Suicide: a Danger Between Surgeons

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Abstract

Suicide has been a growing problem all around the world, with around 1 million deaths registered per year. This scenery affects the medical population more frequently and it has been a concern for more than one hundred years. It has been reported that the work situation to which the physicians are submitted causes distress, burnout and other symptoms that help to develop suicidal ideation. Based on previous works, it was found that among the physicians, surgeons have a higher tendency to be a victim of these disorders, due to work related harassment, sickness presenteeism, unfulfillment feelings and, mainly, the stigma of seeking psychological help. Although, some studies indicates strategies to overcome this situation as regular meetings provided by the work management to discuss stressful work related events and the clarification of suicidal ideation treatment.

Keywords
Surgeons; Suicide; Suicidal Ideation.

Around 1 million deaths by suicide are registered every year-17% of them are related to Indians and 14% happen in developed countries [1]. International data indicate that suicides are more frequent among physicians than among members of distinct areas [2].

It has been known for more than 150 years that physicians have an increased propensity to die by suicide. It was estimated in 1977 that on average the United States loses the equivalent of at least one small medical school or a large medical school class to suicide. Although it is impossible to precisely estimate the number due to inaccurate cause of death reporting and coding, the most used is approximately 3-400 physicians/year, that is about a doctor a day. Of all occupations and professions, the medical consistently hovers near the top with the highest risk of death by suicide [3].
Recent data suggest that the increased risk of suicide which comprehends physicians may begin as early as medical school [4]. Prospective medical students and residents are extremely unlikely to report a history of depression during highly competitive selection interviews. The persistence of depression in these populations and in medical student and postgraduate trainees is unknown, but it is estimated to range from 15-30%. After accidents, suicide is the most common cause of death among medical students. In one study, 9.4% of fourth-year medical students and interns reported having thoughts about suicide in the latter two weeks [3].

Compared with the rest of the working-age population, physicians have a 2.45-fold higher rate of death by suicide than non-physicians [2]. Burnout can have serious personal repercussions for physicians, including problematic alcohol use, broken relationships, and suicidal ideation [5]. Emotional distress, responsibility for patients’ problems, and inter-role conflict may lead to feelings of bearing a burden [6].

Many studies have compared physician mortality with that of the remaining population. Sadly, although physicians globally have a lower mortality risk from cancer and heart disease (presumably related to knowledge of self care and access to early diagnosis), they have a notably higher risk of dying from suicide, the end stage of an eminently treatable disease process [2].

Although suicide is strongly linked to depression, the lifetime risk of depression among physicians is similar to that of the US population in general, which suggests that other factors may be contributing to the larger risk of suicide among doctors. Access to lethal medications and the knowledge of how to use them has been suggested as a factor; however, the influence of professional characteristics and forms of distress other than depression (e.g., burnout) are largely unexplored [4]. Depression, addictive behaviors, burnout, and occupational stress have been cited as dangerous factors for suicide among physicians, especially among younger doctors [2].

The number of suicidal ideation (SI) cases in the latter 12 months for the general US population is approximately 3.3%. The 2003 National Comorbidity Survey found that approximately one-third of individuals with SI make a plan, 72% of those with a plan make an attempt, and 26% proceed directly from SI to an unplanned attempt. In aggregate, these statistics suggest that about 50% of individuals with SI may eventually make a suicide attempt, with the majority of attempts occurring within 1 year of onset of SI [4].

Suicidal ideation is referred to the concern with suicidal thoughts, and it is known to represent a beginning of the suicide process, from lack of disposition and a passive death wish to elaborating plans to commit suicide, and finally self-harm elaborating a suicide plan is related to a significantly higher risk of committing a suicide attempt. Physicians are often severely intended when planning a suicide, putting much thoughts into self-destruction; even rehearsing the action [6].

Suicidal ideation among physicians was also markedly increased among surgeons who perceived they had made a major medical error in the latter 3 months, highlighting the personal consequences of medical errors on physicians. [4] Work-related events are also seen as a contributing factors to suicidal ideation among surgeons, and one of the most relevant is harassment, even though depression was not much associated [6].

Regarding harassment, it was discovered that many surgeons had suffered some type of harassment at work in recent time, whether from a colleague or a superior. About 30% of the Italian surgeons and 18% of the Swedish surgeons had gone through some kind of degrading situation, which is considered a high percentage compared to the frequency of harassment among general population in these countries (3.5-9% in Sweden and 2% in Italy). In addition to harassment from
coworkers, physicians reported in the past to have also suffered harassment from patients and their families which contributed to develop suicidal ideation; although, these cases weren’t highlighted on recent studies. In addition, some data indicate that surgeons’ suicidal ideation is associated with a poor work condition, which consists of harassment in workplace and sickness presenteeism, but also indicate that regular meetings to discuss situations at work could be protective [6].

In a large national study, one out of sixteen responding American surgeons had experienced SI in the previous year. The rate of SI among surgeons 45 years and older was approximately 1.5-fold to 3-fold greater than that of the general US population. The higher rate of SI among surgeons is even more striking considering that surgeons are highly educated, nearly universally employed, and overwhelmingly (88%) married—factors known to reduce the suicide risk in the general population. It is also notable that although individuals aged 45 to 54 in the general population have a lower risk of SI than younger individuals do, the reverse appears to be true for surgeons [4].

More than 12% of the digestive surgical trainees reported suicide ideation; this rate was double the rate that was reported by American surgeons and triple the rate found in the French population for the population of the same age [7]. Stressful aspects of physician training—such as long hours, having to make difficult decisions while being at risk of errors due to inexperience, learning to deal with death and dying, frequent shifts in workplace, and estrangement from supportive networks, such as family—could add to the tendency toward depressive symptoms in trainees [3].

Physicians pursue the arduous task of becoming surgeons to change the lives of individuals facing serious health problems, to experience the joy of facilitating healing, and to help support those patients for whom medicine does not yet have curative treatments. Despite its virtues, a career in surgery brings significant challenges that can lead to substantial personal distress for the individual surgeon and his or her family [8].

Data suggest that surgeons think they cannot give in to sickness or skip work to seek treatment, due to competition inside the workplace, low compensation and the effort dedicated as a surgeon. Such behavior, of working while sick, affects directly the efficacy and the quality of work, while increasing the risks of medical errors. Notwithstanding, this study adds new knowledge to the relation between sickness presenteeism and suicidal ideation [6].

Although the relative risk of death by suicide for physicians compared with the general population in some previous studies was higher for women than for men the absolute rates of SI among the surgeons found by recent studies did not differ significantly by sex [4]. Furthermore, it wasn’t found any difference of harassment experience regarding the gender of the doctors, which contradicts previous information about female surgeons being a more frequent target to humiliating situations than male surgeons. These findings contribute to evidence that work harassment also affects male surgeons [6].

A study found that Suicidal ideation among surgeons was strongly related to symptoms of depression and degree of burnout. Although the relationship between SI and depression is well recognized the association between SI and burnout has only begun to be defined [4]. Litigation-related stress can precipitate depression and, occasionally, suicide [3]. Burnout is known to be caused by the relation of a person and his or her work leading to depersonalization which makes the surgeon stop viewing the patient as a human being, affecting the ability to provide good patient care. Findings indicate that Burnout may affect surgeons in personal and professional ways as their actions concern themselves as well as their family, coworkers and patients [6].

Burnout had a substantial dose-response relationship with SI that persisted on multivariable analysis controlling for symptoms of depression. Notably, the
relationship between SI and burnout was reversible, with recovery from burnout decreasing the likelihood of subsequent SI. A strong association between burnout and SI was also recently reported in a study of more than 2000 Dutch medical residents, although that study did not control for depression. The findings of that study suggested that burnout and depression are independently associated with SI where the consequences of burnout may be particularly important among individuals with underlying depression [4].

Moreover, burnout present two dimensions, exhaustion and disengagement, this second was found to be strongly related as predictor for suicide ideation. Burnout among surgeons was found to be higher than in the general population. One’s disengagement from work may lead depersonalization of their own patients and relatives, affecting surgeons’ work quality and patient care. While working on a competitive environment, one would rather work ill than to recover at home, nourishing a symptom of sickness presenteeism. By pretending to be in perfect shape ignoring diseases and going to work ill, or taking compensatory leave, one covers the fragility that may not be well-perceived in a competitive workplace. Sickness presenteeism has been associated with role conflicts, which is likely to become mediators for mental illness leading to suicidal ideation [6].

A study found three work-related characteristics that are also related to the fact of not seeking help for depression: being currently involved in a medical research, being a surgeon and working at night shifts [1]. The academic clinical environment can be rigorous while dealing with medical research, clinical work and teaching. To achieve the surgeons status, medical trainees need to go through years of study and practice, with new exigences taking places of previous obstacles. This succession of challenges to surpass tend to delay the feeling of fulfillment which leads to burnout due to the distress caused in their personal well-being and lead to burnout. Newcomer surgeons may feel that work is too exhausting and that working as a surgeon is below their expectations, especially when they come from a competitive environment of academic hospitals [6].

Depression could be a result of losing control over one’s own environment, and when surgeons experience high exigences at work causing lack of efficiency and autonomy, they start to feel as if they were losing control of their work performance. Depressive symptoms might as well be related to conflicts involving work-family relation, when one loses the balance between work and family life. It was discovered that such imbalance collaborate to develop afflictions among female surgeons [6].

Surgeons’ reluctance to seek mental health treatment may have implications for patients as well as the affected surgeons. Surgeons’ inattention to their own distress may also adversely affect modeling of self-care and mentoring for physicians in training. This is notable since studies suggest that the prevalence of SI among medical students and residents may be even higher than among surgeons and that these physicians in training are unlikely to seek help on their own initiative [4].

Physicians who have reported depressive symptoms (even those for which they are receiving effective treatment) to their licensing boards, potential employers, hospitals, and other credentialing agencies have experienced a range of negative consequences, including loss of their medical privacy and autonomy, repetitive and intrusive examinations, licensure restrictions, discriminatory employment decisions, practice restrictions, hospital privilege limitations, and increased supervision. Such discrimination can immediately and severely limit physicians’ livelihoods as well as the financial stability of their families. For this reason, well-meaning colleagues or family members who are aware of the depression sometimes discourage physicians from seeking help [3].

A survey of American surgeons revealed that although 1 in 16 had experienced suicidal idea-
tion in the past 12 months, only 26% had sought psychiatric or psychologic help. There was a strong correlation between depressive symptoms, as well as indicators of burnout, with the incidence of suicidal ideation. More than 60% of those with suicidal ideation indicated they were reluctant to seek help due to concern that it could affect their medical license [4]. Other studies reveal that this concern about regulatory intervention is a very common concern hampering help seeking for mental health issues. In addition, other research suggests that 1 in 3 physicians has no regular source of medical care [3].

Physicians’ concern regarding the implications of mental illness on their medical license is likely reinforced by the fact that 80% of state medical boards inquire about mental illness on initial licensure applications and 47% on renewal applications. Other factors, including a professional culture that discourages admission of personal vulnerabilities and places a low priority on physicians’ mental health, may also be barriers to seeking professional help [4].

Although it’s a common sense that a doctor who treats him or herself “has a fool for a patient”, it’s also known that most physicians treat themselves anyway, at least on occasion. This is especially likely when the physician believes that the consequences of seeking treatment may subject him or her to stigma, shame, or worse [3].

Many clinicians are uncomfortable treating fellow physicians, especially in the realm of mental health. The “VIP syndrome,” characterized by well-intentioned, but superficial or inadequate, treatment based on collegiality and concerns about confidentiality, can detract from the effectiveness of therapy [3]. Among Swedish surgeons, the different kinds of model shows that routine meetings to discuss stressful work related situations could be helpful against suicidal ideation. These meetings may offer social support and which may lead to a better work environment and reduce the chances of suicidal ideation. In addition, the meetings could illustrate some information about roles and work situations [6].

Each surgeon should continuously map a career pathway that integrates personal and professional goals with the outcome of maintaining value, balance, and personal satisfaction throughout his or her professional career. Being proactive in avoiding burnout is preferable to reacting to burnout after it has damaged one’s professional life or personal wellness. It’s regular for surgeons to deal with stressful times in their personal and professional lives; however, it’s important to cultivate habits of personal renewal, emotional self-awareness, and connection with colleagues and support systems as well as to find genuine meaning in work to combat these challenges. The surgeons need to set an example of good health. To provide the best care for the patients, it’s necessary to be alert, interested in the work, and ready to provide for the patient’s needs, which means doing everything possible to stay healthy and reflect this feeling in the patients. Maintaining these values and healthy habits is the work of a lifetime. [8] For a better understanding on this subject, knowledge on how to develop a healthy lifestyle and the elimination of risk factors are necessary, which might explain the mortality patterns among physicians by suicide [1].

Physicians pursue the arduous task of becoming surgeons to change the lives of individuals facing serious health problems, to experience the joy of facilitating healing, and to help support those patients for whom medicine does not yet have curative treatments. Despite its virtues, a career in surgery brings significant challenges that can lead to substantial personal distress for the individual surgeon and his or her family. [8].

It’s necessary a work condition concerning the psychosocial factors among physicians, as they are assumed to be at large risk of burnout and job dis-
satisfaction. It is fundamental to identify potential risk for suicidal ideation as well as to create protective measures against it in order to prevent suicide among physician [6]. Physicians in specialties at the front line of care access seem to be at greatest risk [5].

Additional studies are needed to evaluate the unique factors that contribute to the higher rate of SI among surgeons in conjunction with efforts to reduce surgeons’ distress and eliminate barriers that lead to under-use of mental health resources [4].

More education is needed regarding this disease and its disproportionate and needless toll on the medical profession, beginning in the earliest stages of physician training. In addition, there is an urgent need to change the attitudes of those in health care (including those in the regulatory system), as well as the attitudes of the general public, toward mental illness. Such changes might encourage physicians to be more receptive to a diagnosis of depression and enable them to feel free to seek treatment without the fear of repercussion [3]. Therefore, in order to develop better strategies and offer a more prepared institutional support, it is essential to approach the institution’s management and HR with this knowledge [6].

References