

## A PIECE OF MY MIND

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## Healing Physicians

**Last fall**, I sat in a group therapy room listening as a new patient introduced himself and timidly described his recent daily routine. He explained that after work each evening, he stopped at a convenience store to purchase alcohol, then sat in the parking lot, drinking in his car so he could cope with going home to his family. The patients sitting around the circle all nodded in understanding. Many offered words of encouragement, and several shared similar experiences. Like this patient, all members of the therapy group were physicians, and all had recently come to an addiction treatment center after trying unsuccessfully to manage on their own. Development of a substance use disorder is fairly common among physicians,<sup>1</sup> yet the issue remains inadequately addressed. A “conspiracy of silence” among physicians keeps those suffering from addiction hidden, allowing their disease to worsen. It also inhibits physicians in recovery from sharing their success experiences, which otherwise could encourage those who are struggling to seek help.

Last winter, I sat in the well-decorated office of a successful physician colleague who shared his own story with me, describing how stressful life events and the pressures of his medical practice had recently stretched his psychological resources past the breaking point. He became irritable at home and at work, feeling he was a disappointment to everyone. Then, overcome by depression, he secretly began plotting the “perfect” suicide. Fortunately, he learned he was not alone; others he greatly respected were also suffering. As they described their own difficulties, he was able to admit his desperation. After seeking psychiatric treatment, he resumed his roles as a beloved physician and teacher. Sadly, there are too many stories of physicians in crisis and too many tragedies involving physicians who were not reached in time. An estimated 400 physicians die by suicide in the United States each year, exceeding rates among peers in the general population. Most physicians who die by suicide do not receive any mental health care before their death.

Last spring, I sat in the audience of a medical student-sponsored forum on mental health care for medical students. Although the event was optional and was scheduled during the “free hour,” the venue was packed. Students stood in the aisles or behind rows of chairs to hear from the graduating students who volunteered to share their experiences. The panelists described the challenges of trying to succeed in medical school while struggling with depression, anxiety, and other psychiatric conditions. They listed concerns such as stigma, difficulty scheduling therapy appointments, and fear of academic or professional liability related to seeking mental health care, noting that they were initially uncomfortable discussing their struggles with faculty, friends, or even family. How-

ever, the students also conveyed strong messages of hope, describing how their well-being had improved after obtaining appropriate care and encouraging the audience members to use the counseling office as a resource for obtaining help at the first signs of distress. Studies consistently demonstrate that anxiety, depression, burnout, and general psychological distress are common among medical students. Unfortunately, only the minority seek mental health care due to stigma and other negative consequences.<sup>2</sup> Many others suffer throughout training, compromising their well-being and diminishing their ability to learn.

Last month, I sat in a restaurant and learned about a physician in solo practice who had just taken her first vacation in almost two years. Her long days of patient care combined with long evenings spent charting and even longer nights on-call had taken their toll. After less than a week away from the stresses of private practice, she had broken down sobbing, overcome with dread at the prospect of resuming the same frantic pace of life. Upon return to work, she found herself overwhelmed and unable to manage her caseload. After leaving her office to meet with her personal physician that afternoon, she was admitted for inpatient psychiatric treatment under a Baker Act (ie, the physician was involuntarily admitted for emergency care). Rates of psychiatric illness and burnout among physicians have been growing over the past few decades. Yet much like physician trainees, many physicians do not seek medical care for their own physical or mental health conditions, suffering in silence until they reach a breaking point.

Last week, I stood in front of a bustling department at a well-respected academic medical center to present grand rounds on the topic of physician distress. After being confronted with the dire statistics about physician burnout, depression, and suicide, the physicians in the audience remained most concerned about how seeking mental health care could negatively impact a physician in practice. They pointed to difficulties with licensure, practice restrictions, increased cost of malpractice and disability insurance, and other real problems associated with receiving treatment for psychiatric or substance use disorders. They noted the high perceived cost-benefit ratio as a significant barrier and acknowledged concern that referring a colleague for treatment might have significant negative consequences. Despite the fact that physicians in most states may seek confidential assistance from a physician health program, not all physicians have this option, and some may be required to report treatment when applying for licensure. Calls to make confidential treatment available for all physicians and physician trainees, just as it is for nonphysicians,<sup>3-5</sup> and to facilitate re-entry following treatment<sup>6</sup> have been thwarted by vague concerns about “hiding dangerous doctors.” As a result,

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the pressure to hide any struggles prevents physicians from seeking help. This puts our physician workforce at greater risk while we already face a shortage of qualified health care professionals. As a result, rather than protecting patients, these policies primarily serve to deny access to health care for physicians and likely have significant detrimental effects on patient safety and public health.

Today, as I sat in my office, I was contacted by the director of graduate medical education at a large academic health center who was seeking guidance about what to do for resident physicians in crisis. Despite recent efforts to improve resident knowledge, awareness, and access to mental health services at their institution, a member of the house staff had attempted suicide in the past few days. The administrator noted that the gravity of the resident physician's condition had been downplayed by the resident and her friends, due to fears that the resident would "get in trouble" or lose her job. This cover-up resulted in delayed care with almost fatal consequences. Though the field of medicine is becoming more aware of the mental health risks of residency training,<sup>7</sup> more effort is needed to find solutions quickly and efficiently, before more careers and lives are lost. Physician health is not only an issue at "other" institutions. This is a real, significant, and growing problem that needs immediate attention at the global level. It is vital that physicians be encouraged to acknowledge their own distress and afford themselves the same care and consideration they give to patients.

At the heart of excellent medical treatment is the physician who provides competent, compassionate care. So, rather than treating physicians as dispensable and teaching them to put themselves, their health, and their well-being last, we must teach medical students, residents, and practicing physicians that they have a responsibility

to maintain their physical and mental health and to reach out to colleagues who appear to be struggling. Physicians already face pressure to work harder, faster, and longer on a daily basis. This burden begins during medical school and continues well into practice, with spoken and unspoken directives to put patients first; to avoid burdening colleagues; to pick up the slack for team members; to forego vacations; to come to work even when physically ill. But the evidence clearly demonstrates that this way of life is not sustainable, and it does not promote excellence in the practice of medicine. Ironically, when a physician neglects her own well-being, she does a disservice to her patients; when he ignores his own distress, he places undue burden on his colleagues to compensate for mistakes. Yet the recent focus on improving patient safety by targeting medical errors—though extremely important—has largely ignored this vital underlying contributor to quality of patient care.

The time has come to finally and emphatically demand that physicians deserve humane expectations in training and practice and have a right to opportunities for self-care. Taking appropriate breaks or vacations, spending time in mindful meditation, completing self-help interventions,<sup>8</sup> sharing personal/professional struggles with colleagues, and seeking necessary medical and mental health treatment should be viewed as a marker of professionalism, not a sign of weakness. As more physicians share their personal stories of recovery from psychiatric, psychological, and substance use disorders, the stigma will begin to lift. As more educators and supervisors support physicians who seek appropriate care at the first signs of burnout, much anguish and despair will be avoided. As policies are changed to allow physicians to confidentially obtain the mental health care they need, patient care will improve, and physician quality of life may be restored.

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