Speaker 1:

One of the big problems in the whole area of physician health is it tends to be an assumption that physicians can somehow resilience themselves out of the problems, and that if physicians only have a better work life balance and look after each other better, that somehow they'll be able to cope better, and that is just simply not true. The literature shows very clearly that the major factor causing the large amounts of burnout that are around at present time, and now studies vary, but somewhere between 40% and 50% of physicians at some stage during their lives have substantial symptoms of burnout.

Speaker 2:

Hi, I'm Dr. Laura Roberts, editor-in-chief for the Books Portfolio of the American Psychiatric Association, and welcome to the APA Books Podcast.

Today we are discussing potential pathways that lead physicians to the act of suicide. Dr. Peter Yellowlees' new book, Physician Suicide: Cases and Commentaries, depicts ways to reduce the impact of related disorders of burnout, anxiety, depression and addiction, as well as the influence of gender aging, culture and personal resilience related to suicide and physicians. It's my privilege to talk with you today, Peter, and I'm so grateful that you took on this very, very hard subject of physician suicide. I think all of us have been touched by the experience of physician suicide and care so much about our colleagues. What brought you to developing this particular book?

Speaker 1:

So I guess it's just been a long process, basically. I've been seeing physicians throughout my whole career, both in Australia and then for the last nearly 20 years now in America, and have always enjoyed seeing physicians as patients and have had an interest in medical boards and the regulation side of medicine. But what has really struck me from the whole literature is that very, very few really good visual descriptions of physicians as they become unwell and the almost life of physicians. What stresses and pressures are they on physicians throughout their whole careers and before they go to medical school? So I teach in our medical course here, our own medical students about therapy. And I actually use the life of a physician as an example of a patient and work through the various different dynamic issues that occur to all of us during our lives, both professionally and personally.

And so for instance, I make a about delayed gratification. As we all know, as physicians, delayed gratification is a huge deal. People often decide to go to medical school when they're 10, 11, 12 years old, and from literally that time on, they are not doing things that their colleagues and friends are doing because they're trying to buff up their CV and do things that are relevant to get themselves into medical school eventually. And that whole process of delayed gratification goes on throughout our lives. So that we see it with residents, for instance, who have large debt and who can't buy a house at the same time as some of their friends or female residents who maybe don't want to have children because of work and have to delay that right through to retirement where we come and commonly see physicians who don't want to retire because they're still working. The whole persona of being a physician has become very important to them. And again, they miss out on other things in life in some respect. And this has been something that my patients have told me for years. It's a big issue. So really the aim of this book was at a fairly basic level was really just try and give pictures of physicians at different times in their lives affected by different elements of the outside world.

Speaker 2:

I think the book is beautifully organized with your 10 chapters organized around 10 stories, and the stories are poignant and hard.

Speaker 1:

That's correct. And I think the stories are all, first of all, they're all fictional, but having said that, they're all based on reality. So they describe events and situations that I've either come across or heard about from other colleagues or read about. So I've tried to make them as realistic as possible. And as you correctly say, I've tried to develop a whole series of different types of scenarios, literally from a resident discussing his future career with his father and both of them whom are physicians, and looking at the difference of the two generations through to a physician from an Italian background who has ultimately killed himself and the lead up to how that happens. So I've tried to write these scenarios in a way that really then allows me to describe some key clinical issues that relate to them.

Speaker 2:

Thank you. I think chapter seven, where you craft the suicide letter of an aging physician who has learned a couple years earlier that he had cognitive, some neurocognitive condition that was leading to diminished capacity to perform as a physician in his own denial, in his own suffering through that, and then his ultimate decision to commit suicide and the hope that this letter will then help other physicians or help the institutions where they work to address these really tragic situations. Boy, that story was a very painful one to read, and yet it had such truth to it. Can you tell me just a little bit more about that particular scenario?

Speaker 1:

Yes. It's one of the more dramatic scenarios, but it's interesting to actually have to write a suicide letter as an author and to really try and get inside the person's head. And I've seen patients who've been like this and where this has happened, and there's actually quite a big literature on how senior physicians can in fact look like they're practicing well, but then when they have a single day when two or three things happen at once, they can't cope, which is exactly what happened in this situation. And so yeah, what's interesting to write the suicide letter and actually to... then I started Googling how does suicide and looking around the internet for how would I, as an intelligent person try and work out what method I might choose? And so I've put a lot of these sorts of issues actually into the scenario, and I think, I hope it comes out effectively. It's very tragic and sad end in reality for obviously a fairly eminent physician who's had an excellent career.

Speaker 2:

It was really a beautifully written chapter as they all are. When you think about what you were hoping for in developing this book, what impact you would have... What did you aspire to with this book?

Speaker 1:

I really aspired to getting the stories of physicians out there. I've been very heavily influenced personally in fact by both Aboriginal and Native American culture, and have for many years treated patients from both those areas. And for them in particular, stories are really important. And the literature on physician health tends to be a bit academic. It tends not to have large numbers of stories in it for obvious reasons. People don't want to report what actually happens for confidentiality reasons. So I decided I'd try and write a book that really had some interesting stories, but stories that were realistic really to fill that hole.

Speaker 2:

There was a distressing but amazing study that was done with surgeons just a few years ago. Thousands of surgeons participated in this study and a significant barrier to seeking mental healthcare despite feeling suicidal, was fear of being reported or reporting to licensure organizations, professional organizations about the mental health issues they were struggling with. What can we do to try and dismantle either the stigma or these barriers to care for physicians?

Speaker 1:

Yeah, I think there's two levels of stigma as you correctly say, there's the stigma of seeing a psychiatrist and we know there's a big literature on how stigmatized psychiatrists are by other disciplines. And so, that's a common problem. And then there's the extra stigma related to, I've failed as a physician because I've somehow become ill, if in fact people accept that they're even ill. And their fear of obviously some regulatory response and that fear is realistic, there's no question about that. And so, one of the things that I always talk to physician patients about is in what situation might I ever have to report them? And one of the interesting misunderstandings that quite a few physicians have is about the role of medical boards in all of this. They don't fully understand that the reason that this fear is there in reality is because the primary role of medical boards is to protect the patient.

And so whilst we pay our dues to the medical boards, really their main role is as a consumer focused agency. And they're not here specifically to protect us as physicians. And so it's very important to try and treat physicians early before they become impaired. And that's a mantra that I have with all of the patients. And it's something at UC Davis we work very hard on. We try and essentially screen and see any physicians who might be becoming depressed or addicted in the early stages of their illness so that they're not in any way clinically impaired. And as a result, we don't have to report them to a medical board because clearly it that can then become a really difficult situation for them.

Speaker 2:

What advice do you have for young physicians entering psychiatry about the kinds of issues they're going to face throughout their careers and in serving their colleagues throughout medicine?

Speaker 1:

Well, I think the first thing is don't use denial. Unfortunately, we all do that. We all believe that we're somehow good to manage ourselves. And the reality is, as physicians, we're not that special in that we have the same rates of psychiatric disorder and addiction as intelligent, similar people in the community with exception, but in fact, potentially female physicians actually may have slightly higher rates, particularly of suicide specifically. And so don't use denial, look after yourself. I think there's no doubt about that, so you need to think about resilience. We should be teaching resilience in medical schools from day one. Think about your organization and if you are angry or distressed about your organization, you need to try and do something to change it. Don't withdraw and avoid the problem. It's a much better approach is to get involved and try and change things.

And then finally, I think, think about your colleagues. If you can learn to approach your colleagues, if you think that they're distressed, then hopefully they will also approach you if you are distressed or unwell. So I think the young generation that we're teaching now are actually much better than the generation that we come from, and they are much more interested in work life balance, and they're much less interested in the evening tutorial. And I think that's actually healthy, and I think they've got a lot that we can learn from them. But it's a matter of trying to really understand important positive aspects of being

a professional because there are very many positive aspects to that culture of medicine that is heavily professionalized. And making sure you don't fall that fall into the unintended consequences, which can be overwork, doing the EMR on a Sunday evening and basically not looking after yourself, not going to the gym, not enjoying your social activities.

Speaker 2:

And what advice would you have again for your fellow psychiatrists and maybe psychologists who have a patient who's committed suicide, perhaps a physician, but someone where objectively it looks like they have so many things going for them and where it is particularly puzzling or hard to accept the loss of this patient?

Speaker 1:

I think that's a really good question because the statistics are that every psychiatrist has at least one patient during their career that they know very well who suicides. This is not just any old patient, this is someone they've really got to know well. So it's going to happen to most of us, and certainly if you treat physicians, it's likely to happen to you. And I've had two physicians who've killed themselves in my career. And I think you need to think very carefully about the actual grief process itself. I know in one of the scenarios in the book, I actually have the scenario based actually at the church during the funeral of a patient, of a physician who's been treating that patient. And I think that's part of actually the healing process. Now, not everybody goes to that patient's funerals of course, but there's no reason why you shouldn't if in fact that that feels like it would be a good thing to do.

But I think it's important, again, not to deny that this is an important issue. It's a sentinel event essentially. The death of a patient, particularly by suicide, is the equivalent of the loss of a patient on the operating table for a surgeon, for us as psychiatrists. And I think we should treat it at a sentinel event and we should discuss it with our colleagues. We should potentially review what our approach to that patient was. Was there anything else we could have done better or not? And again, take that in an educational way. And that certainly does happen in many health systems, and I think it's certainly something we should encourage.

Speaker 2:

You're listening to Psychiatry Unbound with APA Publishing Books Podcast. We'll be back in a minute.

So I think we have some statistics that maybe will be good to emphasize. So you talked about how every psychiatrist may take care of one or two physician patients who may commit suicide. Do you want to just make a few statements here about how an estimated 300 to 400 physicians die by suicide in the US per year?

Speaker 1:

That's probably an underestimate, and particularly among more elderly physicians where there are probably more suicides than we think, but where they're not marked down as suicides for social reasons by their colleagues. I guess that a very important statistic is that female physicians kill themselves 2.4 times more commonly than equivalent and age matched physicians in the community. And male physicians kill themselves about 1.4 times more commonly. And that's primarily because physicians are knowledgeable and so when they decide to kill themselves, they tend to be successful. But females, because females in the general population kill themselves less frequently than males, female physicians kill themselves significantly more commonly than the general population. Does that make sense?

Speaker 2:

Yeah. Yeah, no, I understand. So maybe a little bit about how we're increasingly aware of the prevalence of mental health issues in medical students and residents and how that may lay down the path for future mental health issues?

Speaker 1:

So we know that between 10% and 15% of physicians have some form of alcohol or substance abuse during their careers. We know that the majority of physicians still have alcohol as their drug of choice, but that increasing numbers of physicians are dependent on opiates. And physicians who tend to be dependent on opiates tend to come from the emergency department or from anesthesiology. And we know that physicians actually quite uncommonly use drugs like meth or cocaine or illegal drugs. In terms of future statistics, it's going to be very interesting to see how many physicians are using marijuana and what screening for marijuana should we be using, because that's going be highly controversial. Some health systems already screen for marijuana at employment, but most do not.

Speaker 2:

And so can you tie together then these issues related to substance use and suicide?

Speaker 1:

Sure. I think we know that in people who suicide in the general population, a large number of them have taken substances of some description. I think it's at least 50% or 60% have taken substances prior to the suicide. There's no reason to suspect that physicians are any different from that, although I actually haven't seen any studies of the amount of substances ingested by physicians who have suicided.

Speaker 2:

I think something that I've become more aware of in the field of suicide is that not everyone who suicides actually has a pre-existing mental illness, that there are really issues around impulsivity, emotional regulation where there's just this catastrophic moment of rupture of belonging or a sense of place that leads to the act of suicide that may not have been contemplated much in advance.

Speaker 1:

I think that's very true, and I think the area where that's probably significant within physicians is in the area of how we call people disruptive physicians, which essentially are primarily physicians who've got personality disorders and who are very difficult people who are well known to their colleagues for being difficult people on committees, often fairly narcissistic and who have a very fragile inner world frequently and certainly tend to be risk takers. And I think that's a group that may not in fact meet formal criteria for depression, but who are at potential danger.

Speaker 2:

You talked about denial and self or delayed gratification. Is there any other humanistic?

Speaker 1:

So I think one of the big problems in the whole area of physician health is that tends to be an assumption that physicians can somehow resilience themselves out of the problems, and that if physicians only have a better work life balance and look after each other better, that somehow they'll be

able to cope better. And that is just simply not true. The literature show very clearly that the major factor causing the large amounts of burnout that are around at the present time and studies vary, but somewhere between 40% and 50% of physicians at some stage during their lives have substantial symptoms of burnout. The studies show very clearly that most of the cause of that can be attributed to organizational issues. In other words, to how the health system works to pressures that are external to the physician.

The biggest pressure in the last decade has clearly been the electronic medical record and that whilst I'm essentially very keen on technology and strongly supportive of it, the reality is many physicians have had to deal with horrible EMRs and spend a lot of time with their work and their home lives quite disrupted by the need to try and keep up with their notes. And that's a big pressure on people. So a very clear message I want to get out is that physicians shouldn't be blamed for this and shouldn't feel that they're the problem. I think they're a symptom of a much broader problem.

Speaker 2:

And then stating the flip side to it, there are many things that institutions can do to try and create a context in which their physicians will be healthier, not languish, where they'll flourish, not suffer.

Speaker 1:

That's exactly right. And there's been several very good studies on that. The Institute for Healthcare Improvement has put out an excellent white paper, for instance, as has the Mayo Clinic, looking at how can institutions in fact improve and what are the organizational changes that you need to start making to try and make life better for clinicians of all times, not just physicians. And I think these approaches, as you correctly say, are focused on the system. And so, one of the things that any new physician or new psychiatrist needs to think about is systems theories and how do they fit into the system and how can the system affect them and how can they affect the system?

Speaker 2:

Institutions may struggle with really coming up with radically new ways of supporting their physicians. It isn't just for the wellbeing of physicians themselves that institutions should take this on. It's also there's this beautiful literature on how healthy physicians support, say preventive health practices in their patients, that physicians who report feeling good and feeling healthy actually have lower lengths of stay for their acutely ill patients. How does that make sense? But we're finding that healthy physicians leads to healthier patients.

Speaker 1:

I think there's absolutely no doubt about that. There's a very strong correlation between both of those things and certainly all of the studies say exactly what you are saying, which is that if you can keep your physicians and all other clinicians in your system essentially happy, enjoying their work, more positive about their work, often more in control of what's going around them, more involved in decision making, listened to so that they really feel validated in what they're doing. There's no doubt if that happens, that patient care will be improved.

Speaker 2:

Beautiful. Good. Again, anything else you want to cap it off with? Very nice.

Speaker 1:

Thank you. The area we haven't covered much is burnout.

Speaker 2:

Yeah, go ahead.

Speaker 1:

So burnout has been described for many years now, and we know that it is a continuing long term problem within the healthcare system. What we don't know really is does having burnout necessarily lead to depression or anxiety or substance abuse? It's probably a stressor, but then so many other things. And I think probably burnout is best seen in most physicians, as actually been really primarily cause from the system. It's really a symptom of a health system that's not working as well as it should be. And I think if burnout is seen as being symptomatic of health systems rather than symptomatic of physicians being unwell, then I think that's a nice way of thinking about how can you then move forward and actually start effectively reducing burnout within the workforce.

Speaker 2:

Yeah, I love what you're saying. There's been this confounding of burnout with whether it's just depression in the physician rather than seeing it as symptomatic of a larger issue. And I think actually the literature on the prevalence of depression and anxiety in say residents and medical students is actually contributing to this confluence and maybe confounding of these different kinds of ideas. One being burnout, institutional contributors to burnout, and then the issues that young physicians and physicians across their life are dealing with that are mental health issues that many people encounter.

Speaker 1:

Yeah. Yeah. One other thing that you may find...a set of thoughts that may be interesting I've talked about a little bit in the book was this issue with admission committees. And in some respects, when we actually try and select pre-med students to come to medical school, we look for people who often have traumatic backgrounds who have what we would now think of as being high ACE scores, those child event scores, who have been through the mill and yet who've survived and managed to academically thrive and get to medical school, and who at the same time are maybe caring and a bit compulsive. And so these are often the people we admit to medical school. Now, if you think about it, these are actually people who are specifically vulnerable towards developing later psychiatric disorders or potentially addictions. And so I think we really have to think very carefully about the background of our physicians when we're talking about medical school admissions and who we're actually choosing as physicians because we're not necessarily choosing the most healthy group.

Speaker 2:

So you say more about this, what evidence would you, instead of the distance traveled overcoming adversity profile of a young student or candidate for medicine, how would you look at evidence of resilience, wellbeing, health?

Speaker 1:

I think that's something we don't really know. And I'm speaking as somebody who's read hundreds and hundreds of the two pages that the medical students have to put together to convince an admission

committee that they need to come into medical school. And they frequently start off with talking about the traumas of their past life or how their family has been affected by a number of medical illnesses and how they have managed to survive that. And it's been interesting and they've then gone and done great things. Now, of course, I'm not in any way suggesting we shouldn't be admitting people who've overcome adversity, but I do wonder whether in fact, we are possibly self-selecting in some cases people who might have more risk associated with them. And what that means, of course, is that we need to be very open about that at medical school and talk to them about this issue. And if there are some young people who are more at risk, we need to try and prevent them having difficulties later on in life.

Speaker 2:

Then of course, there's the experience of being a trainee, maybe losing a patient, witnessing terrible tragedies, accidents, and this idea of traumatizing and retraumatizing young physicians as they go through their training.

Speaker 1:

That's exactly right. In fact, one of the chapters is focused on the second victim, which is a really interesting concept that has actually been mainly developed from a nursing literature and looks at the trauma associated with being close to someone who's died or being essentially the person away from the immediate treating person or the person on the unit where there's been a whole series of deaths or traumas that have occurred. And I think that second victim syndrome is very true, and a number of health systems are now looking at that in more detail and trying to essentially provide some extra counseling and support and interventions for a much wider range of staff than just maybe the individual physician who lost a patient.

Speaker 2:

On an upcoming podcast, we will feature Alan Schatzberg. He will be talking about his textbook, the Textbook of Psychopharmacology Fifth Edition.

So Peter, what advice would you have for treating physicians who are often notoriously difficult patients, but also there are colleagues, there are VIPs in our systems.

Speaker 1:

That's exactly right. And I think first of all, you need to really think about your patients when they're VIPs and especially if they're physician VIPs. There's been a number of, actually in quite interesting papers looking at what does the "I" stand for? The traditional term is important, but in fact it could be either influential or intimidating just as effectively. And so in my approach certainly is to be very clear with those people, and especially if they're physicians, and to assume that they have no knowledge of psychiatry. I think that's the only safe thing to do. A lot of physicians assume that they have too much knowledge or somehow are special because they've been through a six-week course many years ago when they were at medical school, and they must know all about it. The reality is most physicians are actually surprisingly ignorant about psychiatry, and so I treat them as intelligent, rational human beings who could be just as equally a business person.

And I think actually that's the best approach because if you do that, then you don't get caught up with them trying to give you the diagnosis all the time, with them trying to manage their own treatment, with them trying to believe a special patient. And you treat them as you would other intelligent and hopefully

insightful patients, but you don't cut corners. And I think there's a real need for us to actually start looking at how do we essentially treat other physicians and other VIPs. So really no courses as to how to do that I know of, and those sets of guidelines for how to do that. So one of the things I've tried to do in this book is lay out a few possible guidelines as to how as a physician you can treat the VIPs effectively.

Speaker 2:

So give some examples of some of these best practices that you would recommend to your colleagues.

Speaker 1:

Well, the first best practice is actually, if you've made a diagnosis, is to actually talk it through with a patient. Don't assume that they know what you mean when you say that they've got a panic disorder, and to treat them in the same way as you would anybody else. So I'll give them the educational materials, I'll tell them to go away and read about it and come back and have a discussion and be really clear about what is the problem that you are attempting to help them with and treat them for rather than assume somehow they know what you're talking about because they're all proud and they're not going to say that they don't. So assume that they're proud and assume that they're more ignorant about psychiatry, but that they're still highly intelligent people.

My experience overall treating physicians, it is that they really appreciate you being extremely straightforward. So I've told several physicians to their faces that they have a narcissistic personality disorder and without any messing around, and they usually get a bit offended, but then work it out and agree. And so once, if they're told directly, they're told honestly, then my belief is that the great majority of physicians actually really appreciate that, and they also appreciate you making it clear that you have a plan for them because they're coming here to see you because they haven't got a plan and they've often thought about seeing you or seeing other people quite a lot beforehand. And so at one level, they're really looking for someone to help them get back in control of their lives because they're generally out of control by the time people like you and I might see them.

Speaker 2:

Good. How about just really basic issues. Do you call your patient by their first name? Do they call you by your first name? How do you deal with the fact that your peers at the same time as being the treating clinician?

Speaker 1:

Yeah, I think that's very interesting. I tend to be fairly formal and certainly when I'm seeing people initially, and I'm respectful of them as Dr. Smith, just as I hope they're going to be respectful of me. And I think that's the best approach, and I tend to do that with all of my patients. So really for me, I don't treat physicians in a way that is particularly different. Inevitably for some patients who end up on first names basis with who you've seen reasonably regularly. And that happened as a part of a process, I think, over time. But no, I think keeping things reasonably formal is definitely a better approach.

Speaker 2:

Just between you and me, I'm very formal. Yeah, I actually don't call any patients by their first name. Right? Yeah, ever.

Speaker 1:

Yeah, I've got a couple that I do, but people are seen for two or three years.

Speaker 2:

Yeah, it's after a long time. Yeah. Okay. So let's think, again, it's one thing if a physician comes to you and is really seeking some help with their life issues and worries that they're out of control. But how about if you as a physician, observe a colleague where you're quite concerned about them and believe that they really do require mental health support? Do you have thoughts on how best to approach that situation?

Speaker 1:

And I've had to do that a couple of times in my career with fellow psychiatrists, on both occasions, they're people I've known moderately well, and I've actually just asked them out for coffee and I've gone to the local coffee shop with them, and then I've raised a topic in an environment that is completely open but confidential with the corner table in the coffee shop and where they hopefully can't get too upset with me and they completely walk out if they want to. But that is more socially acceptable in some respects and a bit less threatening. And so on both occasions, I've done that with colleagues and it's actually worked out well on both occasions, and they've appreciated me getting away from work so that nobody could see us talking about anything that might be difficult.

I've on both occasions just said, "Hey, just this is my impression. I can't force anything on you, but I'm just telling you that I'm giving you some feedback and doing that as a friend and a colleague. I'm not trying to be too pushy about this, but are you aware that if I'm noticing this and probably other people are as well, and how would you like to deal with that?" So that would be my normal approach to someone in that setting if possible. I see quite a few physicians who don't necessarily want to come and see me and who've been sent to me as I chair the wellbeing committee here at UC Davis. So I see a number of people who are referred to the wellbeing committee. And first of all, I always see them with someone else, not by myself, so that we have some sense of protection and the two of us there together to make sure that our stories are understood.

And then, I'm very clear with physicians that they don't have to see me in that setting, but it's up to them, it's their choice that on the whole, from the wellbeing committee perspective, we are the good guys. We're the guys who can actually help them. We're the guys who are there to try and see if there's a problem that can be treated and that we can assist them with either treatment or monitoring or whatever is necessary in that environment, and potentially ensure that the health system isn't going to punish them to the same extent, or that they're not going to get reported to the medical board. And so it's really up to them if they want to talk to us, they can. If they don't, then just, that's what I'll report back and just say that the individual didn't want to discuss things with us. And so far, touch wood, we've really only had about one person in the last nine years who hasn't then talked to us as a committee in that setting.

Speaker 2:

Yeah, beautiful. Good. I can't see. I'm trying to find the burnout.

Speaker 1:

I'll try again. Sorry.

Speaker 2:

Okay. Yeah, good.

Speaker 1:

I'm getting stupid by your question.

Speaker 2:

No, no, no, no. But I think it's because I have a barrier to it because I so dislike the construct. But anyway, so-

Speaker 1:

Well, ask me about that. I'll tell you my view on that if you want. That's fine. I can agree with it.

Speaker 2:

Yeah. Yeah. Yeah. So the term burnout is somehow uncomfortable for me, and yet it is really a concept that has gained some traction in the empirical literature on physician wellbeing. And so can you just explain a little bit about what the idea of physician burnout is, and then if you could also comment on how you think it may or may not relate to mental illness.

Speaker 1:

So first of all, I completely agree with you. I think it's a very difficult term. I hope it never becomes a formal diagnosis. And I think the symptoms that are reflected in burnout, wax and wan quite dramatically over time and don't have the consistency of symptoms you'd expect to have a diagnosis. So I think of it as being a syndrome, and it's a syndrome that has changed over the years, but nowadays basically consists of three components. The first is essentially just tiredness, physical and emotional exhaustion. The second is a feeling of cynicism and detachment from your patients and from your work. And the third is just feelings of ineffectiveness or a lack of accomplishment at work. So basically you feel tired, you're not interested in your patients, and you don't feel you're doing a good job. That's the bottom line with burnout, and that's all three levels.

Now, the literature suggests that probably about 15% to 20% of people at anyone at time during their careers have all three levels. The problem I have with the literature is that it really is looking at only one of the three levels or one of the three constellations of symptoms. And so, a lot of these big studies that have been done in recent years where levels of 55% of symptoms of burnout have been reported have really only reported one out of those three constellations of symptoms. And it's like saying, "Hey, we've got an awful lot of people who are slightly depressed sometimes." So I'm fairly careful about how you actually assess burnout. And I think that the numbers that have thrown around about at the moment are very easy to misinterpret.

Speaker 2:

And so is there an observation about burnout and the presence of mental illness and burnout and suicide?

Speaker 1:

Yeah, so I think the assumption that most people make, and I would make the same assumption, is that burnout is a symptom of something. As I say, my personal view is it's primarily a symptom of a system in distress rather than an individual, okay? But working in that system is still a stressor for the individual.

And so I would see it as being one off a number of stressors that might lead to depression, for instance, as along with a family history of psychiatric illness, along with maybe drinking too much, along with not being as healthy as you should be. So along with difficulties with your marriage, and all sorts of other things as well. So I just see it as being one of those symptoms. And in some people, and there's a scenario in the book where this occurs, it's burnout, then gradually changes into depression. And I think that certainly does happen, but as in the scenario in the book, there are multiple other stressors as well, not just the burnout that's work related.

Speaker 2:

Thank you. Perfect. Unbelievable. So are there other thoughts on this particular book, Suicide, it's prevalence, getting the stories out there.

Speaker 1:

Yeah. Actually one other very important thing. Okay. Yeah. So about the effectiveness of physician health programs. Okay? So I'll just talk about that. So one of the things that is hidden quite honestly from most physicians is that if physicians have an addiction to whatever substance, there are actually highly effective treatment programs available through the physician health programs that most states have, or in the state, in California's instance that many hospitals have. These physician health programs that typically involve people being assessed, monitored, and treated, have incredibly good recovery rates with rates at five years of about 75% of physicians in them actually both working and being licensed as physicians. Now, that's way better for someone with a substance abuse than any other treatment program I've ever heard of in any non-physician group. And so the physician health programs work through a combination of carrots and sticks.

The carrots are that you keep to practice, the medical board doesn't frequently get told about your problem, but you get appropriate treatment. The sticks are, but the risk is that the medical board will be told or you'll lose your job. And at the same time, you are put through a mandated body fluid monitoring process whereby, you probably have your urine tested depending on the drug and the situation most weeks. But these programs are highly effective. So one of the myths about physician health is that the physician addict cannot be helped. And I would strongly suggest that that's not true, and that any physicians who are addicts who might be listening to this or any people who are wanting to assist colleagues who they think are addicted in some way should confront them and should get them into treatment through a physician health program, because the outcomes of these programs are really amazingly good compared with not getting treated.

Speaker 2:

Beautiful. Oh, that's great.

Speaker 1:

So, no, it's true. It's astonishing. I wrote a paper on psychiatrist being followed up, and it was 80% working and licensed at five years, all of whom had had substance problems that are led to them going into the program initially. It's amazing.

Speaker 2:

Good. Okay.

Speaker 1:

Okay.

Speaker 2:

Okay. Beautiful book.

We hope you're enjoying this program. The APA Publishing Books Podcast, Psychiatry Unbound.

I'm speaking today with Dr. Grace Gengoux, who is a clinical associate professor in the Department of Psychiatry and Behavioral Sciences at Stanford University's School of Medicine. Grace is a licensed clinical psychologist and a board certified behavior analyst who has particular expertise in the clinical evaluation and behavioral treatment of children with autism spectrum disorders. But grace also has an extraordinary interest in the wellbeing of mental health professionals and thought would be just a wonderful person to talk to about Dr. Yellowlees new book, which is on a hard topic about physician suicide and cases and commentaries. So Grace, let me just thank you so much for visiting with us today.

Speaker 3:

My pleasure.

Speaker 2:

I want to welcome. Yeah, I want to welcome you to the APA Books Podcast.

Speaker 3:

Thank you.

Speaker 2:

So you read Dr. Yellowlees book?

Speaker 3:

Yes.

Speaker 2:

Hard book, huh? Beautiful hard book.

Speaker 3:

Yeah. I have to say, the topic of physician suicide is a difficult one to talk about and difficult one to read about. One of the things I appreciated really the most about the book was the writing style really was very captivating. And the way that Dr. Yellowlees decided to bring in the case studies, the fictional case studies as a way of presenting these really difficult topics in a human and very empathic way. I actually loved reading the book. It was quite a page turner and I learned a lot, and I really am going to start recommending it to many of the people that I know, both people who deal directly with physician suicide, but also I think it's a great text for any of us working in the healthcare professions to help us understand more about how we can help our colleagues and for students to learn about prevention strategies. He talks a lot about system and individual prevention strategies, which I loved.

Speaker 2:

Yeah, I thought that I learned a great deal about self-compassion in this book. And I also learned not to blame the victim. We all theoretically would never blame the victim, right? But as he told the stories, looking at the systems components, what set things up that led to these tragedies? I thought was really very, very well illustrated.

Speaker 3:

Yeah, definitely.

Speaker 2:

Let's talk about a couple of the techniques he used in the writing. What made it so captivating? Why was it a book that you wanted to read despite such a hard topic?

Speaker 3:

Yeah, in the introduction, he talked about drawing inspiration from Oliver Sachs and his tradition of telling stories about patients through a narrative approach. So the way the book is organized is that each of the chapters deals with a central theme related to physician suicide or illness or wellness. But starts with a story that's a fictional depiction of probably a drawn from his clinical experience and from the literature, but designed to illustrate the specific challenges around physician wellness. And I think what's so well crafted about the stories is that they read like fiction. It's exciting to find out what happened next, but they also are illustrating the way that the systems, some of the maybe exemplary systems that have been developed to handle physician wellness problems can intervene and can be helpful in challenging situations where physicians are at risk of suicide.

Speaker 2:

So ironically, there's a hopeful message in much of the book, even though it's really focused on physician's suicide.

Speaker 3:

Absolutely. I think that's a real strength of the book, that it illustrates different techniques that can be used in a healthcare system, but also by individual practitioners to prevent suicide. I think there's quite a bit more that can be said about the topic of physician wellness. Maybe there'll be a second book that talks also about wellness, even for those not at risk of suicide, but to enhance the meaningful contributions that professionals can make to their patient health through enhancing their own wellness. But I love that, that optimistic or solution focused approach.

Speaker 2:

Yeah, I think one of the great developments in the field is not just to look at burnout and these negative impairment, very negative aspects of the lives of professionals, but to turn it around and look at how the positive self care practices, self-compassion, wellbeing certainly helps maintain the workforce, keeps people working and caring for others, but also translates into improved patient care practices.

Speaker 3:

Yeah. I remember parts of the book that talked a lot about the importance in healthcare systems of better care for patients, better outcomes for patients, and of course lower costs. But Dr. Yellowlees does

a nice job of pointing out that the activities that support clinician wellness make it easier for patients to improve faster as well.

Speaker 2:

So could you just talk a little bit about how you came to have an interest in this area?

Speaker 3:

Sure. Probably like many of us, I have a professional interest as well as a personal interest. So you mentioned in the introduction that my main area of academic focus is in the area of autism treatment. And in autism treatment, we have found over the years that strengths based approaches to treatment really have the strongest effect. And one of the reasons for this is that children with autism have such difficulty interacting with others, that they develop a feeling of learned helplessness, where they learn that their behavior doesn't really matter in their environment. And one of the things that's very therapeutic about the behavioral treatments we do is that it helps children feel more confident and successful and makes them want to try more.

And as I've worked more and more with children and families of children with autism, I've learned that this is actually true for all of us. We've started to add more work on helping parents of children with autism feel optimistic, build the skills for resilience in their difficult lives. And it turns out that stress doesn't inevitably lead to impairment, but that you can teach resilience and there are types of treatments that really do improve resilience. And as I've been working in this area, I've realized that my colleagues also sometimes suffer from learned helplessness, myself as well. And so I've started to become really interested in what we can do as a psychologists, as psychiatrists, to apply what we know helps the mental health of the individuals we work with to help us be more professionally effective, but also more personally fulfilled.

And then I have to say, as I have two young children, and as a mom, I realized that I had to learn this the hard way myself. When I was pregnant with my second child, I developed a condition where I really couldn't walk without a lot of pain and realized that I had as an ambitious professional and carer, and mother, a very dedicated mother, I had really neglected my own care and hadn't been taking care of myself well enough. And so I started to read a lot about wellness and about how to improve my own self care practices. And it's started a cycle where I met a lot of people who were interested in wellness for professionals and started to try to inspire others to take care of themselves.

Speaker 2:

So how's it going?

Speaker 3:

Well, I have to say everything I've learned has made me realize that this is not... that I'm not alone, that this is not a challenge that only a couple of us face. Actually, this is one of the things that was so also interesting about the book. Dr. Yellowlees talked about the different developmental stages in a professional's career and really highlighted the unique challenges for students, for early career professionals, for late career professionals, and even for mid career professionals, how at every stage of a professional's career, the topic of wellness has really an important meaning. So personally for me, the chance to connect with other people around the topic of improved wellness has helped my personal happiness tremendously and my professional effectiveness as well. It turns out that the happier and

more satisfied we are, and the more we're working on meaningful contributions in a career, the better we feel and the more effective we can be.

Speaker 2:

So this is a podcast, but I'm able to see Dr. Gengoux's face and she's got a big smile, and it makes me smile too. So I think what you're talking about is very, very inspiring. The other thing that I think you saw, let me put it differently. I heard you mention that the solution focused approach that Dr. Yellowlees takes is something that you value about the book. Could you comment a little bit further on that?

Speaker 3:

Yeah, I think there's been quite a lot of awareness, maybe still not quite enough, but awareness of physician burnout and the negative consequences that can come from that, both for the physicians themselves, but of course for their patients as well. But I really think that now in the field, wherein we have a unique opportunity to advance the science around individual and organizational supports that can be put in place to enhance wellness and much more work will need to be done in this area, but Dr. Yellowlees really starts a very important conversation around how to think about both the individual and the organizational improvements that can be made around wellness. So he highlights a few key areas, I think. One is the issue of choice and control.

Actually, back to the work that we do in treatment of autism, we work a lot with the variable of choice across scientific areas. We've seen that when people have choices, it increases their motivation, it reduces their feelings of helplessness. There's even pretty strong neuroscience emerging around how it's not just that people love what they choose, or it's not just that people choose the things that they love, but they come to love the things that they choose. And I think in talking about how to improve physician wellness, one of the systems that can be put in place is greater choice for professionals around their work. Another area that he highlights is the importance of really allowing professionals to make a meaningful contribution that he made a suggestion, I think in one of the chapters about physicians having 20% of their practice devoted to care in an area of strong personal meaning to the physician. This is another thing that's been shown across industries, really, that when people are really connected with the mission that their work relates to, their sense of meaning improves and their wellbeing improves as well.

So I like the suggestions around ways to connect us all with the meaning in our work, the practice of medicine, the practice of psychiatry and psychology. These are fields that have tremendous potential to bring, to make meaningful contributions and can be some of the most rewarding and inspiring choices for a profession. But they also come with serious risks because caring for sick people is hard work. It's not inevitably going to lead to burnout, but a lot of supports need to be put in place to make sure that those who are working with the most challenging patient populations or with the most challenging illnesses, have the support so that they can provide that care with compassion and empathy and with the fullest extent of their expertise.

Speaker 2:

That's beautiful. That really is great. What else? I think Peter, in his preface talks about how 400 physicians end their lives intentionally every year. And we really think that's probably an underestimate. And with issues around addiction and substance use, there may be a number of deaths that aren't counted in that figure. And so, it's given that so many different conditions affect so many different thousands and thousands of people, how do we begin to understand that number of 400, 500, whatever

it ends up being? How would you think about that number of 400 deaths of physicians every year due to suicide?

Speaker 3:

Right. That's a huge number, because behind that are thousands and thousands of people who are suffering. The 400 is the worst case scenario. That's the worst outcomes. And many, many physicians feel the stress of their work and feel isolated and have feel like there's nowhere to turn where they can get private or confidential help. And then there's the effect on their patients, the thousands and thousands of patients that a physician who is unwell might be in contact with.

I think that the book really highlights how important it is to have systems to identify physicians at risk and systems for colleagues to help guide physicians who are at risk into care, and how to provide intervention with enough privacy that physicians feel like they can access it. This is an area where I think the increasing use of technology in treatment will be a huge benefit. Dr. Yellowlees points out in the book how some apps have been developed for helping push through at mental health interventions, of course, to patient populations across the world but there are specific technologies that can help physicians. But also how being able to see a healthcare provider via the web or receive psychiatric care over the internet can really help, on the one hand, decrease some of the burden of providing the care to patients, but also can increase the privacy when physicians themselves need to seek care in their own systems.

Speaker 2:

There have been empirical studies of medical students, residents, practicing physicians, an astonishing study of surgeons just a few years ago, where fear of professional repercussions really prevented them from seeking mental healthcare even when they felt suicidal or were preoccupied with thoughts of suicide even over a sustained period.

Speaker 3:

And I found it surprising. Dr. Yellowlees references several times in the book, even among physicians in general, the access there, he says, "I think 35% of physicians don't have their own primary care physician." And so the access of mental health care is even lower than that, which is quite concerning. And I think those issues around privacy are a key way to break down barriers to access mental healthcare.

Speaker 2:

One of the things that Peter talked about in our interview was the idea of delayed gratification and self sacrifices going with training in the professions and how we get into the habit of not taking care of ourselves.

Speaker 3:

Absolutely. So on the other hand, there are aspects of being a physician or being a mental healthcare provider that do place you at great risk of compromised wellbeing. But on the other hand, I think that there are aspects that of mental health care professionals that really mean that they have great potential for wellbeing. These are usually people who care about taking care of others, care about... believe the science that self care matters, and are very driven and energetic and have been successful in

many of their other endeavors. So it feels to me like there's no excuse not to apply what we know about mental health to ourselves.

Speaker 2:

My own experience has been that it, I've had such a meaningful career in psychiatry that I find it is so inspiring. And so this one dimension of meaning and purposefulness and feeling like you're aligned with that role in life really speaks to me.

Speaker 3:

Yeah, absolutely. I also find that the more that I'm working on the things that I care the very most about, the more that I feel like I have the energy to support other people's wellbeing as well.

Speaker 2:

You and I wrote, well, mostly you wrote this beautiful, beautiful editorial on the topic of wellbeing, and one of the key features of that narrative were the lessons that we could learn from psychology as we think about wellbeing in medicine in particular. So perhaps there's some guidance you could offer from the field of psychology.

Speaker 3:

Right. Well, one of the things that I think a movement that's been happening in the field of psychology for a long time, but is continuing to gain steam is the focus on of positive psychology. The focus on strength based approaches to treatment, the focus on optimism and resilience. Much of the focus of even cognitive behavioral therapy is on how to teach people to be both realistic, but also to break down any unnecessary or unhelpful pessimism that emerges from stressful life experiences. The other area in psychology that I think contributes quite a bit to this discussion is the focus of organizational psychology. There's a lot that both on a very practical level, a lot about the workplace that can be adjusted to promote health. So we know that flexible work hours promote health and access to affordable childcare and household health. And even things like, there was a study I was reading about how the number of patients that a doctor sees doesn't seem to really negatively affect their wellbeing, but the things, the paperwork and the other burdens of the job are the things that really seem to contribute the most to burnout.

For instance, Dr. Yellowlees mentions in one of his chapters, the use of medical scribes to help reduce the burden around the electronic medical record documentation that physicians have to complete. And I think there's a lot from organizational psychology, there's a lot of simple practical innovations that can be put into workplaces to make the just day to day functioning of a worker more efficient. And then at a higher level, that field also has quite a lot to say about how to make people's work lives feel more meaningful. So the ways to increase personal connections at work, personal connections have been shown to really influence wellbeing, maybe more than almost anything else. And how to help people, help professionals be more effective in their leadership style. So I had a chance to talk with some of the folks in the business school and other departments in our university, and there's actually a wealth of information about how to cultivate leaders and how to coach individuals to be more effective professionally. I think access to those kinds of resources is also could be a tremendous benefit to physicians as they are developing their careers.

Speaker 2:

Thank you for sharing this day with us. You're listening to Psychiatry Unbound, APA Publishing Books Podcast.

Speaker 4:

Our host is Dr. Laura Roberts. She is the Catherine Dexter McCormick and Stanley McCormick Memorial Professor and chairman of the Department of Psychiatry and Behavioral Sciences at The Stanford University's School of Medicine. She is also editor-in-chief of the books program at American Psychiatric Association Publishing.

Speaker 5:

Dr. Peter Yellowlees is professor of Psychiatry and Vice Chair for Faculty Development in the Department of Psychiatry at the University of California Davis School of Medicine in Sacramento, California, and president of the American Telemedicine Association, headquartered in Washington, DC. Dr. Grace Gengoux is a clinical associate professor in the Department of Psychiatry and Behavioral Sciences at Stanford University.

Speaker 4:

Our original music is by Willow Roberts. Our coordinating producer, Kyle Lane-McKinley. Our executive producer, Tim Marney. This podcast is made possible by the generous support of Stanford University. We are a production of American Psychiatric Association Publishing, John McDuffie publisher. To purchase copies of this book or other books by our guest or host, please visit www.appi.org. That's appi.org. If you'd like to contact us, drop us an email at bookspodcast@psych.org. We hope you enjoyed this podcast, and thank you for listening.