

Depression and Suicide Among Physicians

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Depression and suicide in physicians are problems generally given too little attention. Depending on specialty, we learn varying amounts about how to evaluate the symptoms of depression in our patients, but little emphasis is given to identifying depression or potential risk for suicide in our colleagues or ourselves, nor are most physicians trained to understand the specific difficulties physicians have in seeking and obtaining treatment for these problems.

Depression occurs commonly, with about 20% of individuals in the general population experiencing a significant depressive episode at some point in their lives. Physicians have a rate of depression similar to that in the population, with 13% of male physicians and about 20% of female physicians reporting an episode of clinical depression during their lifetimes. Medical students and residents experience depression at even higher rates, with some studies estimating the rates as high as 30%.

Depression can lead to significant emotional distress or impairment in social life, home life, and work. Both depression and substance disorders have been identified as major risk factors in the high rate of suicide in physicians, with more than 90% of those physicians who suicide having a history of mood disorder and/or substance abuse. Suicide rates in physicians exceed those in the general population-about 70% higher for male physicians compared to non-physicians and about 250% to 400% higher for female physicians.

Identifying Depression

Although physicians are called on to diagnose depression in patients, recognizing this mood disorder in themselves or colleagues poses particular challenges for a variety of reasons.

In many ways, depression in physicians manifests like depression in the general population, but it occurs in a context of stress and demands that sometimes complicates the diagnosis. Many physicians come to Colorado Physician Health Program (CPHP) because of stress secondary to patient care, to administrative politics, to decreasing autonomy, to increasing financial strain, or to lawsuits. They may find themselves irritable with family or co-workers, or suffering from insomnia, or more withdrawn from efforts to manage increasing demands. While these can be normal responses to stress, if they persist for long periods of time or progressively worsen, these reactions may represent the onset of a mood disorder. Many physicians postpone evaluation because they believe that they are experiencing expectable reactions, but the delay in treatment can lead to a worsening of symptoms.

Physicians as a group have some characteristics which lead to special difficulties in confronting depression. Physicians tend to deny illness, likely because of anxiety about being seriously ill, or because of fears of the effect of an illness on ability to earn a living or on professional standing. This tendency may be all the more pronounced in the context of mental illness and its associated stigma. Many physicians have a need for control which can make it difficult to accept a patient role and to ask others (perhaps especially other physicians) for help.

Often, physicians find it difficult to consider depression in a colleague, let alone to confront a colleague having problems. Since depression can lead to significant psychological distress and eventual work impairment, and is an identified risk factor in the increased suicide rate in physicians, it is incumbent upon all of us to pay attention to warning signs of depression and suicide in our colleagues. While these warning signs are not specific, they may indicate the need for concerned questions or recommendation for evaluation. Physicians with depression may have a decline in job performance or a higher rate of absenteeism. They may become noticeably more withdrawn, irritable, or argumentative. They may be unable to take customary care of their appearance. Depressed physicians may begin to more frequently complain of aches and pains or express concerns of illness. Importantly, problems in depressed physicians may show up in the workplace last, after symptoms have led to withdrawal from community or recreational activities, problems with friends or peers, and eventually difficulties in relationships with family.

Similar Risk Factors for Suicide

Risk factors identified for suicide include mood disorders and substance use problems. The stresses that make physicians more susceptible to the development of depression may also make them more at risk for eventual suicide. Many physicians work long hours, which can deprive them of time spent with supportive family or friends. Long hours can also add to conflict internally and with family between work and personal life. Losses in personal and professional life, financial problems, career dissatisfaction, administrative problems, and excessive professional demands can all contribute to an atmosphere of stress. A special danger for physicians who attempt suicide is that they are more likely to succeed than are those in the general population, possibly because of a greater familiarity with drugs.

Barriers to treatment include both physician personality characteristics and very real concerns about the consequences of seeking treatment. As noted above, physicians may be reluctant to admit vulnerabilities and experience the loss of control that might accompany acknowledgement of mental health issues, or they may simply deny their illness as long as they believe they can function in the workplace.

Physicians may believe that they ought to be able to manage their mood disorders themselves, which can end up with decisions to self treat. Many physicians with depression who present to CPHP relate some history of self medication, leading to inadequate care. As a secondary problem, self treatment may deprive physicians of the support of therapy, which at times is a critical treatment modality for worsening depression. Physicians may also receive inadequate care through “curbsiding” rather than seeking a complete evaluation with development of an appropriate treatment plan. Even in cases of formal consultation, treating clinicians may complicate treatment by deferring to the physician-patient’s ideas of treatment, or by over identifying with the physician-patient and missing more serious illness.

Many physicians worry that the confidentiality of their health problem will not be respected. They worry that peers or office staff may learn about diagnosis or treatment of depression or that reporting may be required to the BME (see below) or to hospital credentialing boards. They may worry that they will be prevented from practicing because a diagnosis of depression will be seen as an indication or confirmation of impairment and inability to practice. Physicians may be concerned that they will be denied health insurance, disability policies, or malpractice insurance if they acknowledge a mental health problem.

The Role of CPHP

CPHP was created to help physicians with problems such as depression, which, if untreated, could impair a physician’s ability to practice. CPHP can provide evaluation of physicians with depression and referral for treatment. CPHP works with physicians to determine whether their illnesses can be managed in a way that allows ongoing practice of medicine, or whether they are truly impaired in the ability to safely provide medical care. At times, the BME refers physicians to CPHP for evaluation in order to ensure that they receive the treatment and monitoring necessary to allow for safe function in the workplace, or to determine if a physician may be unable to practice.

CPHP evaluates many physicians who self refer, which, except in cases of significant impairment, allows them to choose the “safe haven” provision when applying or re-applying for licensure. This option allows physicians to maintain confidentiality about their illness from the BME so long as they are monitored by CPHP and are not significantly impaired.

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