Occupational Health Risks of Practicing Medicine

Physicians are privileged. We are highly educated, work in a profession of our own choosing, and are almost universally employed and well paid. We share in the most intimate moments of our patients’ lives. We find meaning in our work serving others. We can focus our careers on patient care, research, teaching, administration, or a combination of these domains. We have the opportunity to continually learn and grow.

Our privilege comes with a high cost to our mental health. We enter medical school with better scores on mental health assessments than our age- and sex-matched peers, but that scenario changes within the first 2 years of training. Physicians, house staff, and medical students have repeatedly been shown to have higher rates of depression, burnout, suicidal ideation, and suicide than the nonphysician populations to which they are compared.

In 2002, the American Foundation for Suicide Prevention convened a consensus panel of 15 experts to discuss what was then known about physician suicide and depression and identify barriers to treatment. The panel published their recommendations in a landmark 2003 *JAMA* article calling for medical schools, hospitals, and licensing and accrediting bodies to: (1) pay attention to physician mental health, (2) encourage help-seeking, (3) educate physicians and trainees about mental health in the profession, (4) offer support to those in need, and (5) ensure that licensure and accreditation policies and practices were nondiscriminatory towards those with a history of mental health diagnoses.

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In this issue of the *Mayo Clinic Proceedings*, Shanafelt et al present additional findings to support the ongoing need to address mental health in our profession. The authors analyzed data from a 2017–2018 cross-sectional national survey of US physicians to identify suicidal ideation (SI) and attitudes regarding help-seeking. They learned that physicians who are age 25 to 69 years are more likely than a probability-based sample of US workers to experience thoughts of suicide. Although a majority of physicians in the study expressed a willingness to seek help in case of a serious psychological issue, those with SI were the least likely to endorse help-seeking. Suicidal ideation increased in those who had higher rates of depression and higher rates of burnout. Suicidal ideation was also higher in physicians who had been involved in a recent medical error, but not higher in physicians who were engaged in recent malpractice litigation.

The authors are the first to study the relationship between self-valuation and suicidal ideation. Self-valuation is a measure of self-compassion, willingness to engage in self-care, and an ability to forgive oneself for errors. Lower self-valuation in this study was associated with higher rates of SI. The authors have therefore identified a new risk factor for suicidal ideation in physicians and a new target for suicide prevention strategies.

The research described by Shanafelt et al was conducted before the coronavirus disease 2019 (COVID-19) pandemic. From what we know from prior pandemics and early findings from the COVID-19 pandemic, we can expect there to be an increase in mental health diagnoses since the time of the study survey. This anticipated increase in clinician distress and suicidality makes acting on this study’s findings even more imperative. The researchers call upon our profession to improve access to high-quality support resources, minimize stigma associated with the use of such support, and foster self-valuation in physicians and learners.
There is a striking similarity in the call for change in the current article and in the American Foundation for Suicide Prevention recommendations from 2003. In the 18 years between publications, medical institutions have in fact made positive changes to support physician well-being. The Liaison Committee on Medical Education and the Accrediting Council of Graduate Medical Education now require wellness programming for students, house staff, and faculty.9,10 The Federation of State Medical Boards, supported by the American Medical Association and other professional medical societies, have called for the use of language that does not discriminate against those with mental health diagnoses on state licensing applications.11 National and international conferences on physician well-being have been convened. The COVID-19 pandemic has focused new attention on the mental health of physicians, particularly in response to the well-publicized suicide of Dr Lorna Breene.12

These changes are promising, but we cannot be complacent. The need for additional interventions such as those suggested by Shanafelt et al7 is pressing. Estimating that 300 to 400 physicians die by suicide each year,6 we can calculate that approximately 5400 to 7200 physicians have suicided in the 18 years that have passed between the JAMA and the Mayo Clinic Proceedings publications.

We as a society must accept that depression, burnout, and suicide are occupational risks of being a physician. Although this idea has been suggested previously,13 it has not been widely disseminated or accepted. The public may appropriately hail front-line providers for the courage they show caring for patients with COVID-19, but we all need to acknowledge the risks our physicians assume in everyday medical practice.

Labeling the problem of physician distress as a known occupational risk allows us to apply the National Institute of Occupational Safety and Health Administration model of hazard control.13 The benefits of using this model are manifold. We can apply standard practices from other industries to our exposure to occupational hazards that increase the risk for mental health disturbances in physicians. We can assess whether our own health care organizations are on the bottom, middle, or top rungs of the National Institute of Occupational Safety and Health Administration protocol. Acknowledging that burnout, depression, and suicide are known risks of being a physician may open new streams of revenue for research into physician mental health. Most importantly, recognizing our psychological distress as an occupational risk and not as an individual failing helps to destigmatize our personal experiences.

As physicians, we are privileged to do the work of healing. This work comes with known hazards and risks that should be explicitly named and discussed. Shanafelt et al7 have added to our understanding of these hazards and risks in their article, including identifying the new target of self-valuation for suicide prevention. We must apply these new findings, as well as all that we have learned over the past 18 years, to lower the intolerable rates of burnout, depression, suicidality, and suicide before another 18 years pass.

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Potential Competing Interests: Dr Lawrence reports no potential competing interests.

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