Accredited CME Activity

Physician Mental Health:
An Evidence-Based Approach to Change

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Continuing Medical Education Information

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Learning Objectives

Upon completion of this activity, participants should:

- *Describe the prevalence, risk and protective factors of suicide in physicians*
- *Identify the barriers to help seeking and positive culture change, including stigma*
- *Convey individual as well as organizational strategies to prevent suicide and burnout*

Method of Participation

This article is one of four in this CME section that must be read in order to receive CME credit. The others are "FSMB Efforts on Physician Wellness and Burnout," "Update on the UC San Diego Healer Education Assessment and Referral (HEAR) Program," and "Facilitating Help-Seeking Behavior Among Medical Trainees and Physicians Using the Interactive Screening Program."

After reading all four of the articles, CME participants should log-in and register for the CME activity at the web address provided in the "How to Participate in the CME Activity" document, and complete and submit the online post-test and evaluation. The post-test includes questions about each article. The FSMB policy on wellness and burnout is not required for CME credit. It is provided as a supplemental resource.

ABSTRACT: Awareness of high rates of physician burnout, depression and suicide is leading to changes within the medical profession at all levels. Most mental health problems can be effectively managed, but real and perceived barriers — such as confidentiality concerns and fear of negative ramifications on one's reputation, licensure, or hospital privileging — keep many physicians from addressing their mental health needs. Unattended distress has ramifications for physicians as well as the health care industry and patient safety. A number of factors contribute: in addition to individual risk factors and stress load, institutional culture plays a critical role in leading physicians to rationalize and internalize distress as part of their professional identity. There are several initiatives with demonstrated effectiveness in medical settings that can be scaled up for greatest impact: education and stigma reduction efforts, policies and procedures that treat mental health on par with physical health, and efforts that promote an overarching culture of respect. Further strides can be made by addressing hospital and state licensing forms' questions related to mental health — ensuring that questions pertain to competence rather than illness — or replacing questions altogether with a statement encouraging proactive actions to protect physician mental health and safe practice.

Introduction

Physicians who are proactive about their own health — both physical and mental — protect their ability to maintain optimal, safe patient care. Real and perceived barriers lead physicians to avoid addressing their own mental health needs all too often.[1] An unprecedented number of physicians experience burnout, depression and other forms of distress. According to estimates, 300 to 400 American physicians take their lives each year.[1] Stigma within broader societal views and within the culture of medicine play a major role, like blinders, making us

oblivious to times when our own mental health deteriorates, and keeping myths about mental health abounding. Physician distress has reached crisis proportions, having ramifications for physicians, healthcare systems, and, importantly patient safety, particularly when left to spiral out its natural course without intervention. The fact is that most mental health conditions can be managed effectively, and the vast majority of physicians with mental health conditions keep functioning well especially when care is taken, just as most physicians with physical illnesses keep practicing well; in other words, illness does not necessarily equate to impairment.[2]

It can be helpful to view mental health along its full continuum. Like physical health, mental health is the result of dynamic interactions between genes and environment, and encompasses a full spectrum from wellbeing, to burnout, to clinical conditions and suicide risk. The human condition is both enormously resilient with against-all-odds stories abounding, but at the same time, with known impediments that can temporarily dismantle resilience. We must shed our blinders regarding these impediments and have our eyes wide open in order to take action to preserve resilience and protect mental health.

One key factor shaping physicians' behavior surrounding these issues is fear — the fear of punitive consequences or loss of colleagues' esteem as a result of acknowledging mental health struggles. These conditions are actually very common to the human condition, and mostly readily manageable. Common drivers of fear are the perceived or real consequences physicians could face by engaging in mental health treatment. Patient safety can potentially be jeopardized when physicians aren't afforded the same opportunity for prevention and intervention for their mental health on par with physical health. Therefore, it is time to take inventory of our culture and current practices surrounding physician mental health. Clearly, this is an issue that must be addressed for the sake of all — for physicians and the medical profession, and for patient safety. Fortunately, there is a breadth of experience and data that provide evidence-based approaches to ensure physicians find the help and encouragement they need to responsibly manage their mental health while continuing to practice well.

ONE KEY FACTOR SHAPING PHYSICIANS' BEHAVIOR SURROUNDING THESE ISSUES IS FEAR — THE FEAR OF PUNITIVE CONSEQUENCES OR LOSS OF COLLEAGUES' ESTEEM AS A RESULT OF ACKNOWLEDGING MENTAL HEALTH STRUGGLES.

Physician Suicide Rates: Higher than the General Population

The seeds of suicide risk may be sown during medical training, when behaviors and attitudes are modeled and habits related to practice and personal life are formed. During internship, 25% suffer from depression or significant depressive symptoms,[3] and a large meta-analysis finds 28% of residents (50,000 residents, spanning 50 years) experience significant depressive symptoms that may have met criteria for major depression during training.[4] In addition to obvious contributors like stress and sleep-deprivation on top of pre-existing risk factors, such as genetic loading and early adversity, trainees and physicians also face institutional and self-stigma regarding their own mental health needs. High rates of depression, burnout, addiction, anxiety and working in settings that tolerate toxic behaviors and discourage help-seeking, combined with access to lethal means and a greater knowledge of lethality of drugs than the general population, likely contribute to the high rate of suicide among physicians.

A number of studies have demonstrated higher physician suicide mortality rates compared to that of the general population. While male U.S. physicians have a longer life span and lower rates of death due to many medical causes (such as COPD, liver disease, pneumonia) as compared to other male professionals, suicide as a cause of death is over-represented.[5] A meta-analysis by Eva Schernhammer that included U.S. and international studies, which supported the finding of elevated rate of suicide risk for male physicians versus the general male population (OR 1.41), additionally showed that the risk of suicide for female physicians is even higher: two to four times higher than non-physician females (overall OR 2.27).[6]

Another study on physician suicide by Gold et al. affords a more nuanced understanding of the drivers of physician suicide risk compared with what is known about suicide risk in general. The study utilized information from the National Violent Death Reporting System, which in drawing from multiple data sources allows for a richer analysis of risk factors contributing to the suicide: death certificates, coroner data, medical examiner information,

toxicology information, family interviews, and law enforcement reports.[7] Using psychological autopsy method, Gold's study found that the risk factors for physicians who died by suicide differ in certain ways from those of the general population who take their lives. While the prevalence of mental health problems was on par with that of the general population, fewer physicians who died by suicide were in treatment for their mental health problems. Physicians who died by suicide were less likely to have had a recent death of a friend or family member and were more likely to have experienced a job-related problem (three times greater likelihood) than the suicide decedents from the general population group. Among the physicians who died by suicide, the presence of measurable levels of antipsychotics, benzodiazepines and barbiturates occurred at rather shocking rates of 20 to 40 times that of non-physicians. The study concluded that major barriers to help-seeking exist in the medical community, and that these barriers result in less frequent diagnosis and treatment of physicians with mental health conditions and raised the possibility of concerning practices of self-medicating during times of risk.

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Reasons for Physician Distress and Suicide Risk

A number of factors contribute to the problem of unattended physician and resident distress and suicide risk. While long hours, heavy work load and onerous health care system changes are obvious set-ups for burnout and cynicism, a stoic culture of self-sufficiency alongside real and/or perceived barriers to help-seeking allow deterioration in well-being to go unaddressed and to potentially spiral into more severe, entrenched mental health problems. One major addressable factor stems from widespread perceptions concerning discriminatory practices related to mental health by state medical boards and hospital privileging procedures, which has driven mental health problems underground within the medical community. Physicians commonly cloak experiences of anxiety, worry and shame, rationalizing significant feelings of distress as part of their identity as physicians, loathe to draw attention to self-perceived weakness. Concerns about the potential for negative ramifications on their reputation, licensure, or hospital privileging, in addition to numerous other barriers — such as time constraints, uncertainty about whether treatment would help, and worries about confidentiality — keep those in need of help from reaching out.[8,9]

Consequently, life stressors converging with deteriorating mental health creates a serious risk for the physician — a risk that often goes unrecognized and unaddressed, leading to the high rates of depression and other mental health problems, and suicide within the profession. Moreover, left to informal ways of alleviating symptoms such as anxiety, agitation or insomnia, self-prescribing may be a common but dangerous practice, given the short-sighted albeit understandable desire for symptom relief, but without an assessment of the overarching changes in mental health, potential causes/contributors, comorbid conditions and a comprehensive treatment plan with ongoing follow-up. Self-prescribing or informal curbside colleague-to-colleague prescribing may contribute to suicide risk and may at least partially account for the surprisingly elevated rate of benzodiazepines and antipsychotic medications (20 to 40 times higher) in the toxicology analysis of physicians who took their lives.[7]

Cultivating a Healthy Professional Culture

Fortunately, several national initiatives have recently begun to address the issues of physician wellbeing, burnout, and suicide prevention. In 2003, the American Medical Association released a consensus statement recognizing the lack of priority given to physician mental health within the culture of medicine and identified barriers to treatment, including discrimination and licensing.[10] However, in the decade that followed not much change occurred. Significantly, in 2016 the National Academy of Medicine convened a collaborative initiative with the goal of making clinician wellbeing a national priority. The AAMC and the Accreditation Council for Graduate Medical Education (ACGME) have launched ongoing initiatives dedicated to physician/trainee wellbeing. In late 2016, the American Foundation for Suicide Prevention (AFSP) collaborated with the Mayo Clinic to produce a four-minute educational video on physician suicide prevention as well as an online handbook, *After a Suicide: A Toolkit for Physician Residency/Fellowship Programs*, which contains

best practices for preventing suicide and for supporting the aftermath of a suicide within a physician residency or fellowship program.[11] Both resources can be found on the ACGME and AFSP websites.[12]

Self-Stigma Requires Community Response

Given the high stakes for physicians and their mental health, along with recent advances in many relevant aspects of science — from neuroscience to clinical psychiatry — the promotion of knowledge and positive attitudes about mental health has a critical role to play in addressing the problem of physician distress and suicide risk. Stigma operates on the population and individual levels, particularly when an individual becomes distressed. Studies have shown that those who are experiencing depression have more highly stigmatized views than non-depressed people. A study by Schwenk et al., examining a medical student population, revealed that medical students viewed mental health problems with much greater stigma when they themselves were currently experiencing distress.[13] In response to the statement, "If I were distressed, I would seek treatment," a majority (87%) responded "yes." However, of those who reported feeling depressed at the time, only 46% said they would seek treatment. Self-stigma seems to deepen when we ourselves are distressed, and an unfortunate instinctual reflex may be to withdraw from relationships and connection. It is therefore important that even for people who recognize the need for mental health help-seeking in general and who know the warning

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signs, education must target peers and mentors to play an active role in noticing, encouraging and supporting individuals in distress to get help when needed. The signs of deteriorating mental health may be subtle in many cases, but colleagues who work closely together are well poised to notice changes and can make a difference by simply approaching the person with open-ended and caring supportive conversation. Peers and leaders can have a powerful influence by normalizing the seeking of mental health treatment.

Stigma Reduction Initiatives

Stigma reduction is a core component in successful wellness and suicide prevention programs.[14] Education plays a key role, but policies and procedures that make it safe for individuals to seek support, including formal mental healthcare, must be created and enforced to allow physicians to get the help they need when first experiencing distress. This combination of education and policy change is critically important to address fears about mental health and treatment.

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Numerous studies demonstrate a relationship between population suicide rates and beliefs about mental health and help seeking. In a Dutch study of stigma and help-seeking, various regions of high and low suicide rates in the Netherlands were compared.[15] The study showed that among those regions with low rates of suicide, people had more positive attitudes toward help-seeking and experienced less self-stigma and shame about mental health problems. Conversely, a sense of shame and more negative attitudes toward help seeking correlated with higher suicide rates.

Several successful prevention programs have incorporated stigma reduction as a prominent theme. Among the successful suicide prevention programs in countries such as Japan, Germany and Hungary, stigma reduction and increasing access to mental health care are considered core components.[16] From 1996 through 2002, an impressive 33% reduction in suicide rate was accomplished by the U.S. Air Force's suicide prevention program.[17] Stigma reduction was addressed in the leadership, throughout the ranks and, importantly, was given the backing of policy changes that protected the privacy and professional reputation of those who were referred for help, contributing to the success of the program.

A program at the University of California, San Diego (UCSD) School of Medicine, which was developed after the loss of more than 10 physicians and trainees to suicide over a period of 15 years, aimed to reduce suicide risk and enhance wellness via education and an online Interactive Screening Program (ISP) which together created a successful

safety net to recognize risk and prevent suicides.[18] The UCSD program, which began in 2009, has met with tremendous success and is still in operation nine years later. To date, more than 300 physicians, staff and trainees have accepted referrals for mental health treatment through the program; the majority report that they would not have done so on their own. One key to this program's success lies in the *anonymity* the ISP affords individuals to be screened and to dialogue with a counselor to work through their concerns about next steps, in a way that feels safe and comfortable especially during periods of highest risk.

Scaling Up Solutions

A national response to depression and suicide among physicians and trainees is underway. Several key changes have been recommended as critical to these efforts' success: safe and accessible avenues for physicians to address mental health concerns, confidential and timely follow-up and stigma reduction.[19] Specifically, it is important that programs and hospital leaders provide opportunities for those experiencing distress to follow up with a mental health professional without fear of punitive consequences.

While these important national initiatives forge ahead over the coming months and years, there are many local initiatives that have been developed and show promise for improving culture related to physician mental health and help seeking. These positive strategies can be categorized into:

Educational/curricular programs. Example: Stress Management and Resiliency Training for Residents (SMART) program, Massachusetts General Hospital.[20]

Facilitated groups. Examples: Resident process groups, Schwartz Rounds, Balint groups.

Interventions. Examples: online cognitive behavioral therapy (CBT),[21] Interactive Screening Program (ISP).[18]

Policy change. Examples: privacy/confidentiality in help seeking, health care for trainees and staff accessible within or outside home institution.[22]

Targeted programs. Examples: coaching, wellness programs, peer mentoring.

Integrated multi-pronged institutional programs. Examples: Oregon Health Sciences University (OHSU),[23] UCSD Healer Assessment Education and Referral (HEAR) Program.[18]

These efforts are critically important in order to make changes at local and regional levels. And while implementation science research is needed to determine the most impactful strategies, given the great need, current efforts are important and are appropriately inspiring other medical institutions to follow suit.

Questions for Licensing

Another critical change occurring at the state level is the review of the manner in which physician mental health is queried on medical credentialing and licensing forms. The approach has historically been to include questions about health that may lead to impairment, as a way for potential cases of physician impairment that may warrant further investigation to be identified. However, assumptions that predated the science related to fitness for duty concerning mental health may have led to ineffective, and in some cases, inappropriate questions concerning mental health. Among the U.S. states' medical and osteopathic boards, these questions are asked in highly variable ways. Several studies dating back to 1993 have reviewed the manner and focus of questions related to mental health. For example, from 1993 to 1996 there was a significant increase in states asking about not only the presence of a mental health condition, but the effect on "ability to practice"—from 42% in 1993 to 75% in 1996.[24] In 2009, Schroeder et al. conducted a detailed analysis of the questions related to mental health according to two main standards set by the U.S. Americans with Disabilities Act (ADA) (focus on fitness to perform functions of practice, and a specified and reasonable time period—"current or very recent" per the ADA.)[25] Thirty-four of the 49 states (69%) that included questions on mental health contained likely or impermissible items by ADA standards. In 2017, Gold et al. similarly reviewed medical licensing applications.[9,26] Compared with the findings eight years prior, fewer states' applications currently include questions about mental health—84% (43 of 51 applications) versus 98% (50 of 51).[26] However, unlike questions related to physical health, the ones about mental health tend to include treatment history, and only 53% of the 43 applications focus on functional impairment. Dyrbye et al. found that

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not enough progress has occurred between 2009 and 2017, since in 2017 still only a third of states' licensing and renewal questions were consistent with AMA, APA, and ADA guidelines.[9]

One recommended approach for state medical boards is to develop a process for reviewing licensing forms (initial and renewal forms) with a focus on the questions pertaining to mental health. AMA policy provides some guidance: it calls on state medical boards to "evaluate a physician's mental and physical health similarly, ensuring that a previously diagnosed mental health illness is not automatically considered as a current impairment to practice."[10] Moreover, a 2015 position statement by the American Psychiatric Association (APA) recommends that medical licensing bodies not ask about past diagnosis and treatment of mental disorders.[27]

The first consideration for state medical boards as they review their licensing forms could be:

- ***Are there other mechanisms (besides licensing forms) that allow for identification of physicians practicing unsafely?*** If so, there may be no need to include questions specific to mental health on the licensing form since most instances are not being disclosed anyway (only 6% of physicians who had sought mental health treatment endorsed doing so in one recent study[28]). Additionally, the presence of questions about mental health arguably not only historically but currently leads to a paradoxical effect of driving the mental health needs of physicians underground or unattended, leading to a much greater likelihood of problems with practice and the host of other problems with physician distress discussed earlier.

Next, state medical boards could review the questions they ask pertaining to mental health with the following criteria in mind:

- ***Are the questions focused on competence/impairment rather than illness or treatment?*** This is a key differentiation outlined and enacted by the ADA.[29] Many physicians have physical and/or mental health conditions, which do not jeopardize competent clinical practice, especially when appropriately managed.
- ***Are the questions about mental health asked in the same way as questions about physical health?*** For example: "Do you have a physical/mental health condition that is currently impairing you from safe practice?" Most physicians with mental health conditions have conditions that can be readily managed with appropriate treatment and follow-up.
- ***Is there a time constraint in the questions about mental health that is consistent with ADA guidelines ("current fitness to perform a job"[30]) and pertinent to identifying impairment?*** Asking about *current* physical or mental health conditions is the optimal way to keep the frame on this relevant and appropriate. Asking about lifetime history of depression or even over the past one to two years is not likely to yield relevant or helpful results. One example of a recommended way to ask is: "Do you currently suffer from any health condition (physical or mental health) that has compromised you from practicing safely or competently?"

Changing licensing form questions with these criteria in mind could significantly and positively impact the problem of physician mental health problems going unaddressed. Additionally, a communications campaign to physicians in each state about changes in the questions and how the medical board handles disclosed information could also advance a major step forward. One very solid option is to remove questions about mental health altogether and to consider replacing them with a statement about the critical importance of addressing mental health in order to protect one's health and safe practice. This option may be the most impactful next step, even if only for a period of time, while physicians learn about these changes and learn to trust that it is truly safe to address mental health needs in the same way we do our physical health.

INSTITUTIONS AND INDIVIDUALS HAVE A ROLE IN OPTIMIZING PHYSICIAN MENTAL HEALTH AND PROTECTING SAFE PRACTICE. PHYSICIANS SHOULD CULTIVATE THEIR OWN MENTAL HEALTH AND RESILIENCE AS AN ASPECT OF PROFESSIONAL RESPONSIBILITY.

Conclusion

Institutions and individuals have a role in optimizing physician mental health and protecting safe practice. Physicians should cultivate their own mental health and resilience as an aspect of professional responsibility. Health care institutions on local and national levels must make changes necessary to support these efforts. Key to preserving physicians' mental health is an environment conducive to help seeking in the early stages of distress, well before the individual reaches a state of crisis as well as all

points along the way. By addressing existing cultural barriers to help-seeking within the medical community — including the manner in which mental health is included in credentialing and licensing questions — physician mental health will be preserved, and patient safety will ultimately benefit. ■

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