Stress, Burnout, Depression, and Suicide in Physicians: Strategies for Prevention and Psychological Growth

Michael Myers, MD
Professor of Clinical Psychiatry
SUNY Downstate Medical Center
Brooklyn, NY

Disclosure Slide

- Medical Education Speakers’ Bureau: 2-3 grand rounds lectures per year since 2014
- Royalties from books

Learning Objectives

1. Recognize symptoms of burnout, depression, anxiety, PTSD in oneself and colleagues
2. Incorporate new behaviors that preserve wellness and enable more balance in one’s life
3. Learn best practice strategies in coping with – and growing through – the tragedy of suicide in a medical peer

What about stress?

- A clue is your inner sense of “feeling stressed”
- Feeling tense, on edge, nervous, uptight, irritable, physiologically revved up, tearing up
- You feel on a treadmill, not enough down time
- Not multi-tasking as efficiently as usual, making dumb mistakes, forgetting to do things
- Preoccupied, tuned out, having a bit of trouble concentrating, not sleeping well, tired
- You begin to wonder if you’re drinking a bit more than usual – or no longer feel any satisfaction in drinking

What about stress?

- You may be having some somatic symptoms – headaches, upset stomach, diarrhea, back ache, muscle tension
- Dietary changes – not eating as healthily, skipping meals
- Not as relaxed at work or as friendly with staff, nurses, medical students and fellow residents/fellows
- Overall, not a very happy camper
- Looking forward to each day coming to an end

What about burnout?

- Multiple studies = 50% of today's physicians – and increasing
- Highest in EM, Critical Care, Ob/Gyn, Surgery and sub-specialties
- Cause = too much work with not enough reward (non-financial) and too little autonomy (personal agency)
- Symptoms include emotional exhaustion, depersonalization (detachment and loss of empathy) and decreased professional effectiveness
- You are not just tired – you may feel an "erosion of the soul" which is very upsetting

What about burnout?

- You are prone to more medical errors
- Your patients are less satisfied and they are less Rx adherent
- Increased risk of complaints about you – by your supervisor, colleagues, nurses, the students you teach
- You are less satisfied with your work and wonder about remaining in medicine
- You notice some spill over into your personal and family life

What about depression?

- A not uncommon chief complaint in physicians today is the following:
  - *“Hi Doctor Myers, my name is Doctor John Doe, I’m not feeling very well and think I should come and see you. I can’t tell if I’m burning out or depressed or both. I’ve thought of quitting my job…or getting out of medicine all together….or just retiring…but I thought I better talk to someone first….is this something that you can help with?”*

How do I know this is burnout and not clinical depression or both?

- Burnout is specific to and rooted in occupational stress
- Depression is an illness with biopsychosocial determinants – it is serious and carries significant morbidity and mortality
- It requires a thorough and comprehensive history, accurate diagnosis and competent treatment
- It will not go away with retirement or quitting

What about anxiety disorders and PTSD?

- Characterized by a lot of felt physiological anxiety, including worry, that is generalized or specific to certain situations
- The former is generalized anxiety disorder
- The latter is present in one or more phobias, like agoraphobia, crowds, flying, elevators, heights, social anxiety disorder
- PTSD is rooted in trauma – actual or vicarious – and can result in a startle reaction, avoidance, dissociation, flashbacks, nightmares
- Both of these can be terribly disabling and tend to be underdiagnosed and hence undertreated in physicians

Why is all of this so important?

- There is a huge amount of suffering in physicians today and many docs feel alone - and that they just have to “suck it up”
- We are trained to be healers and we pride ourselves on our strength, endurance and resilience – hard to be a patient in need of care
- Many professional resources are available but the stigma associated with reaching out for professional help is rampant in the house of medicine – it is very tempting to turn to alcohol (or other drugs)
- Stigma has two components – felt and enacted – both are common
- Stigma is paralyzing – and it can kill

Wise words………

- *“I don’t want other people to go through what I’ve been through. I know so much more now than I did before Gus got sick…and before he died. We, in the medical profession, need to learn more about this, about depression. We got to talk about it more”.*

    - The words of Peggy Watanabe, MD, who lost her husband Dr. August Watanabe to suicide. “ From *“Why Physicians Die By Suicide: Lessons Learned from Their Families and Others Who Cared.”* (Myers MF 2017)

Why we must pay attention to our personal health and that of our colleagues

- Many psychiatric symptoms/signs are elusive
- Despite having variable amounts of basic mental health knowledge, we physicians may not recognize how ill (or impaired) we have become
- And even if we do, we may not know the resources
- Or we may not be decisive and clear enough to make phone calls and keep appointments
- And if we are still working pretty hard – and without too many cracks in our armor – we may delude ourselves (and others) that we’re fine

Reaching out to each other

- Concerned about a colleague? Someone who seems out of sorts recently, cranky, muddled, withdrawn, thin, late for things, absent a lot, overworking, making inappropriate statements, jumpy, unkempt, ?AOB?, especially negative or grim, etc.
- Whatever you do, do something!
- Are we our brothers’ and sisters’ keepers?

Reaching out to each other
Options:

- Speak to the individual directly
- Ask mutual colleagues if they've noticed
- Speak to the person in authority – training director, chief of staff, VP medicine, division or dept. head
- Call your provincial medical society physician health program for any suggestions they might have about the best approach – do not disclose the name of the individual

Reaching out to each other
Speaking to the person 1:1

- Prepare what you want to say
- What have been your observations about your colleague’s change in behavior and appearance?
- Consider a good time and setting for privacy
- Do not preach, judge, or threaten – use 1st. person singular language

Example

- “Tom, let’s go for a walk, I’d like to talk to you about something. I’m really quite worried about you. I’ve noticed that you’re not your usual self the last few weeks. It seems to me that you’ve lost weight, that you’re quieter than usual, that you seem preoccupied, and kind of sad. I was just wondering if you’re feeling ok or if I could help in any way”

Example

- Depending on Tom's response, try to get a bit of a dialogue happening. This hopefully will make him feel more at ease to open up to you a bit so that you can ask if he's getting any professional help – from his PCP, a psychiatrist, a therapist, spiritual leader. If you're not comfortable that he's getting appropriate care, or any care at all, say so

Example

- Don’t simply give him names of people or resources to call, ask his permission for you to make calls on his behalf. You set it up. And accompany him to the first visit if at all possible. That will ease the journey. If he insists on doing it himself, tell him that you will check back with him in a few days to see if he’s got something in place.

Example

- What if Tom tells you to get lost? Don’t take it personally! This may be diagnostic and that he is quite ill. He may be denying to himself the gravity of his condition, he may be suspicious or becoming clinically paranoid, he may be suicidal. If your observations are corroborated by others, call the resource mentioned earlier for guidance and next steps

Toward preserving wellness and striving for balance

- Pay attention to your physical, emotional, mental and spiritual health
- Pay attention to any/all feedback from your family, colleagues and patients about your well-being and behavior
- Try to leave your defensiveness at the door and strive to listen to and reflect on your reaction to what has been said to you
- Talk to others about how you’re feeling – someone you trust – isolating leads to confusion, distorted thinking about yourself and others and can be dangerous
- Most important, put yourself first!

Toward preserving wellness and striving for balance

- Do not blame yourself for feelings of burnout – it is occupational and systemic – emblematic of how medicine is structured today
- It will take time for this kind of change to occur – excessive workload, clerical burden with electronic health records, imbalance of time spent on the computer and less in face-to-face time with one's patients, maintenance of certification requirements, elimination of questions on licensing applications that ask about diagnosis and treatment of mental health illnesses (vs necessary questions about current impairment)

Toward preserving wellness and striving for balance

- The good news is that the CMA has many initiatives on the go that illustrate the seriousness of the issue and a commitment to working on changes at a national, provincial, organizational and leadership level
- https://www.cma.ca/En/Pages/physician-health-wellness.aspx
- In the meantime, there are many individuals and groups that are working at – and writing about – ways in which each doctor can think about and implement changes in oneself to prevent or combat burnout

Avoiding and fighting burnout

- Pay close attention to your rest and sleep
- Build in and protect time for regular exercise
- Get a family physician and develop a doctor-patient relationship with that individual
- Do not let any job in medicine severely compromise your right to a personal and family life
- Build collegial relationships with your doctor peers, including Balint and narrative medicine groups
- Learn mindfulness meditation, new CBT strategies for facing stress

Losing a physician colleague to suicide

- *“A good friend told me about her death. We didn’t know right away that it was suicide. It was horrible to hear the truth. It came out that she had been struggling. Why is there so much stigma? Why is there that message of ‘don’t show any weakness’ in the everyday world of medicine?”*
  - The words of Pam Swift, MD, author of *Doctor’s Orders: One Physician’s Journey Back to Self.* I spoke to her by telephone on September 18, 2015 about the loss of a doctor colleague to suicide.
  - From the Introduction *“Why Physicians Die by Suicide: Lessons Learned from Their Families and Others Who Cared.”* (Myers MF 2017)

Kay Redfield Jamison, PhD, Professor of Psychiatry, Johns Hopkins Medical School

“No one who has not been there can comprehend the suffering leading up to suicide, nor can they really understand the suffering of those left behind in the wake of suicide”

from the Foreword “*Touched By Suicide: Hope and Healing After Loss*” by Michael F. Myers and Carla Fine

Mirror

NEWS ▾ POLITICS SPORT ▾ FOOTBALL CELEBS ▾ TV & FILM WEIRD NEWS MORE ▾

Doctors are here to save our lives, not take their own

I don't know a single junior doctor who hasn't at times felt utter despair at the burden of trying to keep patients safe in today's overstretched and understaffed NHS

SHARE

COMMENTS

BY DR RACHEL CLARKE

NEWS OPINION

STAPLES
GET MORE. SPEND LESS.
SHOP NOW

RECOMMENDED

Inside abandoned UFO village where families lived in 'spaceships' before flying saucer cabins were left to rot

Woman asked to

...you are okay with this but you can find out more and learn how to manage your cookie choices here

Suicide rates in physicians

- The aggregate suicide rate ratio for male physicians, compared to the general population, was **1.41**, with a 95% confidence interval (CI) of 1.21–1.65
- For female physicians the ratio was **2.27** (95% CI=1.90–2.73)
  - Schernhammer et al 2004

Struggling in Silence: Physician Depression and Suicide (PBS Documentary 2008, DVD available www.afsp.org)

"Every year, three to four hundred physicians take their own lives — the equivalent of two to three medical school classes"

Reactions of the deceased physician’s colleagues (Myers and Gabbard 2008)

- Mourning – full range of emotions and thoughts
- Systemic anxiety – personal vulnerability, contagion fears, who’s next?
- Guilt and blame – at self and others for not doing more, missing clues, not reaching out, failing the physician colleague

Reactions of the deceased physician’s colleagues (Myers and Gabbard 2008)

- Anger and rage at the deceased – for ‘giving up’, being ‘selfish’, leaving his/her family, abandoning his/her patients, ‘dumping’ more work on those left behind, tainting the public perception of physicians as invincible
- Business as usual – calm, cool demeanor, defensive intellectualization and rationalization, ‘suicide is just an occupational hazard when you’re a doctor’

Unique dimensions of bereavement associated with suicide loss

- Unlike deaths from illness or accidents, suicide is a chosen death (albeit during a despairing mood and cognitive constriction)
- Survivors are left with a sense of abandonment, betrayal, and responsibility
- There is not a proper goodbye
- There are many questions and no answers
- Bereavement may be fierce and definitions of normality broad

More wise words………

- *“The greatest obstacle to tackling the mental health issues in doctors is stigma. When my father passed, several physicians – his colleagues and friends at the hospital – suggested that we - my mother and my brother and me - that we cover this up. That we don’t tell the world that it was a suicide. I said ‘No, we are not going to do that, we are telling the truth. This is a derangement of a body organ that killed him”’.*
  - The words of Frank Watanabe, whose father, Dr. August “Gus” Watanabe, while in the throes of a massive depression, killed himself at the age of 67 on June 9, 2009. From “Why Physicians Die by Suicide: Lessons Learned from Their Families and Others Who Cared” (MF Myers 2017)

Coping and growing

- Try to talk about your colleague in the same way you might if he/she had been killed in a car accident or died of cancer
- If you know his/her family, do not abandon them – the stigma and resulting isolation after suicide is terribly painful
- Respond in a kind and supportive way to any queries posed by his/her patients – and yet, protect privacy and confidentiality
- Give some thought to some kind of memorial – lecture, scholarship, etc
- Take care of yourself – including reflection, lots of talking, therapy perhaps – you will grow through this tragedy

Concluding words…

- At the end of the day, suicide is very humbling
- We must always honor the mystery of life and death and be very careful not to project our personal and collective notions of what it means to be a physician onto others
- But we must simultaneously continue our research into the biopsychosocial reasons why doctors kill themselves
- And most important, we must remember those who have died

References

- Dyrbye LN, Trockel M, Frank E et al. Development of a research agenda to identify evidence-based strategies to improve physician wellness and reduce burnout. Ann Int Med 2017. Annals.org April 18, 2017

- Myers MF, Fine C. Touched By Suicide: Hope and Healing After Loss, Gotham/Penguin Books, New York, 2006

- Myers MF, Gabbard GO. The Physician As Patient: A Clinical Handbook for Mental Health Professionals, American Psychiatric Publishing, Inc., Washington, DC, 2008

- Myers MF. Why Physicians Die by Suicide: Lessons Learned From Their Families and Others Who Cared. Amazon, New York, 2017

References

- Parks T. Report reveals severity of burnout by specialty. AMA Wire. January 31, 2017
- Schernhammer ES, Colditz GA. Suicide rates among physicians: a quantitative and gender assessment (meta-analysis). Am J Psychiatry 2004.161;12:2295-2302
- Shanafelt TD, Dyrbye LN, West CP. Addressing physician burnout. The way forward. JAMA 2017.317;9:901-902

Thank you!!!

- Telephone: (718) 270-1166
- Email: michael.myers@downstate.edu
- www.michaelfmyers.com