

SECRETS



TRUTHS

WHEN PHYSICIANS –
AND STUDENTS –
ARE DEPRESSED

BY WHITLEY HILL



THEY are the brilliant ones. With apparent ease and equanimity, they juggle lifesaving clinical care, complex research, long hours, endless paperwork and bureaucratic frustration — and family life from which they are too often absent. Some teach and volunteer as well. They are confided in and trusted. They are witness to their patients' most private moments: those of birth and death, of elation and painful, fearful struggle. They are America's physicians: accomplished, competent — and, too often, suffering from depression.

Studies since the late 1980s have confirmed that there is a crisis in American medicine: Physicians in this country suffer from depression at rates exceeding those of the general population, usually in secret. Between 300 and 400 American doctors commit suicide every year, according to the American Foundation for Suicide Prevention.

Thomas Schwenk, M.D., the George A. Dean, M.D., Chair of Family Medicine, professor of medical education and associate director of the U-M Depression Center, spearheaded a recent study that confirms what many have suspected; namely, that this trend may have its roots in the medical school years. It also lays bare an ugly truth: In the culture of American medicine, despite our apparent new awareness and tolerance of mental illness — and all the programs and therapies and support groups — stigma remains an insidious and powerful adversary. Schwenk and his team decided to focus their attention there.

"If you go back nearly 30 years, there are clusters of studies that show a high prevalence of depression in physicians and a known increased risk of suicide," says Schwenk. "We decided to look into the issue of stigma in depressed medical students to move the field along, to get past epidemiology and prevalence in order to begin thinking about interventions."

The study, "Depression, Stigma, and Suicidal Ideation in Medical Students," was published in the *Journal of the American Medical Association* last September. The cross-sectional

survey was conducted in fall 2009 and drew responses from hundreds of University of Michigan medical students.

Lindsay Davis, a student then between her first and second years, worked on the project with Schwenk. With data from student focus groups, she helped craft the study questions, often drawing from studies of stigma in depressed patients in the general population and adapting the questions to medical students.

The survey began with the Patient Health Questionnaire (PHQ-9), a popular tool for assisting primary care physicians in diagnosing depression. Respondents could then be assigned to one of three categories of depression: none/minimal, mild, or moderate/severe. Questions explored stress and coping in medical school, attitudes about mental illness and seeking mental health care, and demographic features.

The response rate, says Schwenk, was particularly impressive: 65.7 percent (505 of 769 students); the results, worrisome.

It is not surprising that, when asked to agree or disagree that "Depression is a real medical illness," nearly all students polled were in agreement; this view is now widely accepted. But beyond that, the study reveals that medical school can be perceived as a harsh, secretive and unforgiving environment for students who suffer from depression.

Moderate to severe depression was reported by 14.3 percent of students, a rate higher than the 10-12 percent found in the general population. Of medical students who reported high levels of depressive symptoms, 53.3 percent worried that letting their illness be known would be risky. Almost 62 percent of the same students said asking for help would mean the student's coping skills were inadequate, and would result in fellow students respecting them less.

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Schwenk was struck by some of the attitudes the study uncovered. “There were some fairly harsh and negative statements made about students who are depressed — statements about how they’re not as valued as other members of the medical care team, and how medical students with depression might not be as good at carrying out responsibilities or taking care of patients. Of course,” he adds, “not all students believe that.” Schwenk says he’s alarmed that depressed students might be forced to navigate the rigors of their studies while in an environment of prejudice, secrecy and doubt.

A dichotomy seems to be at the heart of the issue. On one hand, the culture of medicine has adopted an attitude of acceptance and caring for patients with depression, but on the other hand, that attitude does not extend to physicians themselves.

A textbook example of the devastating power of that mindset can be found in the story of Doug Jackson, M.D., a respected family physician in a small northern Michigan community. Jackson recalled having his first serious depression as a child. The episodes continued through medical school and into many years as a caring, hardworking doctor devoted to his patients. Unlike many depressed physicians, Jackson sought psychiatric treatment, but he was fearful of disclosing his diagnosis to his partners, his patients, and to the hospital where he worked. He drove to other towns to fill his prescriptions; he paid with cash.

In 2001, deeply depressed and suicidal, Jackson was admitted to an inpatient psychiatric unit and his world began to come undone. “His hospitalization made it very difficult for the secrecy to continue, and that’s when things got ugly with our three partners,” says Loretta Leja (pronounced



Tom Schwenk

“LEE-jay”), Jackson’s physician-wife who also worked with him. “During his hospitalization, they decided that they did not want Doug back in practice. They were annoyed that they had to cover for him in his absence.” The partnership dissolved, but not long after Jackson was back at work, seeing patients and doing well.

Several months later, a peer review action was initiated against him. The source of the complaint was never identified, Leja says. Having served as chief of staff at his hospital for six years, as well as president of the state family medicine organization, Jackson’s investigation was “particularly shameful,” she adds. Despite a private conversation with the chief of surgery and obstetrics, who told Leja that he’d never had any doubts about her

husband's care of his patients, Jackson was monitored. Though compliant with his medication, Jackson became more guarded with his psychiatric appointments, aware that anything he said to his psychiatrist might be reported to the peer review committee.

Jackson committed suicide in July 2002. In addition to his wife, he left behind three children and a stunned, saddened community that had no idea that this dedicated family doctor had been suffering so long in silence.

When asked if she believes the stress of the peer review contributed to her husband's death, Leja pauses. "I don't know," she says quietly, "but we, as a profession, need to help each other rather than discipline each other on this issue."

Not long after her husband's death, Leja attended a meeting of the Michigan Academy of Family Physicians, where Schwenk, a speaker, mentioned his involvement with the U-M Depression Center. Leja approached him and told him that further research on physician depression was badly needed. At her urging, Schwenk led an initial study of Michigan physicians that was completed in 2008 and set the stage for the medical student stigma study.

After spending an hour sharing the results of the stigma study with the students, and talking frankly about some very uncomfortable topics, Schwenk perched on a low wall in front of the class and asked for questions and feedback. After several long moments of pin-drop silence, people started talking.

The questions and comments fairly flew. About the desire to appear strong and in control at all times. About

ON a cold afternoon late last year, Schwenk took to the podium for a Seminars in Medicine lecture for third-year students. Held every Friday, these lectures mark the end of each long and exhausting week, and students are typically happy to forego the question-and-answer section in favor of ending class early. Schwenk's presentation ended differently.



Lindsay Davis

the impossibility of getting help when you aren't in control of your own schedule from week to week. About the pressure to do research when you have neither the time nor the interest. About how there's always someone more tired than you, so it's best never to complain.

Schwenk doesn't hide his admiration for the students he works with. "If I were applying to this medical school today, I wouldn't get in," he laughs. "We select students who are self-motivated. We train them to assume responsibility for very demanding situations at a very early point in their training. The notion that you are not up to it or feel inadequate or are not functioning at

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your fullest level — that's not a concept we deal with very well."

All of which, Schwenk says, makes the study's findings — that stigma about depression is alive and well in the U-M Medical School — not too surprising.

"What it speaks to is the very intense, very demanding nature of medical education," he says. "Students feel under tremendous scrutiny and feel like there is tremendous pressure to be perfect. The amazing senior physicians they see every day make them feel like they're always falling short. We tell our students how remarkable they are and, in the process,

make them feel completely inadequate.

"How do physicians ask for help," Schwenk wonders, "when they're told every day that they have to be perfect?" [M]

THE DANGERS OF DISCLOSURE

For "Jane," a U-M medical student in her clinical years, a recent diagnosis of depression has helped her explain and understand periods of numbness and disconnectedness in her life as far back as high school. "I wasn't feeling happy," she says. "I felt I was kind of walking through life, more existing than anything else.

"I do think medical school contributed to it. It's full of a lot of brilliant people. I had gone from being one of the top people in my undergraduate class to being in the middle, or even on the bottom; I was struggling on tests. And in the clinical years, you feel you're always being watched, that you have to prove yourself. I

had developed self-critical thinking starting in high school, and medical school may have been the straw that broke the camel's back."

Jane sought treatment. Though her academic counselors were supportive, and she herself remains unashamed about her depression, she says she would have been naïve to ignore the dangers of disclosure. Fully aware of the treatment options available to her as a U-M student, she chose to keep her illness to herself and began treatment "outside the system."

Keeping her diagnosis secret from her classmates and teachers, she says, feels unhealthy and dishonest — and unnecessary. "It bothers

me a lot," she says. "I'm a very vocal person; I like to share what I feel and share my experiences. And I would argue that this experience (with depression) will make me be a better doctor."

Articulate, confident, and self-aware, Jane says she is dismayed to hear stories of physicians whose simple disclosure of depression has led to sanctions and even the loss of a medical license. "That's scary to me," she says.

"I want to see the culture change — get rid of these prejudices. But I don't know how we can do that when people with depression can't be honest and share their stories and not worry about repercussions." —WH