

Our Fallen Peers: A Mandate for Change

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Objective: *The author identifies and seeks to remove barriers contributing to physician/medical students' decisions NOT to seek mental health care.*

Methods: *Following a cluster of medical student and physician suicides in one medical community, medical trainees anonymously shared their views regarding seeking mental health treatment in light of the current disclosure requirements for medical licensure. In an effort to identify medical licensure questions that more accurately assess for potential impairment—replacing the stigmatizing global inquiry about past mental health treatment—47 states' medical licensure questions available on the web were examined. Representatives from the state's psychiatric and medical societies joined efforts to formally request the State Medical Board to revise the licensure questions.*

Results: *The State Medical Board unanimously approved the recommended changes.*

Conclusion: *Overcoming stigma within the medical profession regarding seeking psychiatric care is a difficult process requiring ongoing education of our colleagues. Physicians must have the opportunity to seek confidential mental health treatment at their earliest signs of distress in order to maximize their optimal functioning in an effort to prevent impairment.*

Academic Psychiatry 2008; 32:8–12

While the life of a physician can be extremely stimulating and gratifying, it often requires great personal sacrifice (1). The personalities of individuals entering medicine are often driven, perfectionistic (2), and highly self-reliant (3). Suicide rates in physicians are significant (4, 5). Compared to the general population, male physicians have an aggregate suicide rate ratio of 1.41 (95% CI=1.21–1.65), and female physicians have an aggregate suicide rate ratio of 2.27 (95% CI=1.90–2.73) (5). While data are limited (6), it is estimated that approximately 2% of physicians currently have an active substance abuse problem and another 8%–18% of physicians will be affected at some point in their lives (7). Cross-sectional rates of depression in medical students and residents range from 15%–30% and are higher than in the general population (8–10). Despite this reality, stigma attached to mental illness is greater within the field of medicine than it is in the general public (11). Its existence reinforces denial in physicians that they might become ill and contributes to delays in seeking care, unnecessary suffering, self-medication—increasing the risk for impairment—disruptive behavior in the work place, isolation from medical colleagues, medical errors, failed marriages, and dangerously heightens the risk of death by suicide (11). According to suicidologist Edwin Shneidman (12), three events converge for an individual to choose to end his or her life: 1) experiencing unbearable psychological pain and seeing no escape other than death; 2) having ready access to instruments of suicide such as guns, knives, or pills; and 3) being in a highly agitated state of discomfort and anxiety.

In the aftermath of a 12-month period with four physician related deaths including three suicides and one homicide in one medical community, substantial collective efforts were made to identify and reduce barriers to seeking psychiatric care. This state's medical board still required full disclosure for any mental health treatment in its initial and renewal medical licensure applications. See Table 1.

Careful review of 47 state licensure applications iden-

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tified three states that contain this disclosure requirement (13). This disclosure occurs in a forum where confidentiality cannot be assured (board meetings are open to the public), undermining any progress toward decreasing the stigma of seeking help early in the course of illness to prevent impairment.

Following this cluster of tragic physician deaths, the President of the state's Psychiatric Society met with the state's medical licensure board requesting changes in disclosure requirements. The Medical Board extended its assurances that its members needed to know this information to protect the public and that they intended no harm to applicants who sought mental health treatment. They failed to comprehend that seeking mental health treatment does not necessarily imply functional impairment in the practice of medicine and that this violation of privacy served as a strong deterrent to physicians considering reaching out for help.

METHOD

In an effort to educate the board, trainees and physicians were invited to share their anonymous views. An invitation was extended through the medical school e-mail list with the title, "Request for supportive information to change questions about mental health treatment."

The message read:

Dear Colleagues,

If you know of any personal circumstances or examples that would support changing the licensure questions from the current wording asking about 'any past mental health treatment' to asking whether you have 'any medical or psychiatric condition that could impair your ability to practice medicine' I would appreciate your confidential response regarding how the current medical licensure questions impact seeking care.

TABLE 1. (OLD) Mental Health Disclosure Medical Licensure Questions

<p>Initial Application for Medical Licensure Have you been, or are you presently, being treated for a mental health condition? If yes, was this voluntary or the result of a medical board action? Explain.</p>
<p>Renewal Application for Medical Licensure Since your last attestation, Yes ___ No ___ Have you ever been or are you presently being treated for a mental health condition? If yes, was this voluntary or the result of a Medical Board action?</p>

Responses were returned voluntarily and identifying information was immediately removed to protect the identity of the respondents. The results were compiled and submitted to the president of the State Psychiatric Society, who brought them to the meeting with the State Medical Board.

RESULTS

Anonymous Views of Trainees:

"I am a current student in the college of medicine. I considered seeking mental health services in the first semester of my first year, but I did not because I was afraid that I would have to disclose the nature of any treatment I might receive with a medical board or residency program. I finally sought help in the second semester of my second year (over a year and a half later) and it has made a world of difference to my total health and well-being. I'm still reserved about sharing such personal information with any kind of board, but that is something I am willing to face when I think about how much easier that time period could have been for me, I feel foolish for not seeking help earlier. What is even scarier is thinking about those who need help worse than I do but are afraid to get help."

"When I was a 1st year medical student I was in a horrible marriage, and cried every day. We ended up separating during finals of my first year and going through a divorce the first half of my 2nd year. During my separation and divorce, I was on an antidepressant and I truly believe it helped me get through that extremely hard situation and come out happier than I've ever been. That being said, I'm not sure I would want to disclose that information to a licensing committee because it was a very personal experience and lasted for only 6-8 months. It was definitely not something that would impair my ability to provide patient care."

"I am a medical student with a strong family history of depression, so I feel that this issue affects me. Recent tragedies have made me consider what would happen to me if I was overcome by depression and needed medical care. Rather than receiving treatment, I wonder if I would suffer in silence out of fear of being judged, or worse yet held back in my professional career. However, a physician who has recovered from depression could provide empathy, understanding and hope to others who suffer. Physicians should not be made to suffer because they are afraid of seeking treatment for mental illness."

"There have been times when I have considered seeking help but then decided not to go because I might have to ex-

plain it to a medical board in the future. I will admit that my problems were not a matter of life or death. I would like to believe that if I became desperate I would seek medical help, but I think that it would have been beneficial to talk to someone in a confidential setting. I have had issues with depression/anxiety, as I imagine all medical students (if not all humans) have had. There was one period during the second year (for almost 4 months) that I did not fully recognize until I was coming out of it; it was pretty severe. I think if I had already established a relationship with a counselor, who probably would have identified it, it would have saved me and my partner significant distress and probably helped my grades, which dropped."

"I would have to answer 'Yes' to the question of seeking mental health treatment, but do not feel that my ADHD and depression would impair my ability to practice medicine. In fact, I feel that my seeking treatment will improve my ability to practice medicine."

"I personally utilized mental health services several years ago for possible PTSD and OCD over the course of about 6 months. Do I believe that will impair my ability to practice medicine? Not in the least. But it does feel like a black eye as stated in the current application. I know that because I came to talk about my emotional health, I will learn how to better handle stressful situations and will in the end be a better physician for it . . . it is not a sign of professional instability. In fact, I truly believe that people who walk out of a psychiatrist's door are more professionally stable than some who do not."

"I whole-heartedly believe that the wording should be changed to ask 'any medical or psychiatric condition that could impair your ability to practice medicine.' Just like any other medical illness there are some circumstances that a student doctor or physician is indeed impaired due to psychiatric illness, but that does not translate to a transient stressful time when someone reaches out for help to mean that person is impaired. That would be like saying that a student who gets

the common cold is impaired from practicing medicine because he or she sought help."

"I did not seek care as soon as I should have. The current requirement of reporting mental health treatment played a part in my decision to not seek care immediately. I thought if I could handle it on my own, no one would ever have to know. When I realized I could not deal with it on my own, I went for mental health treatment and feel like a new person now."

Reaction of the State Medical Board

The collection of responses opened discussions with the State Board of Medical Licensure. Next, stakeholders from the State Medical Society, the State Psychiatric Society, and the College of Medicine joined efforts to formulate recommendations for specific revisions of the licensure questions (Table 2). They chose questions that specifically identified impairment while protecting the confidentiality of physicians who appropriately seek mental health care to ensure their optimal functioning. The formal request for change is in process.

The State Medical Board approved the recommended modification in April, 2006.

DISCUSSION

Expert Recommendations

In 2003, leaders in the American Medical Association and the American Foundation for Suicide Prevention recognized the significant problem of physician suicide. They formulated a consensus statement encouraging a shift in professional attitudes and institutional policies to support physicians seeking help for the treatment of depression (14).

They identified a profile of a physician at high risk for suicide (Table 3). The Consensus Statement makes a

TABLE 2. (NEW) Medical Licensure Questions

<p>Initial Application for Medical Licensure Have you ever been advised or required by any licensing or privileging body to seek treatment for a physical or mental health condition? If yes, please explain.</p> <p>Renewal Application for Medical Licensure Since your last attestation, have you been advised or required by the State Medical Board or any other licensing or privileging body to seek treatment for a physical or mental health condition?</p>
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TABLE 3. Profile of Physicians at High Risk for Suicide [14] [15]

<p>Sex: Male or Female Age: 45 + (woman); 50 + (man) Race: Caucasian Marital Status: Divorced, separated, single, or currently experiencing marital strife Risk factors: Depression, alcohol or other drug abuse, workaholism, excessive risk taking Medical status: Psychiatric symptoms (depression or anxiety) or physical symptoms (chronic pain, chronic debilitating illness) Professional: Change in status or threats to status, autonomy, security, financial stability, recent losses, increased work demands Access to means: Access to lethal medications, firearms</p>

strong recommendation to ensure that licensure regulations, policies, and practices are nondiscriminatory. They should require disclosure of misconduct, malpractice, or impaired professional abilities and NOT a psychiatric or medical diagnosis (14).

Improvements

Both the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education are leading efforts to require confidential primary prevention programs for medical students and trainees (14). These programs are designed to maximize the mental health and functioning of medical students (16) and residents in training (17) and are becoming readily accepted and utilized in many institutions (18). Trainees learn the signs and symptoms of stress related illnesses such as depression, anxiety disorders, substance use, and relationship difficulties, and are encouraged to seek early treatment to optimize their performance.

Discriminatory Practices

Unfortunately, some physicians in practice who have psychiatric disorders continue to encounter discriminatory practices. As far back as 1983, APA expressed concern that the licensing board questions inquiring about diagnosis or treatment of mental illness will deter physicians from seeking help (19).

One physician with bipolar disorder disclosed his diagnosis to his state licensing board. When mandated to provide his psychiatric records, he refused, pointing out that he was receiving effective treatment and his performance was not impaired. He also advocated that impairment could not be inferred from his diagnosis and that such policies are overly invasive and counterproductive because they deter physicians from seeking help, thereby posing greater risks to patients (19).

Discriminatory insurance practices are common where individuals who have a history of mental health treatment are either refused life or disability insurance coverage or are charged significantly higher premiums.

Unresolved Challenges

Changing medical licensure questions is one step toward encouraging physicians to seek mental health care, but many challenges remain. The personalities of physicians raise their risk for suicide. They are gifted (or cursed) with excellent organizational skills including perfectionism, a willingness to work long hard hours, often neglecting themselves and their closest relationships, and a competitiveness that fuels their need to appear highly competent

and self-reliant (11). While in medical school, students often cope with the stress of medical school by self-medicating with alcohol (20). This stress reduction technique is unfortunately reinforced through a longstanding tradition of alcohol centered medical school events. The importance of changing this tradition is emphasized when taking into account that each of the recent physician deaths was associated with heavy alcohol intake. Twenty-five percent of all persons who commit suicide are intoxicated at the time of their deaths (21).

Monumental cultural change will be necessary to esteem highly the physicians who attend to their own feelings, live their values (22), strive for excellence (rather than perfection), and appropriately rely upon others. One innovative academic institution allows physicians to work less than full time in order to live their values. To their surprise, they discovered that these faculty experienced a significantly higher quality of life, were equally as productive as their full time colleagues, and their patient satisfaction surveys were superior (23).

Dedicated to our colleagues who didn't reach out for help.

Web Resources: The American Foundation for Suicide Prevention (<http://www.afsp.org/physician>).

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