiety and isolation
- High level of introversion and poor social skills
- Borderline states
- Perfectionism – double edged sword in physicians – may be unforgiving of self
- Need for autonomy – wants to set his/her own agenda, eschews intrusion of others, knows what is best for self
- Rugged individualism – from childhood – a way of going through life
- Exquisite emotional sensitivity

Suicide risk factors in MDs

- Personal history of a depressive episode
- Previous suicide attempt
- Family history of mood disorder/suicide
- Lawsuits and/or medical license investigation
- Professional help being unavailable or inadequate
- Poor treatment adherence
- Refractory 'malignant' psychiatric illness

Challenges in accepting 'patient role' and poor treatment adherence

- *“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 his memorial service)

Remember

- In suicidology, one of the key risk factors in people who die by suicide is a previous suicide attempt
- This does not always apply to physicians
- Doctors who kill themselves are distinguished by the (relative) absence of an earlier suicide attempt
- Or denial of or lying about suicidal action in the past

Stigma kills!

- Yet to be eradicated in the house of medicine
- One of the greatest challenges for medicine in the 21st. century
- Judgmental, ignorant, and discriminatory attitudes toward MDs living with mental illness compound their suffering, increase isolation, delay help-seeking, drive denial and self-Rx, and heighten risk for suicide

Stigma 101 (Myers MF 2015)

- Felt stigma (internal stigma or self-stigmatization) refers to the shame and expectation of discrimination that prevents people from talking about their experiences and stops them from seeking help.
- Enacted stigma (external stigma, discrimination) refers to the experience of unfair treatment by others.
- Felt stigma can be as damaging as enacted stigma since it leads to withdrawal and restriction of social support.
- Symptomatic physicians and their families can experience both types of stigma

Other risk factors in MDs

- We know how to kill ourselves – knowledge of biochemistry, physiology, pharmacology, anatomy and toxicology
- Access to surgical instruments, syringes, IV tubing, insulin, KCl, fentanyl and other narcotics, pharmaceutical samples
- Self prescribing vs falsified writing of Rx for family members

The grandson of a physician

- “I remember having the thought that Maurie was a lucky man because he was a doctor and as a doctor he knew how to kill himself – and I don’t know how. I remember being angry and jealous that Maurie Grossberg knew how to kill himself and I didn’t”
 - The words of Jeff Wolk as he recounts being depressed and suicidal. He is the grandson of Dr Maurice Grossberg who died by suicide in 1939 at the age of 43. From “Last Glimmer of Day” and personal interviews with MM

The words of a surgeon who survived a near lethal suicide attempt

- Me: “Do you know where you are?”
- She: “Yes, I’m in an ICU somewhere”
- Me: “Correct. Do you know what happened?”
- She: “I sure do. I took too many pills. I wanted to die. I mean...I want to die”
- Me: “I’m glad you didn’t. I’m happy you survived”
- She: “You are? I’m so embarrassed. I feel ashamed of myself.”
- Me: “Don’t be. You’re in a good place here. Nobody is judging you. The staff here just wants you to get better”
- She: “But I really blew it. What kind of a surgeon can’t even kill herself properly?”
- Me: (taking a risk and attempting some humor) “I didn’t realize that knowing how to kill yourself was a requirement of the American Board of Surgery”.
- She: (smiling slightly) “Good one doc”
- Me: “Get a bit more rest. Then you and I got some work to do. Your depression is still there and it’s got to be treated. We’ll keep you safe here until you’re feeling better”

Why People Die By Suicide

(Joiner Thomas, Harvard University Press, Cambridge, 2005)

1. “Perceived burdensomeness” – a sense that one is a burden on others
2. “Failed belongingness” – a sense that one does not belong to a valued social group
3. “Learned fearlessness” – the acquired capability to enact lethal self-injury

“Learned fearlessness”

- ‘.....the kind of exposure to pain and fear that people also might learn through such experiences as mountain climbing, performing surgery, fighting in wars or being afflicted with anorexia’

Treating suicidal physicians

- Suspicion of suicidal thinking and planning
- Artful thorough and dynamic suicidal risk assessment and formulation in the context of trust and mutual respect
- Document, document, document
- Detailed inquiry of means/method – stockpiled meds, self-prescribed meds, internet ordering of meds, meds stolen/diverted from the workplace, firearms
- Hospitalize for safety – this should be judicious and in consultation with others
- Close follow-up after discharge

Treating suicidal physicians

- Obtain old records of Rx – speak to previous treating professionals
- Collaborative information (especially loved ones) – push for this
- Second and third opinions – especially a good psychopharmacologist
- Work closely with state physician health program if involved
- Practice biopsychosocial treatment model

Treating suicidal physicians

- If split treatment, insure regular contact with psychotherapist and document all communication and any change in status, medication or psychotherapy modality change
- Watch for emerging or masked bipolar illness in treatment resistant depressed MDs
- Insure that any comorbid SUD is being properly treated

Treating suicidal physicians

- Pay attention to transference and countertransference issues that are ubiquitous when one physician treats another
- Always remember that your patient is a hurting individual who just happens to be a physician – do not lower your high standards
- Refer for evidence-based psychotherapies – CBT, DBT, CAMS (Collaborative Assessment and Management of Suicidality) and more

Treating suicidal physicians

- Watch for dangerous symptoms – intractable sleep disturbance, rapid cycling, agitation and emerging subtle psychotic symptoms – act fast and appropriately!
- Brief inpatient hospital stay may be life-saving
- Be kind, compassionate, thorough and clear when you need to be firm, paternal and physicianly – never forget the terror, desperation and shame that lurks behind symptomatic behavior in ill doctors

The words of a physician who survived a near lethal suicide attempt

- My hope is that through the telling of my story, it will encourage others battling depression to realize that relief and success is possible for them as it was for me despite the most direst of circumstances and the most severe and recalcitrant of depressions - the core belief that you are defective is one of the hardest to overcome, but it is possible and there is hope through intensive work with a clinical psychologist and optimization of anti-depressant therapy by an experienced psychiatrist.
 - Interview with Dr Anonymous by MM April 3, 2015

Treating psychiatrist of a physician

- “I am very grateful that I was at his bedside in ICU with his family when he was taken off life support. Such an intimate and sacred time in a secular setting. I got the chance to say ‘goodbye’ and this was helpful in my healing ”
- “Three days later, I received a note in my hospital mail. It must have been written and posted just before he hanged himself *“Dear Dr Myers, sorry I couldn’t go on. I know you tried hard but I’ve lost faith that I’ll get well again. Sorry. Please help my mom. Thanks for helping”*”
 - Words penned after the suicide death of my patient Dr Z who died in 1997 at the age of 43. I had been treating him for 4 years.

Helping grieving medical communities

- You may be called when a beloved physician has died by suicide and the entire medical community is in shock and reeling
- Or in an academic setting when a trainee or faculty person has killed herself/himself
- You can assist by offering to meet with those affected and/or suggest local resources that are at arm's length and provide a safe, non-judgmental setting for all to come together and talk (or be silent)

When a medical colleague dies by suicide

- Mourning
- Systemic anxiety
- Guilt and blame
- Anger and rage at the deceased
- Business as usual

(see Table 11-6, p. 201. The suicidal physician, in *The Physician as Patient: A Clinical Handbook for Mental Health Professionals* (Myers & Gabbard, APPI, 2008)

A family physician's story

- “One of our classmates had taken his own life... and so we found ourselves at his memorial. As I sat there I wondered if any of the speakers would have the courage to address the issue of suicide. Fortunately, one of them, a physician, did, and he reminded us that we have a responsibility to care for each other as we do our patients”
 - Lee J. Physician's suicide prompts introspection, outreach. AAFP. Feb 19/2015. President-Elect California Academy of Family Physicians
 - Interview with MM May 4, 2015

Wise words from the trenches...

- “If given the opportunity to treat a fellow physician, psychiatrists should double their compassion and double their skepticism”
 - Stated by Dr ‘Mark’ after the suicide death of his psychiatrist brother (Myers MF. Videotape. When Physicians Die By Suicide. 1998)

More wise words....

“Distinguishing between bipolar depression and major depressive disorder, for example, can be difficult, and mistakes are common. Misdiagnosis can be lethal. Medications that work well for some forms of depression induce agitation in others. We expect well-informed treatment for cancer or heart disease; it matters no less for depression.

Because I teach and write about depression and bipolar illness, I am often asked what is the most important factor in treating bipolar disorder. My answer is competence. Empathy is important, but competence is essential.”

Jamison KR “To Know Suicide” Op-Ed New York Times August 15, 2014

Thank you!

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