Ruth Adewuya, MD (host):

Hello, you are listening to Stanford Medcast, Stanford CME podcast, where we bring you insights from the world's leading physicians and scientists. If you're new here, consider subscribing to listen to more free episodes coming your way. I am your host, Dr. Ruth Adewuya. This episode is part of our hot topics mini series. And today's episode is in recognition of national physicians who cite Awareness Day, which takes place on September 17. My podcast guest is Dr. Christine Yu Moutier. Dr. Moutier earned her medical degree and completed her training in psychiatry at the University of California, San Diego. Since then, she has been a practicing psychiatrist, professor of psychiatry, dean at the UCSD Medical School, and medical director of the inpatient psychiatric unit at the VA Medical Center.

Ruth Adewuya, MD (host):

After losing colleagues to suicide, she dedicated herself to fighting this leading cause of death. A leader in the field of suicide prevention, Dr. Moutier joined the American Foundation for Suicide Prevention in 2013 as chief medical officer. She also serves as co-investigator for a large national institute of mental health trial on the treatment of refractory depression and advises many organizations and Fortune 500 companies on mental wellness and suicide prevention. Thank you so much for chatting with me today, Dr. Moutier.

Christine Yu Moutier, MD (guest speaker):

Oh, it's my pleasure to be here. Thank you for covering this topic.

Ruth Adewuya, MD (host):

I appreciate that this is a sensitive topic, but also a very important topic that we should all be thinking about and talking about. And so, I wanted to start the conversation by framing the scope of what we're talking about. What does the data tell us about the rates of physician suicide?

Christine Yu Moutier, MD (guest speaker):

Well, we've known for a long time that the risk of physician suicide is very likely greater than that of the general population. And there's a little bit of uncertainty and controversy around that only because of our surveillance system for suicide in this nation is always a little delayed. It's a little bit fractured across the 50 states and our occupational data is not super solid. But we also have studies that have looked at physician mortality due to all causes, including suicide. And have known for actually a number of decades that it is likely higher than the general population. Most definitely for female physicians compared to general population females, a little bit less clear for male physicians. However, if you synthesize a lot of data, what you'll see is that while the rates of suicide during residency training are actually lower than that of the general population, later in one's career, that is when rates tend to rise.

Christine Yu Moutier, MD (guest speaker):

We also know that for other health professional disciplines like nurses, their suicide rates have just now been established through research. And nurse suicide is also elevated at about twice the rate of the general population. We won't know about the impact of COVID for some time. And even then it's going to be, as I mentioned, with some caveats around it, unfortunately. I think the main point to me after living and breathing in this space for several decades myself, is that rather than focusing on the sort of numerical risk or rates, it's the larger picture where our pain points as physicians, what have been limiting us from making the most of our own mental health, our own resilience and suicide protective factors for ourselves as individuals, for our colleagues. And then as a field and as local institutions, how

do you change culture around all of that so that you are actually implementing what the science tells us and be an effective approach to reducing suicide risk?

Ruth Adewuya, MD (host):

What are some of the risk factors for physician suicide and the development of what we call a distressed physician?

Christine Yu Moutier, MD (guest speaker):

There are a number of well established risk factors for suicide that are true amongst the human population and then amongst physicians are accentuated. One of the most potent risk factors for suicide are mental health conditions that are going unaddressed or undertreated. We know that they're as likely to have been suffering from a mental health condition, but less likely to have been engaged in treatment. And the thing is when we talk about suicide and suicide risk in general, we have to always remember that while mental health conditions are one potent risk factor, suicide doesn't occur as the result of any one factor. So, even a mental health condition on its own is generally not thought to be a direct path to suicide, but it's in convergence with other risk factors.

Christine Yu Moutier, MD (guest speaker):

So, for physicians, what rises up in the psychological autopsy literature, which is very small, there's just a couple of studies that have looked at physician suicide decedents next to general population suicide decedents, and looking at all of the deep dive medical, legal, interviews with families, to determine what were the likely intersecting factors at play leading up to their death. And for physicians, what we now know is that they are three times more likely to have had a job related stressor, a disciplinary problem, something job related. Three times more likely than the general population. And they are far less likely to have experienced the usual sort of stressors, losses that are very common preceding suicide for the general population.

Christine Yu Moutier, MD (guest speaker):

The last thing is they are 20 to 40 times more likely to have had substances in their system, in their toxicology reports at the time of death. And those include prescribed medications like benzodiazepines, antipsychotics, and barbiturates. So, we do infer some things based on those few psychological autopsy studies that would say, we have barriers, we're not taking care of our mental health conditions, even though we are highly educated, generally resourced, connected individuals, that there's something in the way of that. And that prescribed medications in the toxicology reports may tell us that either at the time of death, it was part of their lethal means, or there was an informal taking of self prescribing or informal curbside, getting meds from a colleague because I'm not sleeping or because of my new onset panic attacks. But we're not affording ourselves the benefit of a full medical psychiatric evaluation to really get at the underlying roots and have the follow-up necessary for comprehensive care. And so, those are just some of the factors that rise up.

Christine Yu Moutier, MD (guest speaker):

We also know that perfectionism, shame, rejection, humiliation, those are common contributors before a person's attempt or death. And amongst physicians, we can just think about the culture that we live in, the way that we are wired as human beings, we tend to be a little more tightly wired. That's how we succeed in medicine. And not that it's all bad, but when it comes to life threatening distress, that we

only know to apply a certain set of responses, which is try harder, get more disciplined, maybe sleep less so that I can just ramp up my effort. That really reaches a point of diminishing return.

Christine Yu Moutier, MD (guest speaker):

And so, as I'm working with physicians and in my previous role as a dean in an academic medical institution with medical students, really was a message of know when to apply which strategies for ourselves, for our relationships. We have to learn if we don't have it built in already, how to be self compassionate, how to be flexible. It's progress, not perfection, rather than that rigid type of mindset.

Ruth Adewuya, MD (host):

One of the things that I heard you say is one of the important risk factors or stresses is work. I can see how as physicians who tend to closely associate our identity with our profession, and so any problems that arise at work can trigger that. In your experience, what types of events in medical practice may lead to physician distress and to title ideation?

Christine Yu Moutier, MD (guest speaker):

I actually wrote a paper on all of the patterns of distress I was seeing. It's interesting having trained as a psychiatrist where there's a disease model and the medical model and treatment and pathology, whereas in a dean role, you're looking at things much more holistically. And so, I could see how a common theme would be a student or a physician who had already come from a background that for reasons of genetics or early childhood experiences were already prone to mental health struggles, depression, anxiety, substance use, other forms of mental health sort of vulnerabilities. And that was one theme that would then intersect with problems in medical school or on the job, where I see it as a very dynamic interchange, in the sense that if you're already extremely sensitive to perceive rejection or your mood is prone to become more depressed and have a hard time, the depressed brain sees things in very distorted viewpoints.

Christine Yu Moutier, MD (guest speaker):

And that is not something we can afford too much of in our lives as physicians, because we're facing decisions and challenges all the time. And so, academic issues, disciplinary problems, a perceived medical error, problems with interpersonal conflict in a team, an untoward event with a patient and inpatient care, all of those can certainly exempt points in time when a physician or trainee, especially those who already had some level of vulnerability. And I think there's a very practical outcome to that too, that we can think about ways to certainly protect professional development, and patient care, and safety standards, but also be supporting trainees and physicians the whole way through.

Ruth Adewuya, MD (host):

One of the things that comes to mind is, do you think that the socialization of physicians in medical school and residency, does that contribute to some of these patterns that you're talking about, this behavior patterns?

Christine Yu Moutier, MD (guest speaker):

There's no question that the socialization or the informal curriculum as it's been called, all of the messages that we receive in a training and a work environment that overly emphasize self-sufficiency, perfectionism, self-sacrifice to the expense of health, and family, and sleep, the way that distress is incredibly minimized. I'll give a sort of extreme example, but where we could think about how it shows

up in everyday life. As part of my work at UCSD, we launched a program. And so, I was giving talks on this topic to different clinical departments. And in one of the surgical sub-specialties, what I heard when I was showing a list of symptoms that included suicidal ideation as forms and manifestations of distress, depression, burnout, was a response from the chief resident that said, "If I'm not experiencing every one of those symptoms, pretty much every day of the week, it means I'm not doing my job, because I deal with life and death issues."

Christine Yu Moutier, MD (guest speaker):

And so in other words, I should be that stressed, I should be suffering that much. It really logically does not make sense, but in our culture, and hopefully that's an extreme version of it, but we really have not been able to calibrate our own level of distress in a way that we would be able to do for a patient or for a friend or a family member. So, I think there's no question in my mind that there is an interaction between the training environment, and the work environment, and one's own mental health and suicide related outcomes. And again, it's complex because it's not just this causes that, it's always going to be dynamic and interacting between external and internal factors, both risk and protective factors.

Ruth Adewuya, MD (host):

And in that scenario that you mentioned, I can only imagine how that makes it difficult for colleagues to even identify early warning signs. I know it's an extreme example, but when a colleague needs intervention, how do clinicians identify early signs?

Christine Yu Moutier, MD (guest speaker):

I think even despite all of that toxic cultural elements, we also know our colleagues. We work with them sometimes side by side, over long periods of time. And so, to me, although it sounds perhaps a little bit basic or a little bit like making a lot out of a little thing, our behavior patterns are actually pretty darn stable. And when your gut gives you that red flag feeling like, "Whoa, something my colleague just did was like out of character." I think we've written off our own gut instinct around colleagues' distress for a whole lot of reasons. Meaning, what we've already talked about, that there's been an over-emphasis on certain things showing up as signs of success and experiences of distress being interpreted as signs of weakness, rather than simply as being human. We worry about offending our colleagues, all of those things. And we lack a skillset too, sometimes even just having a basic conversation.

Christine Yu Moutier, MD (guest speaker):

But I think things like just showing up late when they're usually on time. And I don't mean just one time thing, but again, when your gut tells you, "Whoa, something seems off," it might be their tone of voice. It might be the way that they talk about either their patients or things in their personal life, seem like they are overwhelmed and struggling. Certainly, they can sometimes use actual language that tips you off to the fact that their mental health is deteriorating and those could be words like, "I'm feeling overwhelmed, I feel trapped." If they talk about feeling like a burden to others, that is really big suicide warning signal.

Christine Yu Moutier, MD (guest speaker):

But again, I think that we have to remember too, that we keep it so zipped up, so that when you are actually seeing something on the outside as the observing colleague, it may in fact mean that what you're seeing is the tip of the iceberg. Now, it might not mean that, it's not an assumption, but what I'm also proposing is that we can be much more caring and attentive to one another, like that sense of

community that we actually are in this together and we need to be watching out for one another and we can take actions on that.

Ruth Adewuya, MD (host):

I really like what you said that we're in this together, it's a community. And I think the more that we are vulnerable with each other, it will lower that bar. Like in that example that you gave, the norm is not for you to experience all of those distressing signs. It takes a safe space. It takes psychological safety within groups to be able to be vulnerable and have those conversations. That's definitely a way that we can move forward. So, you talked about your colleague and some of the warning signs, the flip side is even more challenging when you flip it yourself. So, if you are a clinician and you want to make sure that you are taking care of your own wellbeing, how do physicians go about organizing those signs of distress, those signs of depression in themselves?

Christine Yu Moutier, MD (guest speaker):

Yeah. I went through a process with this for myself over a number of years. We're all unique individuals, so distress, just plain old stress will show up in different ways in each of us. And for some of us, let's take a really common one. When you get stressed, you tend to have a stomach ache, or you tend to start having trouble falling asleep, or you start waking up at 3:00 or 4:00 in the morning, and it's hard to fall back to sleep because there's so much going through your mind. And obviously, stress, and distress, and mental health, and the brain are also taking a form of physiological change. What I had practiced for myself and learned, and what I propose for other people to try out is to take a step back, have some self-reflection, get very objective and be a student of your own past, your own patterns.

Christine Yu Moutier, MD (guest speaker):

And just even in the moment of, let's say, if you are facing something very stressful, what are the first and second signals that pop up anew when you're in that stressful, challenging moment? And think back, is that a stable warning sign for me? In other words, is that the thing that always pops up first? And then what happens next might be dependent on what level of intensity is going on in your life. And also, again, remember it's about many of these things are multi determined, so whatever your genetic loading is. If you've had a history of depression or trauma, if you've had early childhood adversity, those aces apply to us as well. So, I think that's the process. I know it might be different. It takes some real motivation to decide, okay, for me, it was, I needed to actually face something that kept coming up for myself and it was disruptive for my own wellbeing.

Christine Yu Moutier, MD (guest speaker):

By that time I had children, I had patients, I was a dean in a medical school, so for me and the way that I'm neurotically wired, granted, I needed to make it about, I need to do this because I'm a resource to many roles and responsibilities in my life. So, if I keep having these mini meltdowns, whatever it is for you, that's jeopardizing your optimal mental health, not just stability, but optimizing it. You can find all sorts of different reasons to get really serious about that. And it's essentially learning how to develop a practice of self care that is highly individualized and efficient, so that it's not just about doing yoga three times a week, it's about when I see this going on in myself, or even when I see this coming up on my calendar, now I've learned that it means that I'm likely to start ramping up into these kinds of mental health experiences. And then getting ahead of that, making little decisions about how to manage that.

Christine Yu Moutier, MD (guest speaker):

So, I do think you're right, it takes a psychologically safe space. That may not be in the workplace, or it may be. It could be with a partner. It certainly obviously can be with a therapist, which is probably the most obvious and very efficient way to start really taking a look at how does this work for me? How do I tick and how do I make some changes to optimize my thriving and flourishing?

Ruth Adewuya, MD (host):

I also understand that you have lived experience with losing colleagues to suicide. I was hoping you could talk a little bit more about your lived experience with this topic, because I think that's very powerful.

Christine Yu Moutier, MD (guest speaker):

Absolutely. My own lived experience actually starts with my own mental health struggles, and those happened for me while I was in medical school. It led to a whole year off, which felt catastrophic at the time. And I actually think that because it wasn't just something that I could put a bandaid on and move forward and move past, it stopped me in my tracks. It was a big deal. I had to get treatment. Was in that way, afforded the opportunity to have a much sort of deeper transformation where things like the internalized perfectionistic voices that I carried with me, that I had amplified. I thought, yes, the environment you grow up in does matter, of course, but also who you are as a child and the way that you interpret those things and carry them forward. Invisible to me, I had the most demanding, punitive, super ego, meaning my own self talk. And so, I really had to work through that.

Christine Yu Moutier, MD (guest speaker):

And I think because I was motivated and had to make a decision if I was going back to medical school, it sped up my process in a way of figuring things out. I don't know how to explain it otherwise, because there was a deep transformation that happened. So, that even in six or eight months of therapy, I came to this place where I realized that I get to take up space on this planet because I'm a human being, not because I'm achieving. I get to breathe the air around me. And I get to feel for myself the way that I feel so compassionately and with so much grace towards anyone else walking on the planet, but I wasn't giving that to myself. So, that was my initial sort of transformative lived experience moment.

Christine Yu Moutier, MD (guest speaker):

And then fast forward in my residency, there was a medical student that I had worked closely with on a rotation and he took his life. And that was my first experience with loss. And even though he wasn't a close family member, friend, he was a colleague and that did stop me in my tracks. And then over a period of the next, about 15 years, there were 13 faculty physicians at UCSD who took their lives. And I didn't know all of them, but it became part of our institutional history and story that I had the good fortune in a way. Again, it's like when you go through that kind of crisis, which you wouldn't wish on yourself or your worst enemy, but then it has value all of a sudden. Because all of that, those observations and passion that I got to experience, because I had been in that environment where it did not feel safe for me to start dealing with these issues and talking about them at an earlier point in time.

Christine Yu Moutier, MD (guest speaker):

And so, then fast forward after these number of suicide losses, very tragically at UCSD, a number of us, my mentor, and I were put in charge to get to the bottom of this. How many people have died? Is there something that can reduce suicide risk? Because that wasn't clear at the time to most people. The science was just still burgeoning and growing. And also, what does the work environment have to do

with an individual's mental health or suicide outcomes? And those are really excellent questions that thankfully now there is some data to speak to. But at the time we had to go looking for it because it wasn't like you learn these things in medicine.

Christine Yu Moutier, MD (guest speaker):

And so, that really, my own lived experience, were very much part of my own journey to realizing that suicide is a major public health crisis, certainly in the nation, but including for our own selves and colleagues. And we can do something about that. We can change, we can implement simple and more complicated things that must be done in order to allow ourselves to be healthy, and I would add, allow us to be better physicians as well.

Ruth Adewuya, MD (host):

Thank you so much for sharing your story and how you arrived at this place of passion around this topic, which is so, so, so important. I think this is such a great point in our conversation to pivot to what we can do. You already talked about reflection, self care, seeking therapy, and building this community of people around you, that you feel safe to share that. Anything else comes to mind when it comes to self and what are some strategies there?

Christine Yu Moutier, MD (guest speaker):

A powerful thing that any of us can do as individuals, that actually might be really adding value for our own mental health, but also for those around us, is to be more vulnerable. Because whatever that type of sharing is, and it doesn't have to be about mental health, it might be about something going on in your life other than mental health related. But it signals to your colleagues and to your trainees who are on rounds with you or wherever these interactions are happening, that this is an environment where we get to bring a more full aspect of ourselves. And so, I think setting that tone is something that we can do. If you are someone who is suffering and you're keeping that compartmentalized, separate, I would say that first step for that individual is identify one trustworthy person that you can start opening up to.

Christine Yu Moutier, MD (guest speaker):

And while you might say, "What is that going to do? How does talking about my problems help anything about my situation?" And I think what we're not realizing is that oftentimes we're overly focused on the circumstance. So, we're looking for solutions for that financial problem, that relationship problem, that if that person would just behave differently, my life would be better. And what we're not realizing is that our brain, our mind, and the path to healing, all of that is the great mediator between our external circumstance and the outcomes that we're experiencing. And talking about it is that first, but sometimes ultimately powerful step. And allowing all of these insights, the release of shame and stigma, so that we can actually start being much more proactive, which may or may not include all sorts of different things that you get to be the designer of, whether it's self care stuff, whether it's treatment, whether it's a peer support kind of experience.

Ruth Adewuya, MD (host):

Clearly there is a stigma around mental illness. There's a stigma around talking about this issue. Moving from the strategies for the individual to the community, what are some suggestions that you may have for the medical community to band together and stop the stigma around mental illness and having these conversations?

Christine Yu Moutier, MD (guest speaker):

I'll pick up with the same theme of self-disclosure or creating deeper community and authenticity. If you haven't connected to those physicians and other health professionals who are telling their stories, talking about their experiences, hopeful and gritty, it's a very powerful community to be a part of. You can find people on social media. You can actually find in almost every academic medical journal, a story of self-disclosure about something related to wellbeing. But as a medical community, I think we have to face the institutional barriers that have been invisible to us, things that impeded our ability to get mental health treatment, those very clear barriers, like these are the linchpins that must change. And until they do, we will remain from ultimate progress because they're such incredible barriers. And those are the stories and the experiences around medical licensure, the questions that are frankly, illegal, according to ADA standards, to be asking about mental health experiences and treatment at large, that's private information, may have nothing to do with safe practice or competency.

Christine Yu Moutier, MD (guest speaker):

But those are the ways of the old that many states are changing, state by state, their medical boards. But that is also something at a hospital and a medical school, a training program, an institutional level that we have to examine all of our policies and practices. And we have to listen to our community members with lived experience. Some of those stories are hard to hear. Some of them are very complicated. There are also others who have found hope and healing and can tell you what those barriers were, in the way of a straighter path to them being connected to support and resources. So, I think there's any number of things. I do want to say that we are in a time when every national body, from the AMA to the WMC, the ACGME, the National Academy of Medicine.

Christine Yu Moutier, MD (guest speaker):

The Surgeon General just released his report on clinician wellbeing and mental health, which included a section on suicide prevention. This sort of environment is ready for change. It's a question of how do we be strategic and build something over time, because these are not going to be, oh, let's just set up a psychologist who's on campus that will take walk-ins. That could be one part of a multi-pronged approach, but it ideally is strategic and sustained over time, and you keep evolving those efforts.

Ruth Adewuya, MD (host):

Thank you for that. You talked about some really great strategies. I recently learned of The Emotional PPE Project, which was really focused on providing contact information for volunteer mental health practitioners, to healthcare workers who have been impacted by the COVID-19 crisis. Are you aware of other programs similar to that?

Christine Yu Moutier, MD (guest speaker):

Yes. And thank you for highlighting Emotional PPE Project. There's also something called the Physician Support Line, and you can go to physiciansupportline.com. And most hours of the day, there are voluntary psychiatrists staffing that line with no record keeping. It's just for physicians to be able to go over their situation and get some advising and next steps. So, that is a very safe way to go, the Physician Support Line. There's also a program called Pure RX Med. There are actually a number of other organizations that are specifically geared around physician or other health professional mental health, even to the point of offering free therapy or low cost therapy or treatment. And we haven't talked about it a lot, but I will just highlight two other things, that substance use can be a major piece along the path, or sometimes the primary source of distress for physicians.

Christine Yu Moutier, MD (guest speaker):

And so, there are specific pathways to receiving help for that, long before it needs to come to disciplinary action. So, that's really the goal there. And the last thing I want to say is that along the lines of that Physician Support Line, we as physicians, and even those of us who are psychiatrists, we see this last bastion of stigma around taking psychiatric medications ourselves. So, if you have a mental health condition, that is a medical condition. And I would just, again, approach it without stigma like you would for physical health. That oftentimes will hold us anchored to realize, if I'm behaving differently around a mental health experience I'm having, there's probably something wonky about that. And to ground myself in what would I do if it were diabetes or hypertension or a broken leg, any type of physical health problem.

Ruth Adewuya, MD (host):

Thank you for sharing those resources. We'll definitely link to it wherever the podcast is hosted so that people can click on it. As we wrap up our conversation, what's your key message for clinicians who have identified issues in themselves, or have maybe noticed something in their colleagues?

Christine Yu Moutier, MD (guest speaker):

I think the main thing is to start with a basic grounding, that we are all human beings. We all have our own health, includes physical and mental and social, but that mental health piece is something we all have and it's dynamic. So, we can have ups and downs, that's okay. That is normal. But it's also, it should be normal to notice when it's going outside the range and to really get prepared to take some steps when you notice yourself struggling, but also if you notice a colleague struggling. And ways to approach a colleague, don't need to be a big, scary deal. It's simply over coffee or whatever, private setting to approach them in a supportive non-judgmental manner and invite them to share what they're going through. That's it. We're not their doctor. We're not their therapist. We don't have to be. We're just there to listen.

Christine Yu Moutier, MD (guest speaker):

Just don't underestimate the power that comes with that kind of experience. If you are the one, then getting to tell your story to a colleague, you're realizing, "Whoa, maybe this is serious, what I'm going through, and it's okay to talk about this even to a work colleague. And that might unlock my next steps for taking an important, potentially life saving next step." So, that's my basic message. We're humans and we have mental health and that's the starting point.

Ruth Adewuya, MD (host):

Thank you so much for sharing all of your insights on this incredibly important topic. I appreciate you taking the time to speak with me today.

Christine Yu Moutier, MD (guest speaker):

Absolutely. Thank you so much again for highlighting this really important issue.

Ruth Adewuya, MD (host):

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