

Physician Suicide: A Tragedy for International Medical Communities

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"There was no malicious intent. Still, I'm accused of murder. Am I such a terrible person? ... Continue living your lives. And keep good memories of me, knowing that I love you. Forgive me for all that you have been through." - Suicide note of a general practitioner (translated from Dutch), October 2013 (1)

Physician suicide affects medical communities all over the world. Beyond the U.S., at least 37 countries have written in peer-reviewed literature alone about their experiences of physician suicide (2). Earlier this year, I read about a general practitioner who was under investigation as a result of an allegation that his treatment led to a patient's death in 2013 (3). A documentary covers the story posthumously after the allegation was ruled as wrongful -- he had already died by suicide during the ongoing investigation and left a heartbreaking note (1). Another Dutch physician, a psychiatry resident, also died by suicide, according to a case report in the *Dutch Journal of Psychiatry* a year ago (4). The authors also discuss the responsibilities and challenges of supervisors in prevention and postvention of suicide among their trainees.

Like these Dutch cases, an uncounted number of physician suicides occur in international medical communities, whether shared through social networks, online blogs, news reports, peer-reviewed literature, or sometimes not at all. Physicians are bright and high-achieving individuals, placed in the unique position of serving others, carrying great responsibility and skill in their daily work and lives as a result of their professional training. So: what are our societal and community responsibilities to protect our physicians from suicidal behaviors and death by suicide?

How big a problem is physician suicide?

I suspect that every medical community in the world could share news and case reports of physicians who die by suicide in their own languages, if only I had the means to access them to support this. The numbers are important to understand the gravity of the issue, yet are hard to come by. Some also may argue they are unnecessary to proceed with interventions to prevent suicides. Unfortunately, there is no single source of truth to put this question about physician suicide incidence to rest; the numbers are far from perfect. For example, an oft-quoted statement that 300 to 400 American physicians die by suicide annually has shaky links to old data or data that is not generalizable to the larger population of physicians. Suicidal behaviors, like suicidal ideation or attempts, are also difficult to measure systematically. I believe that the lack of clarity sadly can lead to inaction and inertia to prevent such deaths. Until tragedy happens.

While efforts to design better surveillance for physician suicides is ongoing (5), the next questions move towards what to do. The reports that are available, whether anecdotal or systematic, still beg follow-up questions and issues that medical communities affected by suicide deal with. Each community that has experienced such loss probably grapples with the same questions and hopes for a way to prevent suicide among their physicians. Why would a physician -- a healer -- experience suicidal thoughts or die by suicide? What is it about the profession that paradoxically increases their suicidal risk? And, most importantly, what can we *do* about it?

How do we talk about suicide?

Talking about suicide is a starting point. In whatever language or culture, dialogue is an important part of destigmatizing suicidal behaviors and its associated risks. Connecting meaningfully with each other is one thing we can do immediately. Being open and supportive in reflective dialogue with peers, mentees, and other clinicians can go a long way toward humanizing the pain that someone may feel when they are experiencing suicidal thoughts or an acute crisis. Or when feeling fearful of potential consequences of their thoughts and behaviors.

Also, using nonjudgmental language when talking about suicide more generally is an important part of destigmatization. People *die by suicide*. They don't *commit* suicide, like someone who commits a crime or commits a sin, even if this historically was an interpretation of suicide and may still persist as such in some places. They also are not making a commitment to fatal self-harm, like they commit to achieving something. In fact, many suicides are not preceded by diagnosed mental health disorders (6).

Related to this, acute crises may be incredibly important in increasing suicide risk over the short term. Whether physicians are at an increased risk for acute crises that also increase suicide risk has not been studied. However, physicians could be at higher risk for crises, given their high probability of proximity to human suffering or their experiencing second victimization (7,8). Because of this, normalizing discussions about stressful and difficult experiences as a physician, and acknowledging difficult and heavy emotions associated with them are vital.

How can we change our professional culture?

Creating a workplace environment of psychological safety and mutual respect is an extension of engaging in nonjudgmental dialogue. The hidden curriculum has an important but complex relationship to physician suicide (9), as job stress, role strain, and bullying (10), all may increase the risk of suicidal ideation. Furthermore, evidence-based best practices for treating patients with suicide risk factors also benefit physicians as patients (11), which is all the more reason that when professional help is needed, there should be as few barriers as possible for physicians to access it. Stigma, which comes from the community and also from physicians towards themselves, creates sometimes insurmountable barriers to seeking help of any kind. Additionally, fears are often tied to professional reputational concerns, including prospects for career advancement, licensing and credentialing. These are unique to physicians' experience of stressors and possible suicide risks.

Naturally, all of this is easier said and harder to do because of how glacial it can be to change ingrained cultures of practice and traditional hierarchical structures of medical training and workplaces. Also, there are many other factors that can contribute to the complex outcome of suicidal thoughts or death by suicide among physicians (2). Yet what *can* be redesigned -- to reduce risks of suicidal behaviors -- ought to be. Aligning an individual physician's beliefs and values with that of an organization, and designing a healthcare system that sufficiently supports physicians' work-life integration, is a complex but necessary task. Fortunately, many professional organizations and healthcare institutions have begun initiatives to systematically, if slowly, address these issues, so time will tell if these efforts lead to realized benefits for physicians.

What else can we do?

Becoming a physician advocate is an invaluable part of empowering ourselves and each other, and achieving the changes in the medical profession that are needed. Advocacy for physician suicide prevention

is but one of many issues, but I still strongly encourage any physician, medical student, or trainee who has been touched by suicide to consider speaking up. Together, we can collaborate with our physician peers, wherever they may be and with whatever background they may come from, to help each other achieve our best health and well-being while we are supporting that of our patients.

We can also collaborate across disciplines, learning from and supporting each other, including nurses, paramedics, or even veterinarians, police officers, or firefighters, who might also, like physicians, be at increased risk for suicidal thoughts and deaths compared to the general population. September is Suicide Prevention Awareness Month, where September 17th is the second annual National Physician Suicide Awareness Day.

Our powerful clinical voices can help our peers in our local communities, but also help provide the support needed for the international medical community to advocate for physicians' well-being. We might never know if we have prevented a physician's death by suicide, but I firmly believe that should not stop us from trying.

If you are in crisis and need emergency help, and in the United States, call 9-1-1 immediately or the National Suicide Prevention Lifeline (1-800-273-TALK or 1-800-273-8255). If you are in another country, find a 24/7 hotline at www.iasp.info/resources/Crises_Centres.

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