VIEWPOINT

Depression and Suicide Among American Surgeons—A Grave Threat to the Surgeon Workforce

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The house of surgery is faced with an epidemic amid our ranks. Despite priding ourselves on mental and physical toughness that ignores basic physical and psychological needs, mental illness among surgeons is rampant. On the current trajectory, our workforce will continue to suffer in silence, valuable members will leave the field, and our colleagues will continue to die by suicide.

For decades, rates of depression and suicidal ideation among physicians have been high, exceeding that of the general population, with surgeons having one of the highest suicide rates among physicians.[1-3] The mental health crisis may be even worse than best estimation, as available data are likely markedly underestimating the problem due to issues of response bias and underreporting for fear of discrimination and repudiation.

The onset of depression and other mental illnesses begin for many during the long training years of residency. Drivers that sustain poor mental health among practicing surgeons are likely related to the culture of surgery, the rising demands and complexities of the health care delivery system and stigma, and fear of job security due to policies around disclosure and licensure.[4] Recent data suggest that among current trainees, mental health struggles begin as early as the first year of surgical training. In a national sample of surgical interns, the rate of preexisting depression is significantly lower (3.4%) than that of their same-aged peers in the general population. Despite a seemingly "healthier" population entering residency, nearly one-third of interns develop new-onset depression during the first year of training.[5] A subsequent analysis recently presented suggests that depression among interns is associated with higher rates of depression well after training is complete. Curbing this trend is a matter of workforce sustainability, and as a community of surgeons, we must learn, ask hard questions, and step up to address these challenges so that we are better and stronger as we move into the next generation.

Forced isolation, increased workload, and moral injury from the COVID-19 pandemic have only exacerbated existing threats and unmasked how widespread mental illness is among surgeons. Although one could argue that the COVID-19 pandemic highlighted just how resilient health care workers are, it simultaneously demonstrated how wounded the workforce has become. At the peak of the pandemic, 33% of surgeons screened positive for depression, 31% for anxiety, and 24% for posttraumatic stress disorder.[6] Before the pandemic, 1 in 16 surgeons reported suicidal ideation in the past year.[2] In a postpandemic survey of over 600 surgeons and surgeons in training, suicidal ideation in the past year was reported in 1 in 7 respondents (unpublished work). This is higher than the risk of breast cancer for women in the US and means that the next time we sit in a room of surgeons, we don't need to look beyond that room—or aisle—to find ourselves among a colleague or friend who is suffering.

The first question we must ask is why, and the second is what can we do about it? Despite historically high levels of professional fulfillment, the mental health challenges facing our profession and affecting many of our colleagues have continued to grow. The future of surgical culture should value the mental health of each individual as much as it values the work contributed by that individual. We must care for the surgeon more than surgery. Not only is it the right thing to do, but countless examples also suggest that if you care for the individuals, the success of the team and patients will benefit astronomically.

There are many opportunities for us, as a profession, to contribute to the solutions that address knowledge deficits, culture shifts, and policy change. The first part of the solution is filling a knowledge gap within our community. To achieve change, we need to recognize that mental health is health care. Surgery needs to be educated: mental health disorders, including substance use disorders, are diseases, not character flaws. Overcoming them is not a matter of choosing a different profession or will power. When a surgeon develops a physical ailment, we rally behind them, encourage them in their recovery, welcome them back to the profession when they are well, and memorialize those we have lost. We must do the same for those with mental health disorders by removing barriers to confidential care and modernizing licensure requirements that often ask for the disclosure of diagnoses that are well controlled and do not interfere in the practice of surgery or safety of patients.

Recent attention to mental health and suicide among surgeons has led to a few training programs, including our own, implementing process groups. These sessions are led by a licensed mental health professional to work with trainees on how to cope with personal and professional stressors, including deaths in the operating room, fractured relationships, or anxiety around professional advancement and patient care. Additionally, well-being should be incorporated into professional development discussions as surgeons move from training to practice.[7] Rather than always asking what more a surgeon can be doing to produce clinically or promote academically, we should also be asking if surgeons are in a professional environment that is sustainable and offering ongoing opportunities to address critical health concerns.

We recognize that the majority of surgeons may not be personally suffering. However, identifying and helping those who are suffering may salvage a career and even a life. Fellow surgeons foster trust with understanding surgical culture, the profound responsibilities we share, and the barriers to seeking help. Leaders in surgery should consider widespread psychological first aid (PFA) training for members of their teams. There are free online PFA resources, through the American Psychological Association,[8] Johns Hopkins,[9] and others. This training allows peers to recognize when a colleague is in a moment of crisis and safely intervene using evidence-based techniques. We encourage surgical leaders, along with mental health professionals, to develop and implement specialized PFA training for surgeons. Moreover, the very implementation of such a training program increases awareness around mental health issues and thereby reduces stigma as a natural byproduct.

Once we have developed programs and support for those in crisis, we can begin to address the root causes. Contributors to mental health are complex and multifactorial. However, we have an opportunity—an obligation—to change our culture. Initiatives around surgical culture change must move beyond wellness to a framework of health and well-being. Cultural shifts take time, stigma and both overt and unconscious bias of people with mental health disease run rampant. Change is not easy, but neither is surgery. If our institutions are sending the message to keep it quiet, we will. We need to advocate for ourselves and our colleagues, and we need to approach this on every level, from individual opportunities for self-care and mental health treatment, surgeon-led cultural change and, ultimately, the modernization of licensure policies locally and nationally to reflect that mental illness need not exempt surgeons from the practice of surgery. In addition to saving many careers, these steps are needed to save lives. The first step is to discuss mental health openly and without judgment, as a part of overall health. The US Surgeon General Advisory underscores the profound effect of isolation on health. The first step is simple, yet difficult—connection.

ARTICLE INFORMATION

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