Suicide and depression in physicians and medical students

This editorial is written to promote this year’s theme of the WHO “Working together to Prevent Suicide.” Medical students and doctors are unique populations in the community which has a high prevalence of depression, suicide, and substance abuse and are grossly undertreated populations. It should be recognized that medical students, residents, and physicians are human.

Depression prevalence in medical students across various studies ranged from as low as 1.4% to as high as 73%. Indian studies reported depression among medical students varying from 35.9% to 69.3%. Two meta-analysis revealed 27% suffer from depression and 11% of medical students have suicidal ideation. Both studies indicate <15% of total depressed medical students seek help for their depressive symptoms.[2,3] Medical students before entry in medical school have less depressive symptoms and good quality life, but within months, there is an increase in burnout and suicidality symptoms far more than age-matched peers.[4] Schwenk et al. had demonstrated even medical students and doctors have a severe stigma, and many students with depression held misconceptions that antidepressants were less efficacious and academic environment was tougher than other students.[5] Stigma in the workplace constructs such as personal weakness, public devaluation, and social/professional discrimination have been well explained.[5]

Medical profession tops among all other professions in the number of suicide per year. A rough estimate from American studies report 300-400 physician commit suicide every year. On the average this amounts one physician per day commits suicide (Louis AB 2018).[1] The above statistics are grossly underreported and skewed because of reporting the cause of death other than suicide by fellow sympathetic physicians. Indian studies are lacking in these areas, although lacking, there should be no reason to believe the status would be any different in India.

Physicians on the best estimate range have suicide rates 1.4–2.3 times higher than the general population. Depression is at least as common as the general population ranging from 12% of males and 18% of females. Physician symptoms of depression are not different from nonphysicians. Loss of hope is one of the symptoms in them that deter from seeking help from fellow physicians. A physician is not good at identifying depression in fellow physicians. It has been well demonstrated that even close friends of psychiatrists and psychiatrists themselves have committed suicide. Physician lives in artificial delineation from the patient, defining the patient “as others” and they do not belong to “the others” category. This artificial delineation creates difficulty in taking a patient role and seeking the help of a fellow physician. In the Indian context, they live in separate pseudo ideological beliefs considering them to be immune to human diseases and particularly psychiatry disorders. They and the medical community consider it shame and weakness when it comes to depression and suicide. Physicians are also worried about if their psychiatry problems are known to others, which would affect their career both academic and as a practicing consultant. Even physicians and medical students although trained in Psychiatry, harbor a lot stigma in get their psychiatry symptoms evaluated and treated. This stigma impairs the clinical practice, advancement of their career and family life. Although most of the physicians doing the job in the government sector are eligible to get claims of psychiatric treatment expenditure, often do not do so with the worry of shame and isolation. Apart from above one of the most important factors is access to knowledge about and access to lethal drugs, poor vigilance of drug maintenance in hospitals, and dysregulated availability makes them more vulnerable to successful suicide than the general population.

Medical students’ suicide is commonly heard and commonly forgotten. Legha in a “history physician suicide” quotes “despite being surrounded by other caregivers (that) begs a thoughtful assessment of why it happens.”[6]

Despite suicide, depression, and substance are frequent in physicians, medical residents, and students, they often do not take treatment. The stigma of mental health treatment is pervasive among the medical community. Psychiatrists who are not supposed to have a stigma regarding mental illness often self-medicate for psychological disease or symptoms. Emergency physicians, psychiatrists, and anesthesiologists are more prone to substance abuse than other groups of clinicians. Substance abuse is an established risk for suicide. Female doctors have more abuse of substance than females in the general population. Male doctors have 40% more chance of committing suicide, while females have a 130% more chance than the general population.
Doctors are in challenging state even with vast amount of improvement in scientific knowledge and investigations; they have to take a decision which impacts the lives of patients often these “life and death decisions” are stressful to doctor. Scientific community acknowledges in the treatment of disease, it is not only dependent on the scientific caliber of the doctor but also many factors that are known and unknown to medical science that would impact the outcome. Often a negative outcome is seen as a critical failure by the doctor himself, peers, administration, society, and legal community, whereas positive outcome often goes unrecognized. To err is human, but it does not apply to doctors is a view held by the community at large. Present legal suits and work environments have more emphasis on documentation of the clinical work then spending time on the patient. Long hours of practice and sleep deprivation in doctors makes them more prone to burnout, sleep cycle disturbance, and depression. Interphysician competition on the grounds of clinical expertise, research, and administration has made one physician as a challenge to others but not as a support to each other, a large community in which everyone is lonely.

The Ministry of Health and National Medical Council should consider the problem of suicide, depression, and substance abuse as an immediate problem and should make necessary policy changes to help physicians to handle the tough environment. Necessary legislation implemented strictly to be brought to handle mob violence against doctors. If a doctor is diagnosed with psychiatry disorder, more emphasis by the administration should be on the functionality of the physician than his psychiatric diagnosis. Substance abuse and dependence should be treated as a disease rather than a moral flaw. “Continuous medical education programs” should be taken up by an institution to reduce stigma in doctors to seek professional psychiatric help. Personality development programs should be organized to help doctors to handle stress at work and at home. Confidentiality of those physicians who seek professional help is of paramount importance to encourage other physicians to seek help.

Let us help each other to fight depression and suicide.

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