Suicide rates for doctors and young physicians among highest in the US population

By Alex Johnson
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Doctors in the United States confront a high suicide rate as a result of stressful working conditions and excessively long work hours.

Director and chairman of the Southern California Permanente Medical Group, Dr. Edward Wilson, told CNBC that it is estimated that one doctor dies every day by suicide in the US due to "stress and rigorous work schedules."

Doctors and health professionals within the US, according to Ellison, are "stressed to the breaking point" due to stifling work schedules and mounting pressures that stem from patient care.

Depression, the primary cause of suicidal ideation, affects an estimated 12 percent of male physicians and 19.5 percent of female physicians, but doctors are often hesitant to seek treatment due to the stigma associated with mental health problems.

As a result, doctors have the highest suicide rate among any profession in the country: 28 to 40 per 100,000 persons compared to 12.3 per 100,000 for the general population.

According to Ellison, recent data shows that 44 percent of physicians show signs of physical and emotional exhaustion, or "burnout," which can lead to further mental health problems as doctors have difficulty adequately taking care for themselves, such as eating and sleeping properly.

Changes made to the way hospitals and medical centers operate in recent years may have improved the efficiency of the American healthcare system, but at the cost of longer and more exhaustive work schedules for doctors. Doctors are now spending less time with patients in traditional care settings and more time fulfilling extraneous tasks traditionally performed by adjunct staff and employees.

As a result, the suicide rate among physicians has exploded in recent decades. The suicide rate among male and female physicians is 1.41 and 2.27 times higher than that of the general male and female population, respectively.

For example, Dr. Benjamin Shaffer, a renowned surgeon from Washington D.C., hung himself in 2015 after taking his son to school. He had struggled his entire life with anxiety and a severe form of insomnia, which afforded him little time to sleep before operating on and treating patients.

Just days before he committed suicide and in the face of growing personal turmoil, his psychiatrist prescribed two new drugs which merely exacerbated his anxiety and insomnia and even led to paranoia. After he was told that he would need medication for the rest of his life, he concluded that he could never live a normal life again and decided to kill himself.

High suicide rates are also prevalent among medical students. Suicide is the second leading cause of death for medical students. They are three times more likely to kill themselves than their peers in the same age group. As many as 30 percent of medical students suffer from depression.

The work schedules for young doctors transitioning from medical school, customarily referred to as "residents," are extremely onerous. Residents are expected to work up to 80 hours a week with single shifts that can last up to 28 hours.

These grueling schedules are largely the result of the centralized matching system for residency applicants in the hospital labor market and the monopoly held by a handful of hospital chains. Although

employer-controlled labor markets are typically prohibited by anti-trust laws, the system remains the only avenue for residents to become fully licensed doctors.

Centralized matching, commonly referenced as “the match,” allows a handful of employers to select residency applicants without them having any legal right or ability to negotiate the terms of their contracts. This grants hospital conglomerates free rein to implement excessive hours and lower pay.

In 2002, a group of residency students filed a lawsuit against the for-profit selection system, deeming it an unlawful “contract” or “conspiracy” designed to undermine federal antitrust laws. After a federal district court initially ruled that “the match” may be illegal and give an unfair advantage to healthcare institutions, Congress passed legislation immunizing medical training programs from antitrust lawsuits.

Thus, residency programs give hospital employers access to a well-educated, but super-exploited and over-burdened workforce. As a 2017 article in *The Atlantic* noted, “while residency-program administrators no doubt take their educational obligations seriously, residents are also a cheap source of skilled labor that can fill gaps in coverage.” Resident salaries are generally equivalent to those of the hospital cleaning staff and about half of what nurse practitioners get paid even though residents typically work much longer hours.

The long hours residents are compelled to work causes tremendous physical and psychological stress. In response, the Accreditation Council for Graduate Medical Education (AGGME) implemented a “duty-hour” reform policy in 2003, which lowered the maximum weekly hospital working hours from 120 to 80 and the length of single shifts from 48 to 28 hours.

However, this change did little to lessen the severity of residents’ schedules. Surveys show that the reforms led to virtually no changes in work and sleep hours.

A large reason behind the failure of the reforms is that hospitals have not increased the rate of new hires to keep up with the rising demands of healthcare operations. Between 1990 and 2010, the number of patients admitted to teaching hospitals rose 46 percent, but the number of residency spots only increased 13 percent.
