tianity. This long-standing religious presence has made atheists, agnostics, and members of minority religions view themselves as oppressed, but recent efforts to purge the public square of religion have left conservative Christians also feeling subjugated and suppressed. In this culture war, both sides claim the mantle of victimhood — which is why health care professionals can claim the right of conscience as necessary to the nondiscriminatory practice of their religion, even as frustrated patients view conscience clauses as legalizing discrimination against them when they practice their own religion.

For health care professionals, the question becomes: What does it mean to be a professional in the United States? Does professionalism include the rather old-fashioned notion of putting others before oneself? Should professionals avoid exploiting their positions to pursue an agenda separate from that of their profession? And perhaps most crucial, to what extent do professionals have a collective duty to ensure that their profession provides nondiscriminatory access to all professional services?

Some health care providers would counter that they distinguish between medical care and nonmedical care that uses medical services. In this way, they justify their willingness to bind the wounds of the criminal before sending him back to the street or to set the bones of a battering husband that were broken when he struck his wife. Birth control, abortion, and in vitro fertilization, they say, are lifestyle choices, not treatments for diseases.

And it is here that licensing systems complicate the equation: such a claim would be easier to make if the states did not give these professionals the exclusive right to offer such services. By granting a monopoly, they turn the profession into a kind of public utility, obligated to provide service to all who seek it. Claiming an unfettered right to personal autonomy while holding monopolistic control over a public good constitutes an abuse of the public trust — all the worse if it is not in fact a personal act of conscience but, rather, an attempt at cultural conquest.

Accepting a collective obligation does not mean that all members of the profession are forced to violate their own consciences. It does, however, necessitate ensuring that a genuine system for counseling and referring patients is in place, so that every patient can act according to his or her own conscience just as readily as the professional can. This goal is not simple to achieve, but it does represent the best effort to accommodate everyone and is the approach taken by virtually all the major medical, nursing, and pharmacy societies. It is also the approach taken by the governor of Illinois, who is imposing an obligation on pharmacies, rather than on individual pharmacists, to ensure access to services for all patients.

Conscience is a tricky business. Some interpret its personal beacon as the guide to universal truth. But the assumption that one's own conscience is the conscience of the world is fraught with dangers. As C.S. Lewis wrote, "Of all tyrannies, a tyranny sincerely exercised for the good of its victims may be the most oppressive. It would be better to live under robber barons than under omnipotent moral busybodies. The robber baron's cruelty may sometimes sleep, his cupidity may at some point be satiated; but those who torment us for our own good will torment us without end for they do so with the approval of their own conscience."

Taking Their Own Lives — The High Rate of Physician Suicide

Eva Schernhammer, M.D., Dr.P.H.

When I was an oncology fellow in Vienna, a colleague who had attended rounds with me on the ward went home afterward and strangled herself. Only later was it learned that she had suffered from depression. In the course of that same year, three more physicians in my immediate circle — two residents and a department head — took their own lives. This stunning series was my first encounter with physician suicide, and it left many of us doctors with an important message: we must care not only for our patients but also for ourselves. In an effort to prevent further such tragedies, a program

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was launched at the hospital to help physicians and nurses grapple with the emotional effects of caring for the chronically ill. But the suicides that had already occurred were never discussed openly, no one undertook a publicly acknowledged serious analysis of the causes, and no other clear safeguards were put into place. The deaths were simply accepted as a fact of medical life.

Although physicians tend to have healthier lifestyles than those of the general public and thus to live longer, it has been known for some time that suicide rates among doctors are higher than those in the general population (see graphs). And when these tragic events make it into the headlines, as did the recent suicide of gifted heart surgeon Jonathan Drummond-Webb, we begin to wonder why these healers apparently cannot heal the hurt in their own lives.

The gap in suicide rates evidently begins as early as medical school, where overall suicide rates are higher than in the age-matched population. This increased rate of suicide is driven largely by higher rates among women: female medical students commit suicide at the same rate as male medical students,[2] whereas in the United States in general, suicide rates are much higher among men. Evidence from a large study of physician suicide indicates that female doctors, in particular, are much more likely than other women to take their own lives. The combined results of 25 studies suggest that the suicide rate among male doctors is 40 percent higher than that among men in general, whereas the rate among female doctors is 130 percent higher than that among women in general.[1]

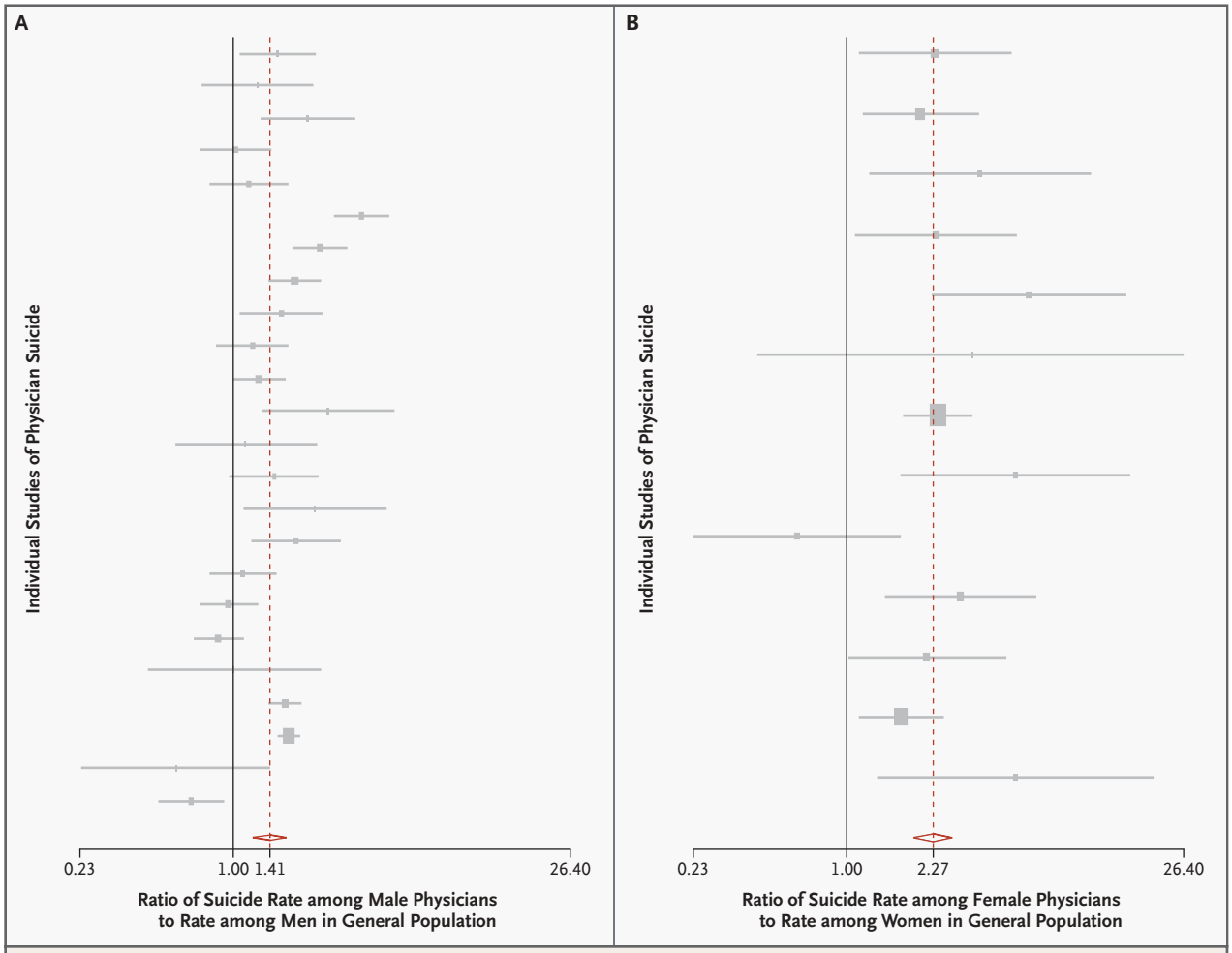
Several factors that may contribute to the suicide of physicians, especially female physicians, deserve closer examination. Physicians may have a higher prevalence of depression than nonphysicians, and depression is clearly an important risk factor for suicide; among female physicians, the risk may be exacerbated by sexual harassment; and when they become suicidal, physicians generally choose effective suicide methods.

A prevalent view is that both biologic and psychosocial factors play a role — and interact — in the decision to commit suicide. There is a higher prevalence of psychiatric disorders among physicians than in the general population. Some 30 to 70 percent of all persons who attempt suicide apparently have an affective disorder (generally depression), a substance-use–related disorder, or schizophrenia.[3] Evidence further suggests that drug abuse and alcoholism, possibly under circumstances of heightened stress or depression, are often associated with the suicides of physicians. Female physicians, in particular, have been shown to have a higher frequency of alcoholism than women in the general population. Drug abuse is also related to specialty, being particularly prevalent among psychiatrists, anesthesiologists, and emergency physicians. Recent reports emphasize that the exposure that anesthesiologists have to drugs as they work represents a risk factor for drug addiction and possibly suicide, indicating that access to drugs may support higher suicide rates among physicians by a variety of pathways. In the general population, according to autopsy studies and other evidence, as many as 25 percent of all persons who commit suicide are drunk at the time of their deaths.

Another way to view the problem is that the professional burden carried by doctors leads to social isolation and an increased probability of undergoing phases of disturbances in their social networks. It has also been noted that physicians tend to neglect their own need for psychiatric, emotional, or medical help and are more critical than most people of both others and themselves. They are more likely to blame themselves for their own illnesses. And they are apparently more susceptible to depression caused by adverse life events, such as the death of a relative, divorce, or the loss of a job.[4]

Being single and not having children have also been linked to an increased risk of suicide, and more female than male physicians are single or childless. Some studies of coping have emphasized that women in general are subject to a double burden — being vulnerable to pressures of both family life and work life. Stress and burnout may be added risk factors for all physicians, and female doctors may feel more stress than their male counterparts because of the difficulty of succeeding in a male-dominated profession.

They may also be the targets of sex-based or sexual harassment, which may, in turn, lead to depression and suicidality. In a study by Frank et al., 48 percent of female physicians reported having experienced sex-based ("gender-based," per study questionnaire) harassment at least once, and 37 percent reported sexual harassment.[5] Moreover, the study established a link between higher rates of harassment and a history of depression or suicide attempts, showing an association between the sever-



Suicide Rates among Male Physicians (Panel A) and Female Physicians (Panel B) in Relation to the Rates in the General Population of the Same Sex.

The size of each box represents the relative size of the study sample, and the horizontal line that intersects the box indicates the 95 percent confidence interval. The dashed red line in each panel indicates the combined estimate. The diamond-shaped box represents the confidence interval. The data are from a meta-analysis by Schernhammer and Colditz.[1]

ity of harassment and the likelihood of depression. Sex-based harassment and sexual harassment are more common in historically male-dominated specialties, such as surgery and emergency medicine. According to unpublished data from a recent U.S. study by Straehley and Longo of the difficulties women face when entering the field of medicine, more than 75 percent of interviewed female surgeons said that they had been harassed. Moreover, according to Frank et al., whose study results concurred with these findings, harassment rates are not declining.[5] It has been argued that the reinforcing of sex stereotypes through the promulgation of the belief that women are innately inferior to men in science may well contribute to the ongoing harassment of female physicians.

Finally, physicians who make suicide attempts are much more likely than nonphysicians to succeed. Among physicians in this country, in fact, there are fewer unsuccessful suicide attempts than completed suicides — a stark contrast to the data for U.S. women in general, for instance, among whom the ratio of unsuccessful attempts to completed suicides is between 10:1 and 15:1.

Not surprisingly, the method chosen predicts the likelihood of success. Women in the general population make more unsuccessful suicide attempts than men, in large part because they prefer

methods that are typically less deadly than those — such as the use of firearms — favored by men. It is possible, therefore, that the higher suicide rate among female physicians simply reflects a combination of the sex difference in the rate of suicide attempts and a higher rate of completion inside the medical profession than outside it.

According to a recent study, doctors most commonly take their own lives by poisoning themselves, often with drugs taken from their offices or laboratories. The fact that greater access to drugs leads to higher suicide rates has long been known — for example, in Australia, an increase in suicides among women coincided with the implementation of a law that made it easier to obtain barbiturates. It seems likely that the higher suicide rate among physicians is related to both their relatively free access to drugs and their medical knowledge, which enhances their ability to use such methods successfully.

There are few interventions in place to help prevent suicide among physicians. Such safeguards might include the provision of discreet and confidential access to psychotherapy and open discussion of the stress encountered in a medical career. The barriers that may prevent physicians from seeking help for mental disorders (such as the threat of losing their medical licenses) must also be addressed. Part of the solution for female doctors must ultimately be to equalize professional conditions in order to reduce stress. In time, perhaps these and other measures will help doctors to do what they do best: save lives, beginning with their own.

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