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Falling Dust: Considering the COVID-19 Effect on Physician Suicide

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The US has an underreported and perpetuating issue with clinician burnout and suicidality. Frontline caregivers consider what 1 year of a pandemic may have done to worsen it.

The following article discusses suicidal thoughts and triggers. Suicide is a preventable act, and resources, including the National Suicide Prevention Hotline, are available at any time for anyone.

Trauma is like shaking a snow globe, Janine Faux, LAC, suggests. Dust and specks settled on the scene are suddenly stirred into a frenzy. The picture becomes blurry, dizzying, indiscernible. Each shake will create a novel situation.

Then the shaking stops. Relative to the speed by which they were whirled to life, the specks practically freeze in flight, and slowly, carefully, fall to new ground.

There is no way to prevent traumatic events from occurring, and there's little possible in the way of altering how someone receives trauma. But in the moments after the trauma subsides, while the dust and specks begin to fall, that's when treatment is possible.

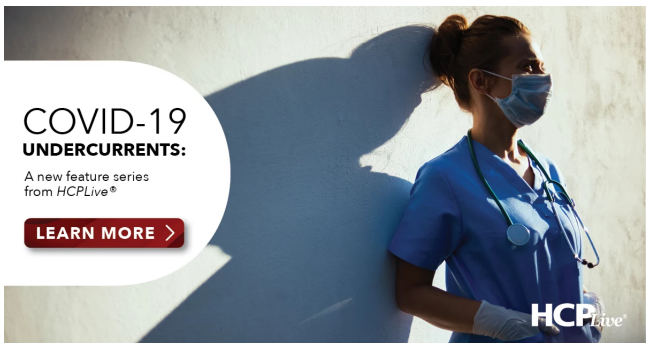
and therapists trying to catch the falling dust for persons who have been traumatized by COVID-19. For exactly 1 year and 1 day today, the pandemic has been a leading driver of distress among a portion of the global population that's been unmatched for years. And now is the time that long-term psychological effects may be prevented.

What's more, the persons at the focal point of COVID-19, the responding caregivers and clinicians, are a group with storied and evidenced difficulties in professional burnout, self-medication, and suicide.

From Faux's experience in counseling clinicians, prior to and throughout COVID-19, she has observed their superlative skill in compartmentalizing the everyday stressors and trauma of treating the sick and dying. To borrow another analogy from Faux: they are capable of storing their trauma very neatly in boxes.

"But then you're dealing with a pandemic, and everything is just flowing into each other," Faux told *HCPLive®*. "There's no more capacity—there's no more boxes to put it in.

"Everything is overflowing."



An Approximate Crisis

There is no concrete data yet on how many clinicians in the US committed or attempted suicide during COVID-19. Obviously, the pandemic is still ongoing; despite good news of late that more people have been vaccinated and fewer daily new cases are reported, this is still a public health crisis out of control.

inconsistent caregiver suicide reporting. For years, investigators have operated with the estimate of 400 annual suicides among US physicians alone. Experts more intimately engaged in the subject, including advocate and author Pamela Wible, MD, have previously told *HCPLive* that tally is an undersell. Despite clinicians being drug-prescribing experts, she has observed colleagues' deaths classified as "unplanned" or "accidental overdoses" by those closest to the deceased.

There's also a matter of health systems and institutions inconsistently reporting the cause of their caregivers' deaths—an issue which has come up recurrently in headline news and in greater discussions around wellbeing advocacy in US healthcare. These instances, even if anecdotal, likely contribute to an underreported rate of US physician suicide.

But even if one was to discount these unknown additions, the rate of suicide among physicians is approximately twice greater than that of the general population. It is, disturbingly, a commonality in US medicine.

Data from the last year, on matters of caregiver burden, has approximated just what effect the pandemic may have had on the rate. Just this week, a systematic review and meta-analysis of 97,000-plus healthcare workers found depression, anxiety, and PTSD were each prevalent in more than 20% of the observed workforce.

A cross-sectional study published in January showed one-third of US adults were experiencing anxiety related to the pandemic. What's more, international research has shown a link between COVID-19 infection and increased risk of developed PTSD. As

healthcare workers comprised 1 in every 7 COVID-19 cases worldwide.

This research and more would indicate a likelihood that yes, COVID-19 has adversely affected the suicidality of the US healthcare workforce. But absolute certainty does not exist, and many experts are wary of supporting that claim without evidence.

Many clinicians, in fact, are wary of the implications behind discussing an issue such as suicidal thoughts in general. Their livelihood may depend on it, Megha K. Shah, MD, MSc, explained.

In some circumstances, few things can more greatly challenge a clinicians' job status than emerging or continued mental health issues. A common worry among physicians in need of counseling or psychiatric care is their medical board finding out, said Shah, of the Department of Family and Preventive Medicine at the Emory School of Medicine.

"I think that is an issue, where physicians do not necessarily feel comfortable reporting if they have mental health issues and seeking help for them," Shah said.

What's more, seeking help for depression or suicidal thoughts may be perceived by clinicians as a personal failure.

Losing Control

Shah is a primary care physician who's experienced her own burdens at the hands of COVID-19 this year. She has lost more patients and more patients' loved ones than in any previous year of practicing medicine. But her worry is for hospitalists and intensive care physicians, who are tasked daily with doing anything possible for the sickest COVID-19 patients.

day in the emergency department, the worry is justified. Windsor, an emergency medicine physician at the University of Arizona College of Medicine – Phoenix, is treating patients in a region which at one point this winter went 59 straight days averaging more than 5000 new COVID-19 cases daily.

At times, her department ran out of high flow oxygen (HFO) devices. Other times, it was BiPAP machines. There were serious discussions on their ventilator counts, though thankfully, there has been no shortage. The conversation alone, though, was a terrifying concept for a physician in a generally well-resourced facility.

Personal protective equipment (PPE) and nursing staff—a vital resource and an integral care team member during an infectious disease breakout—were short in supply. A feeling of failed support and no protection loomed among Windsor's teams. They felt isolated in the middle of a crisis. It was just them and the sickest patients.

With fewer nurses on hand, Windsor was among those spending time with COVID-19 patients whose cases were worsening, having to inform them that they would need to be transferred to the intensive care unit (ICU). She would hold their hand and comfort them, still wary of the virus, uncertain of how a patient would fare at their last resort. And she conducted end-of-life calls between elderly, severely ill patients and their families, unable to visit their isolated loved one by risk of the virus.

She worked 12-hour shifts. They exhausted her. The department switched to 7-hour shifts. They exhausted her. Only now, she was home in time to oversee her kids'

Her days were overwhelming: a job spent in constant worry and tragedy, and a personal life deeply affected by the same virus she was fighting a losing battle against.

The confines of Windsor's escape from work quickly eroded. She made her kids wait to greet her after shifts until she could thoroughly decontaminate. She was scared to pet her dog, at risk of transmission. She felt anxiety, almost guilt, in moments of solitary away from work.

"We have this team mentality in the emergency department, and we want to be there to help," Windsor said. "I'd rather just be in the fire of it than at home thinking about what tomorrow will be like."

It's actually that sensation which Faux has been hearing most from clinician clients during the pandemic. Before cases began to peak, she expected it would be an overwhelmed system and an excess of dying patients that would drive trauma in the field. Yes, that's initially what such clients would want to talk about, but sessions would often boil down to a difficult truth: caregivers feel powerless from COVID-19, out of any control they previously had in their careers as healers. They were either at work, subjected to loss and struggle—or at home, frustrated and needlessly guilt-ridden.

"It's interesting: as a therapist, you're always waiting for the person to tell you what you think is the traumatic part of their story," Faux said. "And what you find is that it's often very different than what (clinicians) are used to dealing with."

As Faux said earlier, clinicians are skilled in compartmentalizing. They often can do so without support

overwhelmed them, they must seek out help—often for the first time.

Systemic Shortcomings

Windsor serves as her institution's chief wellness officer and clinical education director. Part of her work in the latter position has been spent trying to understand why her colleagues weren't attending courses and programs.

It wasn't an issue of interest, she learned. It was an issue of burnout.

"Everybody was so thinly stretched and over-committed in their lives and families that they didn't have any more time to give for one more meeting to attend," Windsor said.

She changed course: host more appealing events, like team retreats. Still, it was like selling a product no one believed in. Self-care and personal wellness were stigmatized, looked at by Windsor's peers as a pathway toward losing medical licenses. Few were willing to admit they could even benefit from a discussion on burnout, while being too overworked to attend the meeting regardless.

Some of Windsor's colleagues, she believed, may have soured on such programs by association with administrations. Excessive electronic medical record (EMR) logging, staffing shortages, arbitrary standards for patient satisfaction—all these issues have been continually cited by physicians reporting burnout, well before COVID-19.

"You can look at all these…things that try to increase the patient experience and satisfaction," she said. "But the problem is they're not focusing on the people delivering the care, and it may no be coming from a good space. So

quality of care that you need out of them."

From Shah's perspective, wellness programs including that managed by Windsor are not consistently available in the progression of a clinician's career. Many medical school curriculums have a wellness component, and most residency programs promote opportunities for such discussions.

"The reality is, though, unless we start doing it at the health system level, when people are entering the workforce, it can get put to the wayside," Shah said.

Windsor would add that there should be more mentorship toward the other end of wellness: young or even aspiring clinicians would do well to better learn about the professional hardships.

As she sees it, the average clinician progresses from one stressful performance to the next: the MCATs, school interviews, medical school, residency application, residency itself, and if they've passed every test, they may begin their career, where the stakes are entirely on them. Any person exposed to a decade-plus of education and assessments may be well-equipped intellectually, but there is no guarantee that they could emotionally bear a stressor less impactful than a global pandemic.

Windsor would like to see more honest conversations occurring between mentors and trainees. It may mean fewer future physicians, but it may also mean fewer lost to burnout or suicide.

"You really have to find resiliency tools and your self-care at a younger age, so that you can offset some of the negativity that comes with the job and the stressors," she said.

that conversation is stressors borne out of a more remotely-connected world—a possibly novel factor in clinician burnout and suicidality.

Over-exposure

Last spring, by sheer necessity, the US progressed its telemedicine systems to a capacity never before reached in a matter of days. Stay-at-home mandates and worry over the still little-understood virus resulted in a pendulum swing from in-person to virtual care.

At one point, months before the summer peak of cases, Windsor walked the halls of her completely vacant emergency department. Patients were weighing the risk of COVID-19 as greater than any emergent care they needed that day. She had never seen the department empty before.

Some 1800 miles away, Shah was reaching capacity. Her primary care practice, like so many others, was offering telemedicine visits. Schedules filled immediately. Outpatient doctors took call after call from the confines of their home—the place where they unwound became the place where they worked. And they worked more and more. Why wouldn't they? It's much harder to say no to an 8 PM phone call than it is an office visit.

"I can access my health records for patients any time of the day, in any place, so there's no turning it off," Shah said. "We've created a system where we can continue to work, and it's becoming harder, especially in the pandemic, to separate the work-home life boundaries."

The US healthcare workforce was facing an entirely new onslaught from their couches, as well. COVID-19 created media frenzies, public health

science, and a mass-level interest in—and scrutiny of—modern healthcare.

Every day, in social media threads, cable news segments, even politician press briefings, the work and guidance of healthcare workers was dissected, challenged, and at times, villainized by laypeople.

In what should be a hallowed moment for an entire profession characterized by lifelong commitment and selfless care, clinicians were under-resourced against COVID-19, and under-appreciated as experts by their communities.

“That’s what I noticed at the start, that the trauma came from a lack of support—what the world was giving back to them in terms of support,” Faux said.

The onslaught of scrutiny into pandemic public health and medical response not only affected clinicians on a personal level—it exacerbated the time which they would have to spend addressing COVID-19.

“I think the politicization of it has delayed our ability to respond to it in a way that we should have,” Shah said. “And all of that trickles down to the day-to-day lives of the people that are taking care of the patients.”

One at a Time

Windsor lost her brother to suicide at 17 years old. She’s lost multiple colleagues, and other acquaintances in the field, to suicide as well. The trend, more often than not, has been that it’s those who seem happy—the people that don’t appear to need a friendly check-in.

Solutions must include ways that incentivize suicidal or burnt-out clinicians to seek care themselves. Though she anticipates its negative effect on the field’s overall mental

thinks COVID-19 is providing an opportunity for at-risk colleagues to reconsider their reservations to help.

“I do believe one of the best things for medicine that's going to come out of the pandemic is it has finally allowed people to say, ‘Yes, I am burned out. Yes, I am exhausted. Yes, I am stressed. I don't know what to do. I don't want to do this anymore’,” Windsor said.

Windsor has already implemented changes small and large to her programs. She’s pushed her wellness groups to seek out two-minute respites from their 12-hour shifts, to just talk with a colleague about something other than work. She’s challenged her team’s tendencies to reply sarcastically to asks on how they’re doing. Honest conversation needs to be encouraged in practices and departments.

It’s small gestures of support that have stood out Shah and her colleagues as well. She highlighted Jason Zgonc, the 12-year-old trumpet player who performed during shift changes outside Emory Decatur Hospital throughout COVID-19, as representative of the greater community support for clinicians.

Shah also spoke to the “sense of purpose” that clinicians may have found in their deeply impactful work during the pandemic, a rekindled motivation through all the turbulence. But she also knows there’s systemic-level factors exacerbated by COVID-19 that may further worsen the field’s mental health.

For one, US caregiver shortages may increase after what transpired in the last year, contributing to individual burnout. Given the disproportionate effect of the pandemic on people of color, Shah hopes whatever young population is inspired to pursue

population, and therefore harboring novel ideas to issues including shortages, burnout, and suicidality.

Even on Windsor's larger scale of strategies, she is fixed on the individual. Given her personal losses to suicide, and her own struggle with burnout as a young clinician, she believes preventing a single suicide in her physician group is equivalent to a life's work accomplished.

She and Faux have partnered through Windsor's non-profit organization Life in Fulfilled Enlightenment (LIFE) and Faux's work with the Arizona Trauma Recovery Network this year to offer free counseling and care for anyone during the pandemic. Faux practices Eye Moment Desensitization and Reprocessing (EMDR) psychotherapy for her trauma and PTSD patients.

The anticipation from clinicians and experts is that COVID-19's comprehensive burden will result in more physician suicides. How severely, or for how long, is uncertain. It may take years, even decades to fully understand the trauma and distress felt by frontline clinicians in this last year.

But COVID-19 has given counselors a guide to seeking out trauma. And it's given clinicians, maybe more greatly than ever before, a reason to seek care for themselves.

The pandemic shook the medical world, but the dust is still falling.

"It's a hard thing for caregivers to know, that sometimes they need care, too," Faux said.

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