Editorial

Physician Suicide: Unnecessary Losses

On a very ordinary day in a very unremarkable year of fellowship training, one of my closest friends gave me a clue I still grieve over missing: she said that in a few days, all the secrets patients and friends had confided in her would be safe forever. I remember thinking it was a strange remark, but didn't pursue it. That weekend, she left her clothes and wallet on a Nantucket beach and swam out to sea. The water must have been terribly cold: it was mid-Fall when she carried out the suicide she clearly had been planning for some time. For years we nursed the hope that one day we might see her again, but eventually we gave up. Her body was never found.

I thought of my friend once again as I read the joint study by Karin Schenck-Gustafsson's group at the Karolinska Institutet in Sweden and Daria Minucci and her colleagues at the University of Padua in Italy in this issue of *Gender Medicine*.[1] Like the women in their article about suicidal ideation in female physicians, my friend had suffered in the competitive environment of a world-class academic medical center—she deeply resented that she was never given appropriate credit for her research.

Many of us have had similar experiences. Shocked by the suicides of four of her colleagues in the year she was an oncology fellow in Vienna, Eva Schernhammer assessed the scope of the problem in a landmark meta-analysis of physician suicide. She reported that although male doctors had modestly higher suicide rates (aggregate ratio, 1.41; 95% CI, 1.21–1.65), female doctors had shockingly higher rates, with a ratio of 2.27 (95% CI, 1.90–2.73).[2] Why these women chose to end their promising lives was unclear. Drug abuse, psychiatric disorders, and the unique strains on female physicians certainly may have played a role, but the risk factors were not precisely delineated in the literature. In 2004, the year in which Schernhammer's article was published, there were only small studies of female physicians, despite their increasing numbers.

This lack of information makes the Swedish-Italian study particularly valuable, because it emphasizes the hazards of working in the competitive environment of an academic medical center. Whereas the Swedish physicians reported degrading or harassing experiences at work, the Italian doctors apparently suffered more from having responsibilities for which they did not have adequate resources. Interestingly, participation in meetings to discuss stressful work situations seemed to be protective for both groups. Unlike other studies in female physicians, there was no significant association between having children or a life partner and suicidal ideation in either cohort.

In a poignant, personal commentary on the problem of physician suicide, Schernhammer said: "The suicides that had already occurred were never discussed openly, no one undertook a publicly acknowledged serious analysis of the causes, and no other clear safeguards were put into place. The deaths were simply accepted as a fact of medical life."[3] I found this to be regrettably true; there is no silence as profound as that which greets the news of a suicide in the medical community. This is particularly true when the victim is young. The higher rate of suicides among medical personnel begins as early as medical school.[3] Most of us have experienced this kind of loss. One student I knew jumped to his death from our dormitory window during examination week. He was a tiny, anxious man who had done brilliant research as a PhD and had been urged to add a medical degree to his list of achievements. He died more than 40 years ago, but I still recall his name and the sound of his voice. I remember that his face and hair were always bathed in perspiration, and he never seemed to be at ease in our company.

In my several decades of teaching, I have been constantly aware of the pressure on medical students, house officers, and colleagues not only simply to survive, but also to excel at a discipline that none of us can ever fully master. To know everything is impossible; our best hope is to not harm our patients, either

with the medicines and procedures we give (or don't give) them or by the real possibility that what we say may increase rather than relieve their suffering. The relentless pressure of our patients' needs and demands—for the relief of pain, cure of their illnesses, and, ultimately, their expectations that we will indefinitely postpone the day of their death—never ceases. Add to these patients' needs our personal need for joy and to fulfill our commitments to family and friends, and you have a potent mix for feeling terminally inadequate to the task. I remember a brilliant young woman, one of my interns, who looked at me with real desperation and said: "My 3-year-old has a 103° temperature and my babysitter hasn't appeared. I have to go home, and I'm on call. What should I do? This is the third day this year I've not been able to meet my obligations here." I explained, not for the first time and certainly not for the last, that a woman with small children pursuing a full-time career feels guilty no matter where she is. At home, caring for her sick child, she feels the pressure of the team operating without her expected presence; at the hospital, admitting one sick patient after another, she continually battles with the conviction that she is neglecting her children.

The best weapon against physician suicide is close communication with seasoned doctors who understand that perfection is beyond our reach, that each one of us most probably has or will inadvertently kill a patient (for which it is essential to forgive oneself), and that it is not only permissible, but mandatory, to reserve time away from the demands of medical practice to sleep, enjoy the company of others, and seek environments that have nothing to do with the compelling arenas in which most of us do our work. That being said, for those of us who learn how to do a good-enough job for our patients as well as for ourselves, there is probably no higher or more satisfying calling. The secret is to find balance; the observation that meeting to negotiate solutions to problematic work situations can be protective is an important finding. But for those of us who teach, awareness of the clues that, in retrospect, seem all too clear is probably the most important responsibility we have.

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