Speaker 1 (00:06):

Welcome. I'm Gora Agarwal. I serve as the Chief Wellness Executive and Vice President at Northwestern Medicine. I'm a psychiatrist and I also serve as the Wellbeing Consultant for the Center for Workplace Mental Health, brave of Heart Foundation. Grant, I'm really excited to meet one of my mentors, one of my heroes, if you will, growing up in this work of healthcare professional wellbeing, Dr. Michael Myers. Dr. Myers, I'd love for you to introduce yourself.

Speaker 2 (00:34):

Oh, thank you, chief. That's very nice. What you've said already. I'm a psychiatrist and I'm a professor of clinical psychiatry at SUNY Downstate Health Sciences University in Brooklyn.

Speaker 1 (00:47):

Thank you very much. And where I became familiar with your work was on a heavy topic, the topic of healthcare worker suicide, physician suicide specifically. And as I was in my training, I remember reading many of the really seminal articles in this field given your professional practice. And so I'd love to just begin by having you share with the audience a little bit about what got you in to into specializing in this field.

Speaker 2 (01:19):

Thanks for the question, Jay. It's rooted in tragedy. When I was a first year medical student, one of my roommates took his life. He was also a first year medical student. It was over the Thanksgiving weekend. It's a long time ago. It was in 1962, and I had no idea at the time, actually, well, first of all, I mean we were all shocked and stunned the stigma associated with suicide back in those days. I can't tell you how profound it was. In fact, it was so severe that no one spoke to us, our class at all, about Bill's death. I remember, of course, standing in front of my class and telling them that Bill had killed himself over the weekend. And I'll never forget the faces of my classmates, but that was it. There was nothing else said. We just buried ourselves in our studies and as you know, it would be very different if he had been killed in a motor vehicle accident or died of lymphoma or something like that. So we've come a long ways since then and that this is a subject that, as difficult as it is, we are certainly talking about it more and studying it more as well. And by the way, I had no idea at that time that I would end up in psychiatry as a specialty and also becoming a specialist in physician health.

Speaker 1 (02:54):

Obviously I know it's been a long time, but still I sympathize with your loss and I'm sorry for the loss that you experienced, and I know that since that time, to your point, we have come a long way. I do believe there's still ways to go, but I'm happy that we have come a long way. And the way we've come a long way is through your work. Your research amongst many others, of course, has been really important. And I know you ended up actually taking a lot of these papers and sort of distilling 'em down and wrote a book on the topic. If you might share a little bit about some of the highlights from your book about what you've learned and what you think would serve our audience. Well,

Speaker 2 (03:39):

Rachel? Yeah, I put the book together because I had reached a point. It was published by the way, in 2017. I put the book together because I felt it was time to really kind of drill down. Actually on some of the, as you know, suicide's, a very complicated complex state. And by the way, the title of the book is called Wife Physicians Die by Suicide. Lessons Learned from their Families and Others who Cared. And

apart from my clinical insights and all of the work I've done as a clinician looking after suicidal physicians and also describing in the book Doctors Who Died by suicide under my watch, the substrate of the book is a project that I embarked on about two years before I put pen to paper, which was interviewing the bereaved loved ones of medical students and doctors who had taken their lives. So I had a small number of individuals, a small database, so to speak.

Speaker 2 (04:59):

But as I began to interview them, that led to more and more. So it got to be really quite an undertaking with a lot of rich insights from of course, family members. But I didn't stop there. I talked with roommates of medical students and residents who took their lives. I talked with training directors. I talked with students who had lost professors to suicide. I talked with psychiatrists who had lost doctor patients to suicide. I talked with physicians who had made near lethal suicide attempts, but fortunately did not die. I wanted to capture, I wanted to capture what was going on just prior to that act that should have been fatal. And finally, I talked with patients of doctors who died by suicide. I wanted to learn from them as well. And so that's what I put into the book. And so it's really a lot of stories and just really a lot of, I think observations and recommendations of things that we can do, like prevention, intervention, and postvention really to reduce the numbers of physicians who take their life each year.

Speaker 1 (06:32):

That's very helpful context, and I can't think of a better data source to help us understand the problem so that we can then obviously intervene. I like the framework you just outlined, prevention, intervention, postvention. I wonder if we might sort of double click on each of those three buckets and learn from your wisdom on what us as individuals and what us as healthcare systems and medical practices might do in each of those buckets. Let's maybe start with prevention. Okay.

Speaker 2 (07:05):

Yeah, good question. Obviously this is one that I've thought about a lot, and I think we look all the way to, obviously medical education, for instance, starting there. And as you well know, it's just so different now. First of all, the curriculum even has portions, whether it's lectures, whether it's workshops, whether it's working groups, having to do with wellbeing of being a medical student, those sorts of things. We also, of course have, I think all medical schools have counseling services for any medical student who is feeling symptomatic. There's also, we've got peer groups now in medical school as well, which are wonderful actually, because they start right at the get go. So it sounds like a big brother, little brother, big sister, little sister, those kinds of things. So right from the very beginning, I think they realize that you're embarking on a stressful career and it's not unusual to maybe in, please go for help.

Speaker 2 (08:26):

The other thing too that I'm very excited about, and this is part of a book that I have in progress right now, which the working title of that is called Physicians With Lived Experience, how their Stories are offering Clinical Guidance. And so I'm interviewing many medical students and residents and physicians beyond training who are speaking openly and writing about an illness perhaps even that they had in pre-medicine. And that the exciting part is that many of them are actually sharing this on their personal statements, applying to medical school. And that's really quite new in a way. And because there's still many who don't do that because they're terrified that that will affect their chances of getting an interview. But there's a whole other cohort of individuals out there who believe very, very strongly that this strengthens their application. And as a psychiatrist and neuropsychiatrist as well, to me, it really is

really fighting stigma because if you can put in your personal statement that you were diagnosed with, oh, say juvenile diabetes, or if you are a survivor of non-Hodgkin's lymphoma, why can't you put in that you had an eating disorder and you're now well, and you learned an enormous amount about what it's like to be a patient and to receive care and things like that.

Speaker 2 (10:01):

So these are some of the things that go into prevention at that level. And of course then we kind of drill down in residency training and then beyond as well. And so then we get into things like the, well, let's call it the ecology of medicine in a sense. And that's when we start to, well, we see burnout in medical students and residents and then beyond. But we all know, I think the systemic nature of burnout and that we're not going to be able to really do our best job until we get at that. And of course, that then involves really very big system changes in everything having to do with the way medicine is structured in this country and all of those forces that have been studied and worked on. And it's a work in progress. And that's where the National Academy of Medicine, for instance, are the things that are being done through the A C G M A or the A M A or the Federation of State Physician Health Programs. A lot of these things that are all looking at the, I would say the ecology.

Speaker 1 (11:23):

So I might memorize the sort of three big buckets I heard from a prevention standpoint, one, decreased stigma and all the sources of stigma. Two, probably critically, importantly, really making sure that we're building connections, communities decreasing the sense of isolation that both training and frankly the practice of medicine often entails. And three is really thinking about re-imagining healthcare so that it is a career that is sustainable and not burn out genic. And obviously I've spent my life's work in that third bucket especially. So I think those three concepts from a prevention standpoint make a great deal of sense, and I do think will make a big difference. Oh, sorry. Go ahead.

Speaker 2 (12:12):

Gee, if you wouldn't mind, I wanted to just speak a little bit if I could, a little bit more about intervention and then postvention.

Speaker 1 (12:19):

Absolutely. I was going to move to those. Yep.

Speaker 2 (12:21):

Yeah, because what I'd like to say about that is that has ramped up as well. I mean, I talked about counseling services, say for medical students, but now I think fortunately, I think it's working a little bit better at the resident and fellow level as well where there's either affordable care that's available. That's one thing. The second thing is whether or not it's now kind of almost built into some programs where it is okay now to actually take an hour away in your workweek to see your psychiatrist or your therapist or something like that. And even in some of the busiest branches of training, like surgery for instance, they're somehow working around this honoring the importance of this that if they don't have a healthy resident, it's going to affect their training and so many things like that. So I think we are making inroads there. I think where we still have a long ways to go that even with insurance, it's not always available though.

Speaker 2 (13:36):

So many psychiatrists don't accept insurance. So there has to be some sort of way that the individual can actually pay for their care. Some will work on a sliding scale, and those things help a lot as well. The other thing that I would like to see, and this is why I'm very excited about some initiatives, I think within the American Psychiatric Association is, I guess we could call it colloquially, something like training the trainer, getting more individuals, early career psychiatrists in particular, interested in looking after medical students and physicians. Because I mean, that's been my whole career. It's, it's been a gratifying career for many years. Well, for 22 years, Dr. Leah Dickstein and I taught a course at the annual meeting of the A P A. It was a four hour course called Treating Medical Students and Physicians, and we loved doing it. And that was the target group, a lot of early career psychiatrists who would come to it.

Speaker 2 (14:40):

It was only four hours, but you cut quite a lot out of it because they had an opportunity to talk to us as well with some of the difficult patients they were seeing and sharing those insights. So that's the other thing that I'd like to see happen. And within that too, our need for the subspecialists within psychiatry as well, it's always been very, very important to me that we as generalists, that we make sure though that if we're struggling with a physician patient, that we got to make sure that we get second and third opinions that they do have access to the more well to the current strategies for treatment resistant depression and the use of ketamine clinics and that they get the option of e C two and that they get the option of various types of psychotherapy built into the treatment as well. So that's what I mean about that intervention. It is gotten much richer and much broader, and that is really helping a lot of symptomatic doctors.

Speaker 1 (15:54):

I love that. And the other part of intervention that we hear a lot, and I think a lot of people ask us about is obviously we're both trained in mental health and understand a little bit about that, but we spent a lot of time in Northwestern teaching medical students and peers the Q P R question persuade refer model, so that if you're concerned about someone or someone expresses some concerning thoughts, how can they help intervene in that sort of crisis moment? Any thoughts on those programs? Or maybe even more simply, how would you teach a non-mental health person how to be helpful to a colleague or a peer that they're concerned about or as expressed sort of a cry for health?

Speaker 2 (16:45):

I love that question because it really is something that I'm very positive about because of how helpful they can be precisely because they're not necessarily entrenched in the health field or in medicine because I think sometimes our higher education or we're so close to something, I think that it backfires on us, that type of thing. I was just talking with somebody just a few minutes ago how individuals who are not healthcare workers actually can see from a distance that these individuals are too perfectionistic, for instance, or that a lot of their behaviors are self-defeating, and those are individuals that I think offer a holistic perspective to our lives as physicians, and that can be so very, very helpful. I'm a psychiatrist who's also trained in couples therapy, and it was really very interesting through my career to look after a lot of doctors with strained medical marriages, but I learned so much about often when they spouse was a non-medical person, maybe even somebody in the arts and stuff like that. They had insights not just for their spouse but for me as the treating psychiatrist. So

Speaker 1 (18:07):

Yeah, we had a great, one of our sessions was about this issue of teaching therapists and psychiatrists, but definitely therapists about the culture of medicine so that they could have this sort of cultural competency and be able to resonate and connect with their healthcare worker patient. And I think there's great utility to that, but we did ask that question of maybe sometimes we need to be reminded that what we think is normal isn't so normal. Your point is well taken. Let's talk a little bit about the postvention bucket.

Speaker 2 (18:41):

Yeah,

Speaker 1 (18:41):

I will. So none of us want it to be in that position, but we will.

Speaker 2 (18:47):

This is extremely important, and I think this is an area of psychiatry and particular in SUICIDOLOGY that is relatively new now. By that I mean the last 30 to 40 years, and I'll tell you why I say that. I think too often, even in our training in suicide risk assessment and looking after suicidal patients and then losing a patient to suicide as we do sometimes as a resident or beyond, we sometimes feel that our work ends then because the patient has died. But what has come through since of course, is the remaining family, the bereaved family, and these individuals, I can't tell you how much I think they are doing. In other words, the so-called survivors of suicide loss, that huge group of individuals out there, and then if we zero down on health professional suicide, they are teaching us so much about things that we can learn going back into prevention.

Speaker 2 (19:58):

So I make statements like post prevention is prevention, that type of thing. I've learned so much of them. There are individuals too that part of their bereavement and healing has to do with having a voice. And so I put together a number of programs over the years at the a annual meeting involving family members of doctors who have died by suicide. They do this at NAMI as well, and many of them are also volunteering to speak with groups of medical students, residents at grand rounds sometimes. I've done a lot of work with the widow of a urologist who actually became a co-author on an earlier book that we did. Her name is Carla Fine. She's a writer and she is very well known in the survivor world through the book that she wrote after her husband died by suicide called No Time to Say Goodbye. And she's an example, one example of individuals who really, really want to make sure that their loved one has not died in vain. And so they've got a lot to say about medical education, medical training, the lifestyle of physicians and things like that that we're learning so much from. And so that's what I mean. I really feel that that's a really highly respected group that is really helping us in prevention.

Speaker 1 (21:38):

I think that's fantastic and really, really great points. I think the other thing for organizations that we want to raise awareness to are some of these after suicide toolkits. Some of them are done by the A m A. Some of them are done by the A C G M E for resident suicide or sufficient suicide, because this is not something that organizations do well in the moment. This is something you have to prepare for in advance and know how you're going to activate the various sources of support that you're going to need after our suicide. So that'll be a part of our links to helpful resources that we have along with this podcast. So really, really important work, I believe.

Speaker 2 (22:25):

Yeah, they're very, very helpful, especially because in those early minutes and hours of a tragic death of a medical student or a resident, everybody is just kind of, and it happens to the best of us. You're kind of running around in circles, but when you've got something that walks you through those early hours and things like that, it's so very, very helpful. And then it goes over into the weeks, and it's, as you well know from examining those toolkits, they're very broad based as well.

Speaker 1 (23:01):

Any last sort of advice for folks listening about if there's programs out there or initiatives out there that you have found that people have begin to implement that you think are really on the right track to continuing to make a measurable difference on this? Anything else that our audience should be aware of?

Speaker 2 (23:25):

Yes. The ones, again, this is making I think, a salute to the American Foundation for Suicide Prevention. I had the good fortune to be the president of the New York City chapter for a few years here, and because we're right here in New York City, then I had access the national division, which is as headed up by Dr. Kti Moti, the Chief medical Officer. For a long, long time. They have had a branch, so to speak, of their broad base having to do with the suicide prevention, certainly in health professionals, but physicians first, but more broadly now, health professionals and they too. And so the interactive screening program is one of the things. The other things that they offer. Now, this is post mentioned, the walks, for instance, in a sense they're fundraising, but yet I have also found for a number of years, I would put together a walk here with medical students and residents, and it gives them an opportunity to actually meet breed families who are volunteering for these walks as well.

Speaker 2 (24:46):

And so that they really get a sense of what it's like out in the real world when a tragedy like this occurs. So there's a big educational, they also have a huge research track too at A F S P. And so they provide the seed money for a number of studies that trainees might like to do. They could be about burnout in medical students or residents or early faculty or something like that. The other thing, of course is, and I'm sure well-known to you, is the Dr. Lord of Brain Foundation vision talk about something coming out of a tragedy.

Speaker 2 (25:24):

Dr. Lorna Breen's, sister and brother-in-law cord, they have done so much in the short number of years since Dr. Bre died. And I think what's the most exciting piece of that at the moment is the way they're tackling the anachronistic and illegal questions that are being asked on both well medical licensing applications and renewals as well as credentialing. And so they've got, as I'm sure tool kits as well that are available on their website, both for individuals and for groups that they can use if they happen to be applying to or working in a state where the questions have not been updated, updated. And they always sort of let us know when and if yet another state has sort of gotten up to speed, so to speak. And I find that very exciting because it's something that not all physicians think about until or if they fall ill.

Speaker 2 (26:32):

And then you realize, oh my God, that's a very intimidating question. And I think we're a little bit slower to make inroads. It has to do with credentialing because they're still asking a lot of questions that are

not appropriate. But there's also a bit of a bright light there, and this is largely anecdotal, but it's kind of big anecdotal, is that many of 'em, when confronted, and I've done a bit of this, have thrown the questions out that it was something they were going to do, but they just forgot. They had no idea that these questions are really kind of intimidated. And the good news part is that every doctor I know who has applied for a position and has not filled those questions out or even taken it more boldly is saying, I refuse to answer these questions. I've never heard of a physician who did that, who didn't get the job. So I mean, in a sense, the questions are kind of ridiculous

Speaker 1 (27:46):

For our audience. We interviewed Cory Feist, and so we encourage you to go to that podcast as well because Dr. Myers is exactly right. They've made an amazing change, and that is a sea change in terms of stigma reduction that we think is something organizations can really make great progress on. Dr. Myers, thank you so much for taking the time with us. Obviously, this is a difficult topic in all our podcasts, webinars before this have really been about how do we not get to this point? What do we do to create a culture where we're not talking about healthcare worker suicide, but it's really important that we do talk about it and we continue to do work in the prevention, intervention and postvention phases. That's within each of our circles of control to continue to address this really important problem. Thank you very much for your time.

Speaker 2 (28:38):

Thank you, G, for having me. It's been a delight to be here. I really appreciate this opportunity.

Speaker 1 (28:44):

Thank you.