



## **PFSP Perspectives: Alberta Doctors' Digest**

### **A physician-public health imperative: Respond to physician mental illness and suicide**

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It was the early 1980s. As a young family physician, I had been sitting on the medical staff executive for only a few months. With no information provided, I recall being summoned, along with the rest of the executive, to the hospital administrator's office one day.

There had been an allegation that a surgeon was seen taking cocaine from a cart in the emergency room; he was to appear before all of us at high noon for an inquiry and with regard to a possible suspension.

He did not show. We discovered none of his family or local colleagues and friends had been notified to support him through these potentially devastating developments. We were dismissed but I received a call in my office later that day. The surgeon had been found on his rural property – he died by suicide.

I agree with authors Dr. Michael F. Myers and Carla Fine: "Suicide touches you and you are never the same. We know from experience."<sup>1</sup>

The account from Dr. Helen Tolhurst, an Australian family physician, may sound familiar: "I felt ashamed of my inability to cope and being unable to talk with my colleagues about the desperation I was feeling. My practice partners were overloaded with work and I felt that to tell them how miserable I was would just sound like whining. So I struggled with my depression, trying to hide how I was really feeling from those around me. Looking back, I sometimes wonder how I survived."<sup>2</sup>

### **Physicians suffer mental illness, too**

One in five Canadians of all ages, education, income levels and cultures will experience a mental illness.<sup>3</sup>

Like other Canadians, physicians not uncommonly suffer from the gamut of mood and anxiety disorders, post-traumatic stress disorder, eating disorders, obsessive compulsive disorder, adjustment disorders and personality disorders. Issues within our marriages and our families may also impact our mental health.<sup>4</sup>

We know physicians experience depression as commonly as the general population. In cross-section, residents and medical students experience a higher level of depression than the general population.<sup>5</sup>

Substance-use disorders (e.g., alcohol) are as common with physicians as anyone else. Many physicians with substance-use disorders have concurrent mental illness.<sup>4</sup>

Mental illnesses have associated mortality. Four thousand Canadians are lost every year to suicide.<sup>2</sup> These Canadians include our patients, neighbors, loved ones and colleagues.

The 2004 *Journal of the American Medical Association (JAMA)* consensus statement on physician depression and suicide reports physicians having higher suicide rates as compared to the general population. The relative risk for male physicians is 1.1:3.4 and for female physicians 2.5:5.7.<sup>5</sup> Current Canadian statistics are unavailable.

Two questions:

- What priority does **Canadian culture** put on mental illness prevention, early intervention and treatment?
- What priority does **our culture of medicine** put on mental illness prevention, early intervention and treatment?

The best principles of public health are important for our medical culture to endorse and practise.<sup>6</sup> This is particularly important as we know that taking better care of ourselves and our colleagues translates into better care of our patients.

### **We need to give up our self-treatments**

Physicians respond to their own mental illnesses in many ways. Many deny their illnesses. Others have anxiety or feel shame with regard to having a serious illness. Many struggle as they attempt to control their symptoms, their treatment or the lack thereof.

Physicians may fear the impact of such illnesses on their financial situation. Moreover, they may fear the risk to their professional standing, whether in the local hierarchy of their department, their academic centre or with the regulatory body.

Do we suffer in a more pronounced way because of the stigma towards mental illness in our medical culture?

Have you used vernacular language in describing patients or colleagues with a putative mental illness? Do we consider the impact of our thoughtlessness and expression of stigma on our patients, our families or our colleagues?

A psychiatrist who regularly treats physicians suffering with depression commented, "The hard-ass attitudes of some specialties and departments certainly do not make it easy for people to seek help."<sup>7</sup>

Would you be able to consider a mental health issue in a colleague? You might be aware that your colleague has uncharacteristically displayed the following:

- Decreased job performance or impairment
- Increased absenteeism
- Withdrawn
- Irritable, argumentative
- Decreased care in appearance
- Increase/change in physical complaints

Remember, with mental illness, as with substance use disorders, work is often the last to go.

Physicians are at risk for suicide for a variety of factors that may include:

- Mood disorders
- Substance-use disorders
- Long hours and decreased social supports
- Excessive work/life harmony conflicts
- Losses personally, professionally or financially
- Career dissatisfaction, administrative problems, excessive professional demands
- Greater familiarity and access to drugs (a specific risk)<sup>8</sup>

Dr. Myers describes the deadly triad of physician suicide risk as:

- Unrecognized, untreated or under-treated psychiatric illness
- Suicidal diathesis
  - Impulsivity
  - Aggression
  - Agitation
  - High anxiety
- Stigma in the patient and internally in the treating physician<sup>8</sup>

It is important to be able to recognize the warning signs of a person considering suicide. These signs might include the following:

- Threatening/talking of wanting to hurt or kill himself
- Looking for ways to kill himself by seeking access to firearms or available medications or drugs
- Talking/writing about death, dying or suicide, when these actions are out of the ordinary for the person
- Exhibiting one or more of the following signs:
  - Hopelessness
  - Rage
  - Acting recklessly or engaging in risky activities
  - Feeling trapped, like there is no way out
  - Increased alcohol or drug use
  - Withdrawing from family, friends and society
  - Anxiety, agitation, unable to sleep or sleeping all the time
  - Dramatic mood changes
  - No reason for living; no purpose in life<sup>1</sup>

Choosing to help your colleagues by recognizing these signs and assisting them in getting help is as essential as CPR.

However, we may experience losses by suicide that we could not have predicted or perhaps happen subsequent to the ravages of what can be severe, chronic illnesses.

“Suicide is a death like no other. It is deliberate and chosen. Is it rational? Rarely. Desperate? Always. Ignited by internal pain, suffering and absence of hope? Almost always. And it always leaves behind a legacy of mystery and devastation.”<sup>1</sup>

As colleagues, we may experience the gamut of feelings, individually and as a community, when a physician dies by suicide. We need to support our colleague’s family and each other. We will grieve.

Dr. Myers fondly quotes Elie Wiesel: “Memories, even painful memories, are all we have. In fact, they are the only thing we are. So we must take very good care of them.”<sup>8</sup>

As a medical community, we must encourage each other to overcome our “physician character” to seek help and treatment early. Treatment is as effective for us as the general population. This is sometimes surprising to physicians.

A physician with post-partum depression, treated with psychotherapy and an antidepressant, once remarked to me, “That antidepressant really works. All those years I prescribed it and I thought it was probably just a placebo effect.”<sup>9</sup>

We need to give up on our always inadequate self-treatment. We can learn to appreciate the gift of a physician-physician-patient relationship and of being cared for. It is time to address the poor practice of “curbside” consultations and treatment. Do you really want to be complicit in your colleague receiving suboptimal care?

We must fight the stigma of mental illness for our patients, our families and our colleagues. It is imperative that we work to eliminate consequences for physicians seeking treatment.

Confidential access to assistance, support and referral is available to Alberta physicians, residents, medical students and their immediate families by calling the Physician and Family Support Program (PFSP) at 1.877.767.4637.

## References

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