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Suicide in Physicians: Toward Prevention
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No one talks about suicide -- especially in the medical community. When Carla Fine's husband, a prominent New York physician, killed himself, his colleagues reacted to his unexpected death with extreme discomfort and collective silence regarding the circumstances.[1] Her initial reaction was to cover up her husband's death in order to "protect" his medical reputation and preserve his legacy as a healer and fixer, and this placed a huge burden on her emotional state.

Ms. Fine's husband, who was in private practice and on the staff of several hospitals, used his medical expertise to prescribe and self-administer a lethal overdose of intravenous thiopental. His devastation concerning the death of both of his parents within a short period of time never appeared to interfere with his practice of medicine or his functioning as a physician, and his devotion to his work confused her as to his true state of mind.

The medical community rejected Ms. Fine outright, despite a long history of both professional collaborations and social interactions with her and her husband. In her book *No Time to Say Goodbye: Surviving the Suicide of a Loved One*, she describes similar experiences of immediate "banishment" by the medical community of other spouses of physicians who killed themselves, which serves to increase and reinforce the survivor's feelings of guilt, shame, and isolation.[2]

In addition, while many suicide survivors of physicians recount how their loved ones were visibly depressed or impaired in the months and days preceding their deaths, they express amazement and resentment that this behavior was tolerated and/or ignored by the medical community. There is widespread agreement about an immediate need for increased discussion and preventive measures for physicians about the topic of suicide, beginning in medical school and continuing through their entire professional career.

According to psychiatrist Michael Myers, MD, the stigma attached to mental illness is greater in the house of medicine than in the general public.[3] Stigma, a pernicious force, reinforces denial in physicians that they might fall ill, contributes to their delay in getting medical care, compounds suffering, confuses and frustrates doctors' families, drives self-medicating, and dangerously heightens the risk of death by suicide. And when physicians do kill themselves, the conspiracy of silence surrounding their deaths may aggravate feelings of isolation and shame in their survivors -- and thwart our public health efforts at prevention.

The psychiatric disorders most associated with suicide in physicians are: major depression, bipolar illness, alcohol and other drug abuse and dependence, anxiety disorders, and some personality disorders (especially borderline personality). Doctors with a dual diagnosis of a mood disorder and substance use are most at risk. The profile of a physician at high risk for suicide includes these variables: male or female; age 45+ (female physicians) or 50+ (male physicians) years; white; divorced, separated, or single; alcohol or other drug abuse, workaholic, gambler, risk taker, thrill seeker; psychiatric symptoms of depression and anxiety; physical symptoms of chronic pain or chronic debilitating illness; change in (or threat to) status -- autonomy, security, financial

stability, recent losses, increased work demands; access to lethal medications; and access to firearms.[4]

Empirical research about the epidemiology of depression in doctors[5] and anecdotal reports document that physicians are vulnerable to mood disorders. Several factors have been postulated. Many physicians are "wounded healers" -- their personal experience with loss, abuse, trauma, and family conflict while growing up has attracted them to a helping profession. Some are genetically predisposed because there is mental illness in their families. Some physicians have suffered psychiatric illness in adolescence, college, or medical school -- they may have another episode later. Many physicians are hard-working and driven perfectionists who don't cut themselves much slack -- they are prone to undue guilt, self-recriminations, and despondency. Medical work is often rigorous -- long and/or irregular hours, frequent on-call time, night and emergency work, sleep interruption and loss, and tending to very sick and dying patients can take a toll on health and a positive outlook on life. And a high percentage of physicians have alcoholism in their family histories -- whether it is genes or modeled behavior or both, doctors have to watch for chemical dependency in themselves.

Because physicians are notorious at avoiding getting help when they are ill, mental health professionals who treat physicians must respond quickly when a physician calls.[6] The doctor may already be very symptomatic, weak, despairing, and suicidal. A thorough biopsychosocial assessment is imperative (preferably with collaborative information from a loved one) and is essential in instituting an immediate, short-term, and longer-term treatment plan.[7] Assessment for imminent suicide is no different from assessment for lay people: if hospitalization is necessary, including involuntarily, this must be done. Concerns for the physician's privacy, confidentiality, and reputation are to be respected, but safety must never be compromised. The treating professional should always remember that the patient is a suffering individual first, an individual who just happens to be a physician.

Too often, physicians' families feel left out of the loop. They are essential to provide much needed information to the treatment team (given physicians' tendency to deny, minimize, rationalize, and sometimes "outsmart" the professionals). They need and deserve medical information and explanations. They warrant compassionate support. Not uncommonly, the physician's spouse and/or child or children may themselves need an assessment or treatment. They can often benefit from support groups that may be available in the community (National Alliance for the Mentally Ill, Depression and Bipolar Support Alliance) or through the county or state physician health program.

If a physician dies by suicide, it is recommended that the treating professional meet with the family. Respecting confidentiality, these meetings can be very helpful and therapeutic for all parties. Many therapists attend the funeral or memorial service. If the physician was in a hospital at the time of his/her death or died shortly after discharge, critical incident debriefing is essential for the staff. And so are psychological autopsies or presentations at Morbidity and Mortality Rounds. And the therapist should reach out for personal help -- whatever form that might take. How else do we heal? How else do we learn?

Enormous advocacy work needs to be done -- beginning with orientation programs for first-year medical students. They need to know that they are precious and are cared about. In addition to education and making health services available to them and to physicians,

we need to keep fighting the culture of medicine that rewards punishing work, harassment in our medical centers, inappropriate self-sacrifice, neglect of our families, and eschewing of our responsibility to each other as brothers and sisters in medicine. We need to laud physicians who "come out of the closet" and tell their personal stories of living with psychiatric illness.[8] We need to listen to the stories of husbands, wives, and children of doctors. We need to fight stigma, in word and deed, until it is completely eradicated from our society.

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