

# Physician Suicide:

*risk factors and prevention*

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**A** surgeon, depressed and desperate, jumps from a fifth-story balcony, falling to his death. A young family physician, struggling with drug dependency, places a plastic bag over his head, secures it around his neck with tape, then injects himself with a lethal overdose of narcotics,

assuring that if the injection doesn't cause death, asphyxia will. And, as the national media has recently highlighted, a GP psychotherapist and new mother jumps in front of a subway and dies a week later.

All of these events, and many others like them, have happened recently in Canada. But this last instance of physician suicide captured public attention because the woman carried her six-month-old son in her arms with her to oblivion.

Physician suicide is not a new phenomenon. Every time a physician takes his or her own life, family, friends, patients and colleagues are deeply affected. When it happens, we quietly and uncomfortably take note. Sometimes we're surprised or confused. If we knew the physician, we were unlikely to have been aware of the extent of their suffering. We feel the ache of sadness, of senseless loss, then we move on. But with their passing, they have taken a piece

of us with them.

Why did this happen? Could we have helped? What about their family afterward? Can such a tragedy be prevented?

Perhaps the question which most are left asking is the essential paradox of physician suicide: Why do individuals, trained to respect, promote and preserve human life, end their own prematurely? And, surrounded by healing resources as they practise their craft, why have these services not been effective at preventing this outcome?

Much has been written about physician suicide in an attempt to answer these questions and others. A detailed review of this issue may be found in *The Handbook of Physician Health*, published by the American Medical Association.<sup>1</sup> It is beyond the scope and intent of this article to review this literature, but a few essential elements must be addressed.

Most published data, based upon

studies conducted in the United States and elsewhere, place physician suicide rates at 30 to 40 per 100,000 population per annum, rates at or above those of general populations, even when matched for age and gender. Female physicians are reported to commit suicide at a rate much greater than matched groups of women in society (30 to 40 per 100,000 versus 10 to 12 per 100,000 respectively).<sup>2</sup>

The American studies are summarized in the chapter on suicide in *The Handbook of Physician Health*, written by Dr. Morton Silverman. This data must be considered in light of methodological difficulties in conducting such studies that daunt our ability to know the truth, including non-standardized and haphazard case finding protocols, inconsistent case definitions, poor or inaccurate record-keeping in instances of physician death, no investigation of uncertain causes of death, difficulty of matching to comparison groups, and more.

All of this might mean that actual physician suicide rates are even higher than currently estimated.

There is a notable paucity of published Canadian data regarding physician suicide, but an unpublished study conducted over the last 10 years by Dr. Douglas Graham of the Physician Support Program in British Columbia is quite revealing.

Dr. Graham reports that the annual physician suicide rate in B.C., considering all cases he could identify between 1991 and 1998, was 21.9 per 100,000 population. The suicide rate in the entire population (unmatched) over the same period was 13.9 per 100,000 per annum.

Among other professional groups in B.C., Dr. Graham reports suicide rates of lawyers and nurses to be very similar to that of the general population, while dentists committed suicide at a higher rate than doctors, namely 27.6 per 100,000.

We may conclude that physician suicide, while not a frequent occurrence, is not uncommon. Whatever the actual rate in Ontario, or Canada, or among male or female physicians, it's too high.

Why do some doctors take their own lives? Suicide does not occur without some underlying causal factors or predisposition. Suicide is a natural, albeit extreme and final, outcome of a number of disorders when insufficiently treated. Most notably, suicide is strongly associated with psychiatric illness, including mood disorders (especially depression) and substance use disorders. Physicians who suffer from these disorders are at risk.

The trappings of life, possessions or material wealth, probably have little to do with suicide risk. Often, physicians who have committed suicide have experienced significant losses: failure of important relationships, the death of loved ones, financial setbacks, revocation or suspension of professional licence, reputation damage by any real or perceived insult, an inability to work or enjoy work for any reason.

A positive family history of suicide and the conditions which lead to it, previous suicidal gesturing, and access to lethal drugs, along with knowledge of their use, also contribute to physician suicide.

Significant stresses usually precede suicide, and doctors experience considerable strain in their role as healers. As listed in the *Handbook of Physician Health*, role strain involves

at least three areas of challenge for the physician to master:

1. Inordinate time and work demands.
2. Extraordinary sense of responsibility for human life and death.
3. Inadequate and inconsistent psychological supports.

The first two are easy to understand. The third point requires some examination.

Why might a physician in pain fail to seek and use the supports and services that would alleviate his or her suffering?

First, it must be recalled that the common disorders that lead to suicide also impair insight and judgment. Depressed or substance-dependent physicians may deny the extent of their problem, or feel that they can manage their symptoms themselves.

Some physicians succumb to the temptation to treat these disorders themselves and prescribe antidepressant and sedative medications for personal use.

Few physicians have their own family doctor, or if they do, they are often unwilling to disclose their symptoms when they are so "secret" or emotional in nature.

A sense of shame and stigma still exists for anyone experiencing these feelings — maybe even moreso for physicians, who are often trained, and regarded, to be able to rise above such problems. Perfectionistic and proud, they suffer in silence, successfully portraying a calm and competent outward appearance.

Medical training includes significant experience of self-denial. Physicians learn to go without sleep, meals, recreation and time with family and friends as a matter of routine while acquiring the vast amount of knowledge and skill required to practise medicine. Many will continue to deny their own personal needs while serving those of others in medical practice. This pattern of behaviour may be deadly for a doctor prone to suicide.

Many suffering physicians may not be aware of the services available to them. Or, if they know of them, they

may be reluctant, or even afraid, to use them. Some mistakenly believe that if they confide in a treating physician, that physician will notify regulatory authorities. Sometimes doctors experiencing litigation stress are advised not to talk to anyone about their case. They interpret this as a prohibition upon calling for personal help, fearing that records damaging to their legal case will be created.

Fear of discrimination from life and disability insurers is another reason for reluctance to call for help. These fears, mostly, but perhaps not entirely, based upon misperceptions, are transmitted to spouses and others who would be in a position to call for help. Thus, they remain silent as well.

These factors, and more, merge to create the most tragic irony: physicians, healers in our society determined to reduce and prevent suffering in others, are themselves peculiarly vulnerable to the ultimate expression of human distress — death by one's own hand.

Prevention of every case of physician suicide is not possible, but individually and collectively there is much that can be done.

Any physician who suffers actively from a disorder prone to suicide, who has experienced significant strain or loss, who expresses or demonstrates suicidal thought or intent, must be viewed at high risk for suicide. Such a case is a medical emergency. Expert, objective care must be provided as soon as possible, by any means available, including involuntary commitment for psychiatric assessment.

It is the responsibility of the medical profession to improve medical training and the process of professionalization in order to promote self-awareness, healthy self-care practices and lifestyle balance for doctors as core values.

Physicians and their family members must be educated about risk factors, the subtle and overt signs of physician distress, professional obligations toward one another and the services available to respond to physicians in need.

Where lacking, physician support

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services must be developed. Naturally, efforts must continue to reduce physician role strain at all levels and for all reasons.

### OMA Physician Health Program and Helpline

The Ontario Medical Association offers resources to assist physicians and their family members who may be in distress.

The OMA Physician Health Program (PHP) is designed to help physicians and their families deal with problems of substance abuse.

In recent years, the PHP has received a growing number of calls regarding physicians experiencing personal problems of other types.

All callers are offered brief problem assessment by PHP staff and appropriate referral to helping resources around the province. Each case is dealt with on a confidential basis.

To obtain further information, or to inquire about confidential coun-

selling services, contact Dr. Michael Kaufmann, Medical Director, OMA Physician Health Program, at 1-800-851-6606 or (416) 340-2972.

Dr. Kaufmann's Physician Health column appears bimonthly in the *Ontario Medical Review*.

The OMA Helpline is a service that offers collegial advice on an anonymous basis to any physician caller anywhere in Ontario.

Names of Helpline volunteers and their telephone numbers are listed in the full-page Physician Health Services advertisement, which appears monthly in the *Ontario Medical Review* (see p. 18).

### Personal reflections

Any suicide is tragic, but the suicide of a physician can be especially devastating. Many are left feeling deeply saddened, abandoned, guilty, and even angry when a physician dies prematurely in this way.

To the friends and loved ones who

remain: we respect your grief and share it in our own way, we pray for your eventual comfort and we are here to help as best we can.

To those who have left us: we wish you could have confided in us, we're angry that we let you suffer and were not able to help, we are sorry if we let you down in any way...and we miss you.

OMR

### Endnotes

1. Goldman LS, Myers MM, Dickstein LJ, eds. *The Handbook of Physician Health*, American Medical Association, 2000.
2. Ibid.

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