Title: Hospital-Acquired Depression: A Troubling Phenomena

By: David Arroyo

Word Count: 4,833

Key Terms: Doctors, physicians, mental health, depression, burnout, culture in medicine

Abbreviations:

ACEM = Australasian College for Emergency Medicine
ACRRM = Australian College of Rural and Remote Medicine
AHPRA = Australian Health Practitioner Regulation Agency
AMA = Australian Medical Association
CSF = Coping and solutions focused
ICD = International Classification of Diseases
RACGP = The Royal Australian College of General Practitioners
RANZCP = The Royal Australian and New Zealand and College of Psychiatrists

Acknowledgements: The author would like to thank Jessica Arentz for her comments on this piece as well as Lars Eriksson for assistance with the search strategy. The author also wishes to thank author and physician, Dr. Pamela Wible, MD who has dedicated much of her career towards helping doctors in distress and has helped shed a light on an important issue of much relevance to the author. She was a great inspiration throughout the development of this paper.

Declaration of Originality: *I declare herewith, that this essay is my own original work and further, confirm that this work has been composed in its entirety by the aforementioned author, has not been plagiarised, and has been appropriately referenced. Findings have not been fabricated, there are no relevant disclosures, and this work has not previously been published*.

Letter to the Reader

First and foremost, I would like to express my gratitude to the reader, for taking the time and energy to read my perspective on doctors' mental health. I was pleased to write this essay, as it is centred on an issue that is both very important and very personal. This essay was written to discuss the inherent features, acknowledge the cultural shortcomings, and recognise the ongoing systemic failures that lead to psychiatric morbidity in doctors, thereby unveiling the dark trend that afflicts this profession. Perhaps most importantly, it will also demonstrate that there are plenty amongst us that understand the distress and that doctors are never alone in their distress.

When we see the future of medicine, we see artificial intelligence, new treatments, new cures, and we will undoubtedly witness the wonders that the field has to offer. Yet, we often forget to envision a future where our healthcare providers are not suffering, where we have ultimately healed the wounds that cannot be seen, palpated, or percussed. Although this essay focuses on data pertaining to current and future doctors in Australia, the author acknowledges that there are various circumstances specific to different countries resulting in a doctor's mental health demise. Nonetheless, this essay will describe issues that do not know borders, and are therefore shared amongst doctors around the world. While this essay does focus specifically on the unique issues pertaining to doctor's mental health, it is important to acknowledge that many other healthcare providers suffer and remain silent. They are not forgotten.

Words in this essay were carefully chosen and underwent repeated scrutiny to ensure that themes are adequately expressed while mindfully implementing evidence-based research to support each viewpoint. At the header of each page, you, the reader may note a quotation. These lines originate from published works authors, poets, and philosophers who suffered the worst throes of depression. They are also from our brothers and sisters in medicine that succumbed to a mental health condition as a result of working in this profession. Though unconventional in standard essay writing, they were inscribed for the principle purpose of foreshadowing the most essential motifs and lessons that will be found throughout each successive folio. These lines were selected after a meticulous search of many hundreds of published passages, excerpts, and quotations, and the conscientious decisions to use them for this paper were taken under careful consideration, bearing in mind relevant themes as well as the distressing nature of some of the content. It is the hope of the author that these quotations will entail meaning to the reader while providing a greater perspective of the reasons that the author chose to write this paper.

Coupled with strong misconceptions by the public and perhaps even by our own loved ones and colleagues, many clinicians experience a seemingly unremitting daily assault on their mental health. This author believes that there is no better job in the world than being a doctor and inherently, we did not choose this life, it chose us. Yet the reality exists, there is no profession that is more dangerous, and suicide has simply become an occupational hazard. The prevalence mental health morbidity or mortality that face doctors globally can and should be described for what it is- a massive crisis, and public health emergency.

Despite the detail that this essay hopes to provide, it will only scratch the surface of a much greater longstanding and multifactorial issue affecting contemporary medical practitioners. Regardless, the prevention and management of these issues is indeed paramount; for it is the fear of this author that a decade from the now there will still exist essay contests to evaluate the persistently high rates of mental health issues disproportionally afflicting doctors.

This essay will ultimately use evidence to call for a change to the culture of medicine, a change that is much needed. Finally, this essay is a call to action, to show compassion, not only to our colleagues that are so often suffering in silence, but also to show compassion towards ourselves. As much as we want to be, we are not invincible. To the distressed doctor who has endured and suffered, the author reminds you that you are valued, you are needed, and above all, you are human, with very normal fears.

To those that write a final letter to be read, but never to be answered.
To the distressed student who sacrificed much and is expected to give more.
To the trainees that are beyond overwhelmed and are experiencing the darkest of thoughts.
To the doctors that feel empty, lost, damaged, alone, and hopeless.
And to the loved ones that were never able to say goodbye.
This is for you

Introduction

The notion that all individuals are predisposed to mental illness was well chronicled by the philosopher Plato in *Timaeus*, where he became among the first of his colleagues[1] to demonstrate a primitive, yet pragmatic, understanding of the complex dynamics of mental health resulting in a modern truth: *we are all susceptible*. While contemporary conceptualizations of mental illness have long evolved from the times of unbalanced humours, diseases of the *psychē* (soul), and "cold bile" as underlying aetiologies, there still persists a fundamental, yet pervasively false perspicacity that, as modern-day healers, doctors are somehow exempt from the stressors that lead to mental health deterioration. The Universe is governed by a set of rules; and not unlike Newton's renowned laws of motion, the laws of psychology are no different: persistent and substantial psychological stressors without a method of adequate relief or sufficient resilience will negatively impact one's mental health, whether outward signs are present or absent. Doctors are subject to a multitude of stressors, all of which have the potential to upset the systems and pillars responsible for maintaining the balanced haemostasis of one's mental health specifically, the biological, psychological, and social paradigms. Indeed, the medical field is unique from other professions, unapologetically offering an overwhelming workload, immense pressure, unrelenting competitiveness, and unrealistic expectations. These factors significantly increase the risk of depression, anxiety, stress, emotional exhaustion, depersonalization, and suicide[2-5] and are significant contributors to the extraordinarily high incidence of burnout[6, 7] that has plagued doctors across continents and cultures for decades. The statistics are troubling. In the United States, becoming a doctor is considered to be the most dangerous job in the nation, with the highest rate of suicide of any other profession, even higher than those in the military.[8] In the United States alone, an estimated 300-400 doctors commit suicide each year,[4, 5, 8, 9] an amount equivalent to an entire cohort of medical students. Disturbingly, it is likely that this figure has been underestimated since suicides are often not listed on death certificates. The factors that lead so many doctors to fall victim to psychiatric morbidity are not unique to one country, and therefore cannot reasonably be explained by personal, demographic or lifestyle factors, nor attributed to a specific type of medical system, specialty or culture. This is a worldwide issue. Australian doctors experience psychological distress well above the Australian population and other healthcare providers.[2] The prevalence of depression has reached over four times than the general population and nearly a quarter have experienced suicidal ideation.[2] Female doctors in

Australia are at a particularly high risk, experiencing psychological distress, burnout, psychiatric disorders, and suicidal ideation at a higher rate than their male collagues.[2] Of note, female doctors have a suicide completion rate three times greater than women in other occupations.[10] Additionally, the issue of burnout is significant, affecting Australian doctors at alarming rates, with a third to more than half currently experiencing burnout.[2] These rates are similar to doctors in New Zealand[11, 12] and the United Kingdom.[13] This essay will explore the prevailing factors that lead to the decline of a doctor's mental health.

Hospital-Acquired Depression: A Troubling Phenomenon

From nearly the moment that medical students take their oaths, the assault on one's mental health begins. Students know that they will make sacrifices to study medicine, but the understanding that the medical field may take a significant mental health toll is generally overlooked and underappreciated. Upon entering the profession after graduation, the harsh reality of medicine awakens the new doctor who once envisioned something much different than the realities of the medical field, resulting in the mourning over the loss of an ideal profession that was once placed on the highest of pedestals. Many factors that lead to this demise have been well-described in the literature, yet, a doctor's mental health is often not discussed, silenced by both professional and societal stigma. Indeed, the medical field is full of stressors (Figure 1) that target the mental health of a doctor with pinpoint accuracy.

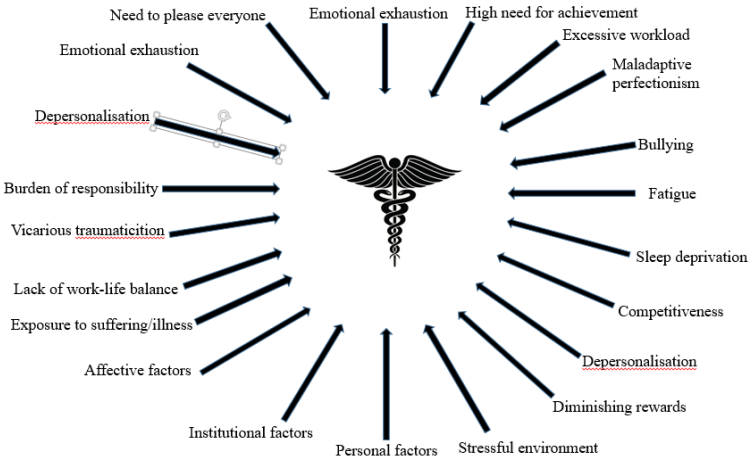

Figure 1. A multitude of factors target the mental health of doctors.

Therefore, it should not come as a surprise that depression among doctors is prevalent worldwide (Table 1). In Australia, doctors experience significantly high levels of psychiatric morbidity,[2, 10, 14-17] which typically manifest as depression, anxiety, burnout, and suicidal ideation, eroding into both their personal and professional lives.

Table 1. Estimated prevalence of depression in doctors of selected countries compared to prevalence in the general adult population.

Country	Prevalence of Depression among Doctors	12-Month Prevalence of Depression in the General Population	Training level and specialties examined in study
Australia	5.0-60%[2, 15, 18] 29-53% (Physician trainees)[15, 18]	5.9-10.4% [2, 19, 20]	Doctors and residents
Bangladesh	39.6%[21]	4.1%[20]	Resident doctors
Brazil	12.0% [22]	5.8-10.4% [20, 23]	Doctors- All specialties
Canada	34%[24]	4.7% [20]	Doctors- All specialties
China	28.13-65.3% [25, 26]	3.8-4.2% [20, 23]	Doctors- All specialties
Germany	39.5-56.6% [27]	5.2%[20]	Resident doctors
India	30.1%[28]	4.5 ± 0.4% [20, 23]	Doctors and residents
Japan	8.3% (male); 10.5% (female)[29]	2.2-4.2% [20, 23]	Doctors- All specialties
Netherlands	29% [30]	4.9 ± 0.5% [20, 23]	Doctors- All specialties
Nigeria	1.3% (Doctors) 17.3% (Residents)[31]	3.9% [20]	Doctors and residents
Pakistan*	25.8%[32]	4.2% [20]	Doctors- All specialties
Saudi Arabia	20%[33]	4.5% [20]	Resident doctors
South Africa	70%[34]	4.6-9.8% [20, 23, 34]	Doctors- All specialties
Tunisia	30.5%[35]**	4.9% [20]	Resident doctors
United Kingdom	36.1%[36]	4.5% [20]	Doctors- All specialties
United States	26.7-27.2% [3]	5.9-8.3 ± 0.3% [23]	Doctors- All specialties

*Limited data available

**This study showed that 30.5% of participants had "definite" depression symptoms and 31.5% had "probable" depressive symptoms for a total of 62%.

Note: Due to differences in study methodology and assessment, it is difficult to derive a single estimate for the prevalence of depression by country. The criteria largely used for depression statistics implemented the DSM-4, however, there were no significant changes for diagnosis between this and the current DSM-5. The definition of a medical resident may differ by country, but generally can be accepted for an individual that is undergoing training after having completed a medical degree.

Is it simply the nature of the burden of caring for others that has caused the high rate of mental health issues? Or are there modifiable factors that target the mental health of doctors? This essay will answer these questions, and will discuss some of the most important issues leading to the mental health demise by demonstrating a troubling phenomenon which has been termed, hospital-acquired depression. The paradox of hospital-acquired depression can be defined as the chronic exposure to the unique forms of stress specific to medical practitioners, leading to clinically relevant mental health toxicity.

The burnout debate: Why is it controversial?

The nature of the medical field is demanding, and the pressure has never been worse. Burnout rates are exceptionally high among doctors worldwide[2, 6, 13, 15, 28, 34, 36] and have reached pandemic levels. Burnout is typically described as a syndrome of emotional exhaustion, depersonalization, a diminished sense of personal accomplishment, and reduced professional efficacy.[2, 6, 7, 15] The syndrome may be accompanied by a reduced sense of purpose, cynicism, emptiness, depression, and lethargy, and ultimately results in the severing of the link between an individual and his or her work. Burnout has become a clinically relevant issue as doctors suffering from burnout have been associated with medical error.[37] A controversial debate exists as to whether this reflects a form of depression. Whereas there is good evidence of the depressive nature underlying the burnout paradox,[13, 15, 38] a controversy ensues when considering the definition of burnout, as well as the methods by which it is measured. The fluid definition of burnout becomes problematic when attempting to measure prevalence, as studies can show a significantly wide variation depending on the definition used.[7, 38] The lack of standardization is evidenced by a recently published review which revealed that burnout rates among doctors range from 0-80.5%,[7] depending on the definition and measurement. If burnout is, in fact, a manifestation of depression, then it can be managed similarly, through self-care, psychotherapy, and through pharmacological methods. Currently, burnout is not a recognised diagnosis in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders. The World Health Organization announced that they will recognise burnout as an "occupational phenomenon" in 2022 with the release of the International Classification of Diseases (ICD-11), however it will not be listed as a separate diagnosis.[39] Further efforts must be made to clarify the definition and management of burnout.

What is the best method to manage burnout in doctors?

As evidenced, managing burnout in doctors is complicated. In order to determine interventions that have been attempted, a systematic review was performed (See Appendix 1 for search strategy). Of 1,693 results, six recently published review articles of interest were selected which best summarise findings for various interventions used to manage burnout. The reviews, all published within the last three years, are outlined here:

- A 2019 systematic review by *Venegas et al*. of 17 studies was conducted between 1998-2016 to identify interventions to improve resilience in physicians.[40] The authors found a great variation between their approaches, duration, and follow-up periods. They concluded that there was weak evidence to support any single intervention, in part due to a low quality of evidence for measuring outcomes.[40]
- A 2016 review and meta-analysis by *West et al*. sought to determine the quality and outcomes of published literature to prevent and reduce burnout.[41] The authors examined 52 articles and concluded that individual-focused and organisational strategies resulted in reductions in burnout, although overall burnout rates only decreased from 54% to 44%.[41]
- A 2019 review by *Locke and Lees* included 31 studies of interventions used to reduce stress in doctors between 1990-2017, found evidence for mindfulness, reflective groups, and coping and solutions focused (CSF) interventions to manage stress levels.[42]
- A 2018 systematic review by *Wiederhold et al*. included 13 studies regarding the range of interventions for burnout management, determined that there is likely a significant impact resulting from both specialization and personality traits.[43] This suggests that a holistic approach with multiple techniques are warranted to manage this condition.
- A 2017 systematic review and meta-analysis of 20 controlled interventions for managing physician burnout by *Panagioti et al*. found that the strongest evidence for effectiveness was through organisation-directed interventions, although this was seldom performed.[44]
- A 2017 systematic review of 23 articles by *Clough et al*. evaluated psychosocial interventions to reduce occupational stress and burnout in doctors.[45] The authors found that interventions were based on cognitive-behavioural approaches, relaxation, and supportive discussion. They reported a lack of quality among all reviewed studies but found that cognitive-behavioural interventions had the strongest evidence for

reducing stress, and that there was some evidence for relaxation-based strategies. Interestingly, the authors found no evidence for the effectiveness of discussion-based interventions.

No review was able to definitively determine the best practice for reducing burnout or improving resilience in doctors although there is emerging evidence that improving the provider-organisation relationship may exhibit clinical relevance.[41, 44] Since it is currently difficult to determine which intervention is likely to help an individual doctor, care needs to be personalised. Providers and organisations may have to attempt multiple techniques in order to reduce burnout levels. Listening to and working with doctors experiencing burnout may help bring about change at the organisational-level to help reduce stressors in the workplace. Doctors that are feeling the effects of burnout can begin managing this condition through open discussion with support staff and employers. Additionally, they should consider speaking with a psychologist or counsellor to who can aid with coping strategies. Burnout in doctors may be a consequence of something much larger at its core. It is not a failure of resilience or capacity, but a reflection of a medical field that is broken. Fortunately, general awareness of the magnitude of burnout has improved. However, more high-quality research needs to be conducted in order to more effectively address the issue. The issue of burnout must be resolved, for if left neglected, both patients and doctors will continue to suffer the consequences.

Bullying in Medicine

No discussion about doctor's mental health can be complete without specifically addressing the topic of bullying in medicine. Unfortunately, bullying is so engrained into the medical field that it is considered to be a normal occurrence. This is nothing new. The hierarchical system of medicine allows for the bullying of less senior staff and medical students. The power imbalance results in a vulnerability, especially when senior staff have power in the form of grade control or recommendation letters required to advance a resident's career. This issue requires attention. Some are bullied and harassed to the point of leaving medicine and others to the point of suicide.

All senior staff were in training at one point. Their past treatment or the methods that they believe make for better doctors, may reflect and guide their behaviour. When bullying does occur, speaking up results in a frightening scenario. First, a resident must *prove* its existence. No small feat. Even if this were to occur, being able to get away from the senior or the senior's

gossip and potential blacklisting efforts is realistically not possible. Due to the structure of many hospitals and medical systems, it might even be difficult to avoid the perpetrator. If accusations against a senior colleague are investigated and unproven, the resident may have to return to working with that individual again. Regardless of the outcome of an investigation, what prevents the senior colleague who bullied from speaking with other senior doctors? The answer is nothing. This can result in further ostracisation and tacit blacklisting. The hassle is often not worth it, and is a significant reason that bullying is underreported. The perception that a fair investigation would occur against a senior doctor is a yet another reasonable fear. Additionally, many who witness bullying and harassment do not report it for similar reasons.

The hierarchical system in medicine allows and sometimes even encourages bullying. The power of senior staff is often great and sometimes unchecked. Anti-bullying policies are present in all hospitals and health systems, and there are even laws against it, but simply creating rules and regulations does nothing if the culture remains the same. Medicine has simply become accustomed to bullying and the issue will not resolve until a cultural shift, along with active management and support is in place.

To Err is to Doctor

It is no secret that despite even the best of efforts, doctors misdiagnose, make mistakes, and this will sometimes result in a patient's harm or even death. These types of mistakes are not uncommon. In fact, in the United States, medical error has been found to be the third leading cause of death.[46] Often when a patient dies, a second, overlooked victim is affected; the doctor. It is well established that medical errors result in lost confidence, decreased job satisfaction, and insomnia. The feelings of responsibility and guilt create a form of secondary traumatization. In addition to the fear of reprisal, feelings of worthlessness and inadequacy are common, often leaving the doctor with a form of post-traumatic stress. Doctors entered the medical field to serve others and save lives. They never envisioned themselves becoming the villain. Some within the medical field argue that doctors should not be considered second victims, but this is erroneous. They are victims of medical culture that punishes imperfection and lacks sympathy, thereby allowing for the embodiment of shame and the internalization of despair. A pervasive cycle ensues as depression in doctors is known to lead to further medical errors, creating an

inauspicious cycle which cumulates in a state of worsening mental health. The culture of contemporary medicine breeds insecurity and forces doctors to appear invulnerable. This is maladaptive, and forces doctors to sacrifice their mental wellbeing. The only solution is for the field to culturally deemphasise this form of perfectionism and understand the fundamental principle that all doctors are imperfect, and that failure in medicine, even when a patient is harmed, is not an inherent weakness.

The AHPRA myth- A justified fear?

There is a pervasive concern culminating in a harmful, yet widespread myth that must be addressed: the fear of a report to the Australian Health Practitioner Regulation Agency (AHPRA). The prevailing belief is that doctors cannot disclose mental illness to another healthcare professional unless they wish to risk punishments such as significant practice restrictions, public shaming, and even loss of registration. Are any of these assumptions accurate? The practical answer is, in short, *no*. This myth will be debunked shortly.

Prior to debunking this myth, one must first acknowledge the shortcomings of AHPRA and Australian law. The mission of AHPRA is to protect the public through the regulation of health practitioners to ensure safe healthcare throughout Australia.[14] AHPRA investigates formal complaints and addresses concerns over the impairment of doctors following reports by other healthcare practitioners. Recently, Parliament passed a new law titled, *Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2018* which, in addition to increasing penalties for offences under Australian law, intends to "support registered practitioners to seek help for a health issue (including mental health issues)."[47] According to Queensland Health, the legislation is designed to provide treating doctors guidance when making the determination of impairment.[48] However, a number of medical organisations representing a combined total of over 53,000 Australian practitioners opposed the bill stating that it is ambiguous, unhelpful to doctors wishing to seek mental health treatment, and ultimately discourages doctors from seeking help for their mental health conditions[49] (Table 2).

Table 2. Australian medical organisations opposing Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2018 in its current form[49]

Australian Medical Association (AMA) Queensland
The Royal Australian and New Zealand and College of Psychiatrists, Queensland Branch (RANZCP QLD Branch)
The Royal Australian College of General Practitioners (RACGP)
Australian College of Rural and Remote Medicine (ACRRM)
Australasian College for Emergency Medicine (ACEM)

Proposed amendments to the law advocated by these organisations were denied.[48] The new law is applicable to every state but Western Australia which had implemented similar laws over a decade ago. This indeed has the potential of eroding a trust that doctors give to their patients yet feel that they are not entitled to receiving themselves. With this in mind, feelings that AHPRA has created a structural stigma is not unjustified. Under the pretext for patient safety, doctors may understandably feel that they are being unfairly, and perhaps unethically, targeted for seeking help for a mental health issue.

Additionally, the AHPRA investigation process may in itself raise concerns. In 2017-18, 35.5% of notifications took more than six months to resolve[50] and the potential for a prolonged fight over a doctor's profession may trigger or worsen issues such as depression and anxiety. For the doctor that is already suffering from a mental health issue, this process is detrimental and may feel like a punishment for experiencing something that is commonly found in the general population. As a result, it is not uncommon to find that doctors seek treatment far away, use pseudonyms, and pay cash for mental health services. Moreover, if the investigation is not concluded in favour of the doctor, an easy to perform search on APHRA's website may reveal an AHPRA reprimand. It is important to note that, under the AHPRA investigation process, practitioners are considered competent until proven otherwise. With the aforementioned information in mind, the myth that APHRA is a reasonable threat to medical practitioners will be dispelled here.

Under mandatory reporting laws to AHPRA, there is a *significantly* high threshold for the mandatory reporting of a healthcare provider for mental impairment that detrimentally impacts their ability to practice, and action taken against a practitioner for mental health impairment is exceedingly rare. For example, in 2017-18, of the 63 mandatory notifications made throughout all of Australia for impairment, only 13 had resulted in a suspended or cancelled registration.[50] Of relevance, a 2013 study showed that the distribution of all complaints filed against doctors over the previous 11 years was significantly skewed.[51] The study showed that 3% of Australian practitioners accounted for 49% of total complaints with 1% accounting for 25%.[51] Therefore, it can be reasonably stated that those cases where sanctions were imposed were exceedingly rare outliers and that these practitioners posed a realistic danger to the public. Additionally, the specific circumstances of these cases were unknown and may have overlapped with other APHRA-related issues of misconduct. It is important to note that given the number of doctors in Australia with a mental health disorder, a doctor seeking help is highly unlikely to even have to go through the process of an AHPRA investigation, let alone experience any consequences. Moreover, the vast majority of those forced to undergo any investigation are absolved. Therefore, the evidence shows that, though not without its flaws, AHPRA is not the enemy of medical practitioners and need not be viewed as one. That leaves the question: Given the exceptionally low probability of reprisal, why do doctors often feel that AHPRA is a realistic threat?

Doctors do not trust their own

Perceived social condemnation among both the public and one's colleagues is the driving factor for the fear of an AHPRA notification. There are several other important factors behind a doctor's reasons for not seeking treatment for a mental health condition, supported by an abundance of high-quality evidence. Stigmatization may perhaps be the most common reason doctors cite for not seeking professional help, both in Australia and worldwide.[2, 16, 52-54] This is evidenced by a shocking finding from Beyond Blue's 2013 National Mental Health Survey regarding how doctors feel about their depressed colleagues. An astounding 31% of female doctors and 45% of male doctors in Australia did not believe that doctors with a mental health

history would be as reliable as the average doctor.[2] This sentiment has already been passed to the next generation as evidenced by an Australian study of younger, mostly depressed, physician trainees that did not seek help, and in whom the vast majority (88%) believed that doctors should portray a health image.[15] Despite these sentiments, there is no evidence to suggest that a doctor that is treated for a mental health condition is impaired or at an increased risk to patients. Surprisingly, stigmatization among doctors in Australia might very well be worse than in the Australian general population.[17] Other factors for not seeking help include embarrassment (59%), lack of confidentiality (52.2%), and the impact on their right to practice (34.3%).[2] Doctors may fear that a report might increase the risk for lawsuits, affect hireability, and affect salary negotiations, all representing a threat to one's finances. Not unlike the Australian general population,[55] there was also a generalised preference to self-manage (30.5%),[2] which may be seen as a reportable violation depending on how a doctor chooses to self-manage. Those that do seek treatment despite these concerns, are likely to keep their condition a secret which can lead to feelings of isolation and loneliness, which contributes to mental health decline.

Where does the mistrust begin?

Perhaps the most influential experiences arise during the medical school years. A 2015 study found that that students witnessed supervisors negatively judge students who sought help for burnout and their colleagues revealed mental health problems of other colleagues.[56] Despite reaching the crux of ethics training during medical school, the evidence suggests that students are still susceptible to the confidentiality-divulging gossip which creates the potential to ruin a student's reputation and perhaps follow them throughout their careers. These factors are among the reasons that only a third seek help for their own mental health conditions,[56] and these types of experiences are likely reasons that doctors reaching the even the highest level of their training do not seek help. It is well-established that students become more empathetic after completing rotations in psychiatry.[57-59] Since these studies are performed on a student population that have completed their psychiatry rotations in recent years, perhaps doctors need regular mental health education to help prevent the empathy dissipation. Education about to how to appropriately address a colleague in distress, coupled with available support is key.

"I needed someone to tell me to stop working. It was the fear of telling people I couldn't do this anymore, it felt like a sign of weakness or my own failing." – Dr. Michael Weinstein, MD

The first encounter

At the present time, despite the issue of doctor's mental health being at the forefront, and an evidence-base that has never been better, both doctors and medical students are failing. Doctors tend to internalise the perceived negative views of their colleagues resulting in an unhealthy refusal to seek treatment for issues that are unlikely to fade over time. Doctors should feel supported by their colleagues without any form of judgment. Doctors must also be aware that a colleague that discloses a mental health issue could be doing so for the first time.

The first experience of disclosing a mental health condition, whether to their healthcare professional or colleague, has the power to alter how they will approach any current and future issues. A negative experience could mean that they never seek help again. Therefore, it is the *responsibility* of all doctors to demonstrate a supportive response and handle mental health disclosures, appropriately. The bioethical principles of beneficence and non-maleficence that are expected for any patient must be consciously applied to fellow doctors without judgement, in the forms of dignity and empathy, and arguably most important of all, with complete confidentiality. The importance of appropriate handling cannot be understated, and these personal and professional responsibilities cannot be abdicated. Doctors fear stigma. Therefore, it cannot be surprising that the current environment leads to a reluctance to seek help and a tendency to leave mental health issues unaddressed. It is considered to be a brave decision when a doctor does disclose a mental health issue, but really, should it have to be a *brave* decision? Or should it simply be the norm? With the prevalence of mental health conditions so greatly affecting those that take on the task of healing others, disclosure to colleagues and seeking professional help should not seem so difficult nor should it come with any fear of reprisal. The unfortunate reality is that the medical field has not come close to reaching that point. It will take many more generations of doctors that have suffered, learned, witnessed, and spoken out in order to create a culture that is mentally healthy for doctors. Through promotion, education, and open discussion, both medical students and doctors can change attitudes and nurture a new culture. The idea that a doctor is susceptible to suffering *and* still be competent is one that needs to be made commonplace. This sentiment must become the norm from the first day of medical school, especially since this is when the stigma and silence begin. This will help create a much needed

change in culture. Change never fast and is always met with resistance, but it is inarguable that the prevalence of mental health problems among doctors should have already reached its peak.

Acknowledging the Fear: A Doctor's Identity

Fear is the driving force behind a doctor's silence (Figure 2). Fear guides doctors around a deceptive and circular path, one that complicates any return to normalcy. Simply put, the fear is rational; fear of the lack of confidentiality, the fear of stigma, and the fear of the disintegration of one's professional career are understandable in the contemporary environment. It is not, however, the result of depressed or altered thinking that leads doctors to believe that they might be targets. Terms such as "mandatory reporting" are understandably daunting to the doctor with a mental health issue and is synonymous with personal, professional, and legal repercussions.

Figure 2. A word cloud developed from qualitative studies based on a doctor's mental health. These words represent the feelings and attitudes experienced by healthcare providers that have experienced a mental health issue.

The most overlooked fear for many is the loss of one's identity. For many, becoming a medical doctor is not simply a career choice, it is a way of life, a driving force, and a guiding light. The title often replaces one's name, demonstrated each time one is called "doctor" while at work. The loss of the hard-earned privilege to practise medicine results in the loss of identity. It has been argued that it is fallacious to connect one's self-worth to a profession, and that mental health issues manifest in doctors due to personalities that reflect and define an egoic state. For many, this profession does represent an insignia of self-worth and though the notion that one's

self-worth is connected to a profession may be erroneous, it must be understood that for those that have sacrificed much to earn their profession, it is central to their identity and the threat of losing any aspect of the profession is overwhelming. A doctor will fight and sacrifice almost anything to preserve the essential privilege to practise, even at the expense of his or her own mental health. It has been said that the only true happiness lies in knowing who we are. If one subscribes to this theory, the loss of an identity, which for doctors is the right and privilege to practise medicine, means that there is a permanent loss of happiness and therefore is the loss of the euthymic state.

Healing Our Healers: A Novel Solution

In response to a doctor suicide, Stanford University's general surgery residency created the first of its kind program, a mandatory wellness program called "Balance in Life."[60] This program is available to all, and is designed to facilitate discussion regarding the challenges that residents face on all facets of life. Residents attend confidential meetings during protected time with a clinical psychologist who specialises in coaching high-performance teams. Though it will not change the stressful nature of this profession, these types of programs allow for the development of a culture where empathy, compassion, resilience, and self-care are emphasised. Others are beginning to catch on. For example, Mount Sinai Medical School has implemented an annual mental health check-up in response to the suicide of a final year medical student. It is unfortunate that these programs tend to arise after a student or doctor has taken their own life. Compulsory "Balance in Life" programs are novel in the medical field, and therefore long-term data on outcomes are limited, however, it is likely that the community, support, and understanding that is received through these programs will lead to favourable outcomes in terms of self-care and overall improvements in mental health. These programs should be mandated everywhere, and will likely comprise a significant component of future programs that assure adequate mental health care for doctors.

Framework for Action in Australia

There are a number of potential solutions that must be attempted in order to both prevent and manage the mental health issues arising as a result of hospital-acquired depression are outlined

below. These can be broken down into actions and responsibilities of both the system and the individual to help change a culture that results in mental health demise.

Systemic Solutions

1. Development of mandatory programs dedicated to confidential, open discussion, teamwork, reminiscent of Stanford University's "Balance in Life" program. These programs need to be mindfully developed, accounting for the local culture and the needs of individual systems.
2. Confidential screening programs for mental health issues with appropriately trained healthcare professionals.
3. Admit medical students not solely based academic performance, but based also on sophisticated aptitude testing.
4. Provide confidential support from individuals that cannot control a doctor's career trajectory.
5. Assure humane working hours and preserve a healthy work-life balance.
6. Fund research for the health and wellbeing of doctors and medical students.
7. Mandate and promote a "Doctor's Bill of Rights" which outlines reasonable working conditions for students and doctors.

Individual Solutions

1. Group or individual activities outside of medicine to support both physical and mental health.
2. Recognise and offer compassion to colleagues.
3. Teach others methods of fostering resilience.
4. Avoid persecuting others for mistakes and imperfection.
5. Report inappropriate behaviour
6. Do not gossip or speak ill of colleagues

Conclusion

Medicine is among the most challenging fields in existence, one in which psychiatric morbidity is endemic and suicide simply an occupational hazard. The medical field has largely overlooked the mental health and wellbeing of its doctors. The evidence overwhelmingly demonstrates the magnitude of the problem. A change in not just the medical system, but also in the culture is long overdue. This will prove to be challenging and will be met with resistance, but it is time for a significant change. This is not simply a human resources issue, but is indeed a human rights issue.

This essay has been written in memorandum to the many thousands of doctors who have lost their battle to suicide as of the date of this submission, and to the many more who will take their own lives later this year.

Resources for help

If you or someone you know is in crisis, there is help. Please contact any of the following:
Beyond Blue Lifeline: **13 11 14**
Beyond Blue Suicide Call Back Service **1300 659 467**
https://www.beyondblue.org.au/get-support/get-immediate-support

For confidential support for issues affecting doctors such as work-related stress, bullying, harassment, discrimination, sexual harassment, substance use, personal stress, mental health, trauma counselling, self-harm, suicide, violence, grief and bereavement:

RACP Support Program: **1300 687 327** (Australia)
0800 666 367 (New Zealand)
https://www.racp.edu.au/fellows/physician-health-and-wellbeing/i-need-support/racp-support-program

Appendix 1

PubMed search strategy for burnout interventions in doctors:

"Burnout, Professional"[Mesh] OR burnout[tiab] OR "psychological workload" OR "Stress, Psychological"[Mesh] OR "Anxiety"[Mesh:NoExp] OR "Depression"[Mesh] OR anxie*[ti] OR anxious*[ti] OR depress*[ti] OR stress*[ti] OR strain[ti] OR burden*[ti] OR "psychological load" OR "Burnout, Professional"[Mesh] OR "Compassion Fatigue"[Mesh] OR “emotional exhaustion” OR “mental fatigue”

"Physicians"[Mesh] OR doctor[ti] OR doctors[ti] OR physician[ti] OR physicians[ti] OR residency[ti] OR resident[ti] OR residents[ti] OR registrar[ti] OR registrars[ti]

"Job Satisfaction"[Mesh] OR “job satisfaction” OR resilience OR wellness[ti] OR prevent*[ti] OR "Happiness"[Mesh] OR intervention*[ti] OR program*[ti] OR trial[ti] OR educat*[ti]

References

1. Ahonen M. Ancient philosophers on mental illness. History of psychiatry. 2019;30(1):3-18.
2. Beyond Blue: National Mental Health Survey of Doctors and Medical Students Melbourne, Australia2013 [Available from: https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report_web.
3. Rotenstein LS, Ramos MA, Torre M, Segal JB, Peluso MJ, Guille C, et al. Prevalence of depression, depressive symptoms, and suicidal ideation among medical students: a systematic review and meta-analysis. Jama. 2016;316(21):2214-36.
4. Andrew LB. Physician Suicide: Medscape

2018 [Available from: https://emedicine.medscape.com/article/806779-overview#a1.
5. Prevention AFfS. Facts about physician depression and suicide 2019 [Available from: https://afsp.org/our-work/education/healthcare-professional-burnout-depression-suicide-prevention/.
6. Kumar S, editor Burnout and doctors: prevalence, prevention and intervention. Healthcare; 2016: Multidisciplinary Digital Publishing Institute.
7. Rotenstein LS, Torre M, Ramos MA, Rosales RC, Guille C, Sen S, et al. Prevalence of burnout among physicians: a systematic review. Jama. 2018;320(11):1131-50.
8. T'Sarumi OO, Tanwar D. Physician Suicide: A Silent Epidemic. American Psychiatric Association (APA) 2018 annual meeting; May 5, 2018; New York City, NY, USA2018.
9. Davis M, Detre T, Ford DE, Hansbrough W, Hendin H, Laszlo J, et al. Confronting depression and suicide in physicians: a consensus statement. Jama. 2003;289(23):3161-6.
10. Milner AJ, Maheen H, Bismark MM, Spittal MJ. Suicide by health professionals: a retrospective mortality study in Australia, 2001–2012. Medical journal of Australia. 2016;205(6):260-5.
11. Chambers CN, Frampton CM, Barclay M, McKee M. Burnout prevalence in New Zealand's public hospital senior medical workforce: a cross-sectional mixed methods study. BMJ open. 2016;6(11):e013947.
12. Surgenor LJ, Spearing RL, Horn J, Beautrais AL, Mulder RT, Chen P. Burnout in hospital-based medical consultants in the New Zealand public health system. The New Zealand Medical Journal (Online). 2009;122(1300).
13. Imo UO. Burnout and psychiatric morbidity among doctors in the UK: a systematic literature review of prevalence and associated factors. BJPsych bulletin. 2017;41(4):197-204.
14. Agency AHPR. National Registration and Accreditation Scheme Strategy 2015-20 2017 [Available from: https://www.ahpra.gov.au/About-AHPRA/What-We-Do/NRAS-Strategy-2015-2020.aspx.
15. Axisa C, Nash L, Kelly P, Willcock S. Psychiatric morbidity, burnout and distress in Australian physician trainees. Australian Health Review. 2019.
16. Lyons Z, Laugharne J, Laugharne R, Appiah-Poku J. Stigma towards mental illness among medical students in Australia and Ghana. Academic Psychiatry. 2015;39(3):305-8.
17. Beyond Blue: Information Paper: Stigma and discrimination associated with depression and anxiety 2015 [Available from: https://www.beyondblue.org.au/docs/default-source/policy-submissions/stigma-and-discrimination-associated-with-depression-and-anxiety.pdf?sfvrsn=0.

18. Elliot L, Tan J, Norris S. The mental health of doctors: a systematic literature review: Beyond Blue. 2010.
19. Statistics ABo. National Health Survey: First Results, 2017-18 Canberra2018 [Available from: https://www.abs.gov.au/ausstats/abs@.nsf/mf/4364.0.55.001.
20. Organization WH. Depression and other common mental disorders: global health estimates. World Health Organization; 2017.
21. Zaman S, Rahim M, Khan A, Habib S, Rahman M, Ahsan M, et al. Prevalence of Depression Among Post-Graduate Medical Trainees: A Multi-Centre Survey. BIRDEM medical Journal. 2014;4(1):18-21.
22. Assunção AÁ, Machado CJ, Prais HAC, de Araújo TM. Depression among physicians working in public healthcare in Belo Horizonte, Brazil. Social psychiatry and psychiatric epidemiology. 2014;49(8):1219-29.
23. Bromet E, Andrade LH, Hwang I, Sampson NA, Alonso J, De Girolamo G, et al. Cross-national epidemiology of DSM-IV major depressive episode. BMC medicine. 2011;9(1):90.
24. Association CM. CMA National Physician Health Survey: A National Snapshot. Canadian Medical Association; 2018.
25. Wang J-N, Sun W, Chi T-S, Wu H, Wang L. Prevalence and associated factors of depressive symptoms among Chinese doctors: a cross-sectional survey. International archives of occupational and environmental health. 2010;83(8):905-11.
26. Gong Y, Han T, Chen W, Dib HH, Yang G, Zhuang R, et al. Prevalence of anxiety and depressive symptoms and related risk factors among physicians in China: a cross-sectional study. PloS one. 2014;9(7):e103242.
27. Bernburg M, Vitzthum K, Groneberg DA, Mache S. Physicians' occupational stress, depressive symptoms and work ability in relation to their working environment: a cross-sectional study of differences among medical residents with various specialties working in German hospitals. BMJ open. 2016;6(6):e011369.
28. Grover S, Sahoo S, Bhalla A, Avasthi A. Psychological problems and burnout among medical professionals of a tertiary care hospital of North India: A cross-sectional study. Indian journal of psychiatry. 2018;60(2):175.
29. Wada K, Yoshikawa T, Goto T, Hirai A, Matsushima E, Nakashima Y, et al. National survey of the association of depressive symptoms with the number of off duty and on-call, and sleep hours among physicians working in Japanese hospitals: a cross sectional study. BMC Public Health. 2010;10(1):127.
30. Ruitenburg MM, Frings-Dresen MH, Sluiter JK. The prevalence of common mental disorders among hospital physicians and their association with self-reported work ability: a cross-sectional study. BMC health services research. 2012;12(1):292.
31. Gu A, Onyeama G, Bakare M, Igwe M. Prevalence of depression among resident doctors in a teaching hospital, South East Nigeria. International Journal of Clinical Psychiatry. 2015;3(1):1-5.
32. Atif K, Khan HU, Ullah MZ, Shah FS, Latif A. Prevalence of anxiety and depression among doctors; the unscreened and undiagnosed clientele in Lahore, Pakistan. Pakistan journal of medical sciences. 2016;32(2):294.
33. Al-Maddah EM, Al-Dabal BK, Khalil MS. Prevalence of sleep deprivation and relation with depressive symptoms among medical residents in King Fahd University Hospital, Saudi Arabia. Sultan Qaboos University Medical Journal. 2015;15(1):e78.

34. Rossouw L, Seedat S, Emsley RA, Suliman S, Hagemeister D. The prevalence of burnout and depression in medical doctors working in the Cape Town Metropolitan Municipality community healthcare clinics and district hospitals of the Provincial Government of the Western Cape: a cross-sectional study. South African Family Practice. 2013;55(6):567-73.
35. Marzouk M, Ouanes-Besbes L, Ouanes I, Hammouda Z, Dachraoui F, Abroug F. Prevalence of anxiety and depressive symptoms among medical residents in Tunisia: a cross-sectional survey. BMJ open. 2018;8(7):e020655.
36. Khan A, Teoh KR, Islam S, Hassard J. Psychosocial work characteristics, burnout, psychological morbidity symptoms and early retirement intentions: a cross-sectional study of NHS consultants in the UK. BMJ open. 2018;8(7):e018720.
37. Tawfik DS, Profit J, Morgenthaler TI, Satele DV, Sinsky CA, Dyrbye LN, et al., editors. Physician burnout, well-being, and work unit safety grades in relationship to reported medical errors. Mayo Clinic Proceedings; 2018: Elsevier.
38. Bianchi R, Schonfeld IS, Laurent E. Physician burnout is better conceptualised as depression. The Lancet. 2017;389(10077):1397-8.
39. Organization TWH. Burn-out an "occupational phenomenon": International Classification of Diseases 2019 [Available from: https://www.who.int/mental_health/evidence/burn-out/en/.
40. Venegas CL, Nkangu MN, Duffy MC, Fergusson DA, Spilg EG. Interventions to improve resilience in physicians who have completed training: A systematic review. PloS one. 2019;14(1):e0210512.
41. West CP, Dyrbye LN, Erwin PJ, Shanafelt TD. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. The Lancet. 2016;388(10057):2272-81.
42. Locke R, Lees A. A literature review of interventions to reduce stress in doctors. Perspectives in public health. 2019:1757913919833088.
43. Kalani SD, Azadfallah P, Oreyzi H, Adibi P. Interventions for physician burnout: A systematic review of systematic reviews. International journal of preventive medicine. 2018;9.
44. Panagioti M, Panagopoulou E, Bower P, Lewith G, Kontopantelis E, Chew-Graham C, et al. Controlled interventions to reduce burnout in physicians: a systematic review and meta-analysis. JAMA internal medicine. 2017;177(2):195-205.
45. Clough BA, March S, Chan RJ, Casey LM, Phillips R, Ireland MJ. Psychosocial interventions for managing occupational stress and burnout among medical doctors: a systematic review. Systematic reviews. 2017;6(1):144.
46. Makary MA, Daniel M. Medical error—the third leading cause of death in the US. Bmj. 2016;353:i2139.
47. Agency AHPR. Legislative amendments on mandatory reporting and fake practitioners 2019 [Available from: https://www.ahpra.gov.au/News/2019-02-26-legislative-amendments-on-mandatory-reporting-and-fake-practitioners.aspx.
48. Hayes P. Mandatory reporting laws pass without profession-recommended changes RACGP

2019 [Available from: https://www1.racgp.org.au/newsgp/professional/mandatory-reporting-laws-pass-without-profession-r.
49. Practitioners TRACoG, Queensland AMA, Royal Australian and New Zealand College of Psychiatrists QB, Medicine ACoRaR, Medicine ACfE. Queensland doctors call on State Government to save lives 2018 [Available from: https://www.racgp.org.au/gp-news/media-

releases/2018-media-releases/december-2018/queensland-doctors-call-on-state-government-to-sav.
50. Agency AHPR. Annual Report 2017/18

2018 [Available from: https://www.ahpra.gov.au/annualreport/2018/notifications.html.
51. Bismark MM, Spittal MJ, Gurrin LC, Ward M, Studdert DM. Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia. BMJ quality & safety. 2013;22(7):532-40.
52. Adams EF, Lee AJ, Pritchard CW, White RJ. What stops us from healing the healers: a survey of help-seeking behaviour, stigmatisation and depression within the medical profession. International Journal of Social Psychiatry. 2010;56(4):359-70.
53. Hassan TM, Ahmed SO, White AC, Galbraith N. A postal survey of doctors' attitudes to becoming mentally ill. Clinical Medicine. 2009;9(4):327-32.
54. Gold KJ, Andrew LB, Goldman EB, Schwenk TL. "I would never want to have a mental health diagnosis on my record": A survey of female physicians on mental health diagnosis, treatment, and reporting. General hospital psychiatry. 2016;43:51-7.
55. Brijnath B, Antoniades J. "I'm running my depression:" Self-management of depression in neoliberal Australia. Social Science & Medicine. 2016;152:1-8.
56. Dyrbye LN, Eacker A, Durning SJ, Brazeau C, Moutier C, Massie FS, et al. The impact of stigma and personal experiences on the help-seeking behaviors of medical students with burnout. Academic medicine. 2015;90(7):961-9.
57. Janoušková M, Weissová A, Formánek T, Pasz J, Bankovská Motlová L. Mental illness stigma among medical students and teachers. International Journal of Social Psychiatry. 2017;63(8):744-51.
58. Pascucci M, Ventriglio A, Stella E, Di Sabatino D, La Montagna M, Nicastro R, et al. Empathy and attitudes towards mental illness among Italian medical students. International Journal of Culture and Mental Health. 2017;10(2):174-84.
59. Lyons Z, Janca A. Impact of a psychiatry clerkship on stigma, attitudes towards psychiatry, and psychiatry as a career choice. BMC medical education. 2015;15(1):34.
60. Dua M. Residency Program Balance in Life 2019 [Available from: http://med.stanford.edu/gensurg/education/residencyProgram/residentlife.html.