

Breaking Silence, Breaking Stigma

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Introduction

By Sandeep P. Kishore

The *NAM Perspectives* paper, “Breaking the Culture of Silence on Physician Suicide” [1], brought together four unique voices from surgery, nursing, medical training, and the clergy to consider what had led Kaitlyn, a young medical student, to take her own life on April 11, 2013. Drawing from personal experiences, the authors exposed what they thought was a culture of silence under intense pressure that pushes physicians and trainees to experience depression and in some cases to tragically end their lives. But these are just four opinions based on four experiences. The authors hope to bring more voices into the conversation by asking others who are comfortable doing so to share their own reactions to situations they have been forced to navigate throughout their education and their careers as health care providers.

Dr. Jasleen Salwan has taken up that challenge and agreed to reprint her entry from the Yale Internal Medicine periodical, the *Beeson Beat*. The piece, titled “Breaking Silence, Breaking Stigma,” [2] provides a strong step in normalizing vulnerability—and will ideally encourage other young physicians to share their experiences, solutions, and paths forward. Anyone else can join the movement by sending their written thoughts, opinions, or personal accounts relating to the culture of silence to sunny.kishore@gmail.com. These written comments will be shared only if the writer and those easily identified in the remarks provide explicit permission to do so.

Breaking Silence, Breaking Stigma

By Jasleen Salwan

Source: Salwan, J. 2017. This piece first appeared in the Beeson Beat, Yale University's internal medicine housestaff periodical, in April 2017. It is reprinted with kind

permission from the Beeson Beat and Dr. Jasleen Salwan. Minor edits have been made to this text since its original publication.

In a late March issue of the *New England Journal of Medicine (NEJM)*, the dean of my medical school published a beautiful essay on the tragic death of one of my classmates. Kathryn had committed suicide last August. Earnest and humble, Dr. Muller's piece demonstrates his ongoing commitment to promoting wellness among medical trainees in a way that is not reactionary but rather proactive and sustained. With student input, he and his colleagues are studying ways to enhance work-life balance, relieving the pressure to perform according to unforgiving metrics, and expanding access to mental health resources. As I read his thoughtful words, a gnawing question formed in my mind: Why has a medical school community with deeply compassionate leadership seen two trainee suicides in one year? More broadly, if Hippocrates's words are true that those who love medicine also love humanity, how does profound suffering pass unnoticed among our own? Perhaps we residents can play a role in bringing that suffering out into the open. While continuing to expect confidential mental health services, we should at the same time foster a culture that embraces open conversation about experiences with depression and other mental illnesses.

Trainees often worry that stigma against mental illness is rampant in medicine, but in fact, an examination of the evidence assuages this concern. According to one study, medical students who suffered from self-reported moderate to severe depression were more likely to believe that peers and faculty held negative attitudes about the competence of trainees with mental illness than were students with minimal or no depression [3]. Thinking about the converse of this finding is heartening: those who did not suffer from depression did not actually harbor the perceived prejudices

against those who did. Fear of stigma among people with depression—which could be partially attributable to feelings of worthlessness caused by the disease itself—seems to be a larger problem in medicine than the stigma perpetuated by others is. We should invite those members of the medical community living with depression to share their stories, making it clear that self-disclosure will be met not with persecution but rather with admiration.

The notion of soliciting dark or deeply personal anecdotes from our colleagues cuts against the doctor's impulse to protect confidentiality. However, the opportunity to share experiences with mental illness before an open-minded peer audience can enhance medical professionals' self-acceptance. Dr. Kay Redfield Jamison, Dr. Alice W. Flaherty, and Dr. Adam B. Hill (the latter's essay immediately follows Dr. Muller's in *NEJM*) have embraced their psychiatric diagnoses and empowered themselves to describe how depression, bipolar disorder, and/or addiction have made them more empathic and creative providers. The opportunity to publish one's private thoughts may be more valuable than a guarantee of anonymity that enables repression of those thoughts.

The combination of closeness as a community and passion for medicine places residents in a special position to open up to one another about intimate health issues, and it seems a logical extension to speak about the mind as openly as we already do the body. I was

out to dinner with a group of co-residents one evening when one of us, who had excused herself to use the restroom, sent a text message to say that we need not wait for her before placing our orders. When she returned, the group showed support not by assuming that she wanted to bury an awkward moment, but rather by giving her the space to speak openly about what had delayed her. We asked how she was feeling and assured her that we were perfectly comfortable hearing about the details of her gastrointestinal troubles—even over our meal, because, after all, we were all doctors. As she spoke without embarrassment, each of us found ourselves chiming in with our own experiences of digestive difficulties in the setting of working long and inconsistent hours. With little effort, we had normalized something that was known to be common but that carried shame when kept secret.

Trainees know that depression is highly prevalent in our community, with estimates as high as 43 percent [4,5]. We need not be afraid to acknowledge when we suspect it. We can ask each other about sadness, feelings of worthlessness, and even thoughts that life is not worthwhile—and draw on the epidemiologic data to offer the validation that no one enduring these experiences is alone. By normalizing open dialogue about mental illness as a common condition that many medical providers live with, we can encourage treatment and aid our leadership in preventing recurrent tragedies.

If you are suicidal and need emergency help, call 911 immediately or call 1-800-273-8255 if in the United States. If you are in another country, find a 24/7 hotline at www.iasp.info/Crisis_Centres.

References

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