

# Each Day, One Doctor Dies by Suicide in U.S.

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Contributing Writer

Each day in the United States, roughly one doctor dies by suicide. Studies over the past 4 decades have confirmed that physicians—especially women physicians—die by suicide more frequently than people in other professions or those in the general population.

“Physicians have the means and the knowledge and access to ways to kill themselves,” Dr. Paula Clayton, a psychiatrist and medical director for the American Foundation for Suicide Prevention, said in an interview.

But the data on physicians dying by suicide are difficult to come by, and “we certainly don’t have any data that [say] any particular specialty has any higher rates of suicide,” she said.

Although no information is available on the risk of suicide by specialty, researchers do know that physician suicides are equally divided between men and women, whereas in the general population, four times as many men kill themselves as do women, according to Dr. Clayton.

Awareness of the problem remains low, and professional and cultural barriers deter or prevent physicians who are depressed from seeking treatment for their illness, Dr. Clayton said. For example, most physicians do not have a regular source of health care; only 35% of doctors have a personal physician, and even fewer interns and residents have a doctor themselves.

Dr. W. Gerald Austen, surgeon-in-chief emeritus at Massachusetts General Hospital, has first-hand experience. Twenty-eight years ago, when he was surgeon-in-chief, one of his younger staff committed suicide. And about 11 years ago, a surgical resident committed suicide.

Those deaths were the saddest moments of his career, yet Dr. Austen said he doesn’t know what could have been done to prevent these young physicians from taking their own lives.

“It wasn’t as if the institution and the department weren’t aware that they had some problems,” he said in an interview. “Both of these individuals were under psychiatric care. They were believed by both their doctors and their contemporaries and colleagues to be doing rather well.”

In each case, the surgery department re-

viewed the situation with the psychiatry department, Dr. Austen said, and “we certainly did everything we could in terms of their family in both cases.” But he said the department didn’t find any procedures to change internally as a result of the deaths.

It’s possible that increasing awareness of physician depression could help get physicians the help they need before it’s too late, Dr. Austen said. “Friends who work with people in medicine need to be aware that, if they see something that concerns them, they need to transmit the message to the powers that be.”

But it’s difficult to know the difference between someone who is simply unhappy, and someone who is clinically depressed and potentially at risk for suicide, he added. “[Physicians believe] their job is to help other people with problems. If they have a problem themselves, they would prefer to not have people know about it,” said Dr. Austen.

“There’s this proudness about their ability to cope,” Dr. Clayton said. “They are reluctant to seek help because they fear the stigma will harm them—people won’t refer them patients, the hospital might revoke their privileges, and licensing could become a problem.”

State medical licensing boards ask for information on whether the person applying for licensure has been treated for a mental illness, and that information can affect licensing, she said. “I worked with a physician who took lithium,” she said. “The state board made him get blood drawn periodically to prove he continued to take it. That’s punitive—they don’t do that for other illnesses.”

However, some progress has been made: A total of 19 states now focus specifically on whether an applicant is impaired because of psychiatric illness, she said.

Dr. Clayton’s group recently funded the production of three films on physician suicide as part of an ongoing outreach campaign that seeks to educate physicians about depression. One of the films was designed specifically as an educational video for use at medical schools. Because many of the mood disorders that can lead to suicide might become evident first during medical school, where professional and institutional barriers already exist, the goal of that program is to encourage medical students to seek help for depression. ■

Table 10:  
Percent of RA Patients Reporting Adverse Events  
in Controlled Clinical Trials\*

Event	Placebo Controlled		Active Controlled (Study III)	
	Placebo <sup>†</sup> (N = 152)	ENBREL (N = 349)	MTX (N = 217)	ENBREL (N = 415)
Injection site reaction	10	37	7	34
Infection (total)**	32	35	72	64
Non-upper respiratory infection (non-URI)**	32	38	60	51
Upper respiratory infection (URI)**	16	29	39	31
Headache	13	17	27	24
Nausea	10	9	29	15
Rhinitis	8	12	14	16
Dizziness	5	7	11	8
Pharyngitis	5	7	9	6
Cough	3	6	6	5
Asthenia	3	5	12	11
Abdominal pain	3	5	10	10
Rash	3	5	23	14
Peripheral edema	3	2	4	8
Respiratory disorder	1	5	NA	NA
Dyspepsia	1	4	10	11
Sinusitis	2	3	3	5
Vomiting	-	3	8	5
Mouth ulcer	1	2	14	6
Alopecia	1	1	12	6
Pneumonitis (“MTX lung”)	-	-	2	0

\* Includes data from the 6-month study in which patients received concurrent MTX therapy.

<sup>†</sup> The duration of exposure for patients receiving placebo was less than the ENBREL-treated patients.

\*\* Infection (total) includes data from all three placebo-controlled trials. Non-URI and URI include data only from the two placebo-controlled trials where infections were collected separately from adverse events (placebo N = 110, ENBREL N = 213).

In controlled trials of RA and psoriatic arthritis, rates of serious adverse events were seen at a frequency of approximately 5% among ENBREL- and control-treated patients. In controlled trials of plaque psoriasis, rates of serious adverse events were seen at a frequency of < 1.5% among ENBREL- and placebo-treated patients in the first 3 months of treatment. Among patients with RA in placebo-controlled, active-controlled, and open-label trials of ENBREL, malignancies (see **WARNINGS: Malignancies**, **ADVERSE REACTIONS: Malignancies**) and infections (see **ADVERSE REACTIONS: Infections**) were the most common serious adverse events observed. Other infrequent serious adverse events observed in RA, psoriatic arthritis, ankylosing spondylitis, or plaque psoriasis clinical trials are listed by body system below:

Cardiovascular: heart failure, myocardial infarction, myocardial ischemia, hypertension, hypotension, deep vein thrombosis, thrombophlebitis

Digestive: cholecystitis, pancreatitis, gastrointestinal hemorrhage, appendicitis

Hematologic/Lymphatic: lymphadenopathy

Musculoskeletal: bursitis, polymyositis

Nervous: cerebral ischemia, depression, multiple sclerosis (see **WARNINGS: Neurologic Events**)

Respiratory: dyspnea, pulmonary embolism, sarcoidosis

Skin: worsening psoriasis

Urogenital: membranous glomerulonephropathy, kidney calculus

In a randomized controlled trial in which 51 patients with RA received ENBREL 50 mg twice weekly and 25 patients received ENBREL 25 mg twice weekly, the following serious adverse events were observed in the 50 mg twice weekly arm: gastrointestinal bleeding, normal pressure hydrocephalus, seizure, and stroke. No serious adverse events were observed in the 25 mg arm.

#### Adverse Reactions in Patients with JIA

In general, the adverse events in pediatric patients were similar in frequency and type as those seen in adult patients (see **WARNINGS** and other sections under **ADVERSE REACTIONS**). Differences from adults and other special considerations are discussed in the following paragraphs.

Severe adverse reactions reported in 69 JIA patients ages 4 to 17 years included varicella (see also **PRECAUTIONS: Immunizations**), gastroenteritis, depression/personality disorder, cutaneous ulcer, esophagitis/gastritis, group A streptococcal septic shock, Type 1 diabetes mellitus, and soft tissue and post-operative wound infection.

Forty-three of 69 (62%) children with JIA experienced an infection while receiving ENBREL during three months of study (part 1 open-label), and the frequency and severity of infections was similar in 58 patients completing 12 months of open-label extension therapy. The types of infections reported in JIA patients were generally mild and consistent with those commonly seen in outpatient pediatric populations. Two JIA patients developed varicella infection and signs and symptoms of aseptic meningitis which resolved without sequelae.

The following adverse events were reported more commonly in 69 JIA patients receiving 3 months of ENBREL compared to the 349 adult RA patients in placebo-controlled trials. These included headache (19% of patients, 1.7 events per patient-year), nausea (9%, 1.0 events per patient-year), abdominal pain (19%, 0.74 events per patient-year), and vomiting (13%, 0.74 events per patient-year).

In open-label clinical studies of children with JIA, adverse events reported in those aged 2 to 4 years were similar to adverse events reported in older children.

In post-marketing experience, the following additional serious adverse events have been reported in pediatric patients: abscess with bacteremia, optic neuritis, pancytopenia, seizures, tuberculous arthritis, urinary tract infection (see **WARNINGS**), coagulopathy, cutaneous vasculitis, and transaminase elevations. The frequency of these events and their causal relationship to ENBREL therapy are unknown.

#### Patients with Heart Failure

Two randomized placebo-controlled studies have been performed in patients with CHF. In one study, patients received either ENBREL 25 mg twice weekly, 25 mg three times weekly, or placebo. In a second study, patients received either ENBREL 25 mg once weekly, 25 mg twice weekly, or placebo. Results of the first study suggested higher mortality in patients treated with ENBREL at either schedule compared to placebo. Results of the second study did not corroborate these observations. Analyses did not identify specific factors associated with increased risk of adverse outcomes in heart failure patients treated with ENBREL (see **PRECAUTIONS: Patients with Heart Failure**).

#### Adverse Reaction Information from Spontaneous Reports

Adverse events have been reported during post-approval use of ENBREL. Because these events are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to ENBREL exposure.

Additional adverse events are listed by body system below:

Body as a whole: angioedema, fatigue, fever, flu syndrome, generalized pain, weight gain

Cardiovascular: chest pain, vasodilation (flushing), new-onset congestive heart failure (see **PRECAUTIONS: Patients with Heart Failure**)

Digestive: altered sense of taste, anorexia, diarrhea, dry mouth, intestinal perforation

Hematologic/Lymphatic: adenopathy, anemia, aplastic anemia, leukopenia, neutropenia, pancytopenia, thrombocytopenia (see **WARNINGS**)

Hepatobiliary: autoimmune hepatitis

Musculoskeletal: joint pain, lupus-like syndrome with manifestations including rash consistent with subacute or discoid lupus

Nervous: paresthesias, stroke, seizures, and central nervous system events suggestive of multiple sclerosis or isolated demyelinating conditions such as transverse myelitis or optic neuritis (see **WARNINGS**)

Ocular: dry eyes, ocular inflammation

Respiratory: dyspnea, interstitial lung disease, pulmonary disease, worsening of prior lung disorder

Skin: cutaneous vasculitis, erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis, pruritus, subcutaneous nodules, urticaria

Rx Only. This brief summary is based on ENBREL prescribing information v. 33: 03/2008

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