An Epidemic of Suicide Among Physicians on Probation

Ralph Crawshaw, MD; John A. Bruce, PhD; Patricia L. Eraker, MD; Marvin Greenbaum, PhD; James E. Lindemann, PhD; David E. Schmidt

IN 1976, the members of the Oregon Board of Medical Examiners grew uneasy with the incidence of suicide among the physicians they had placed under close examination and probation. Since its inception in 1889, the board has acted through its power of licensure as the primary force regulating the medical profession in the state of Oregon. The board is composed of eight members who represent a cross section of the geographic distribution of physicians in the state. Board members are generally appointed by the governor from a list, proposed by the Oregon Medical Association, of physicians who are recognized and respected in their communities.

The disciplinary mode of the board is expressed in its powers of probation. When a physician in Oregon is found culpable of professional misconduct of sufficient weight to merit probation, his license to practice is suspended and immediately rein-

In the spring of 1977, the board had approximately 40 physicians on probation or under investigation for probation (Table 1). Most unusual, however, was the disturbing fact that during the preceding 13 months eight of these physicians had committed suicide, and two were recovering from serious suicidal attempts. The impact on the board members was understandably great.

While it is recognized that the present sample is too limited for statistical analysis, the suicide rate for the general population is about 15 per 100,000, and that of physicians in general is thought to be about 77 per 100,000. The Oregon rate for our sample of probationers, however, if it could be extrapolated to a larger population, would approximate 20,000 per 100,000. In any case, in the eyes of the Board of Medical Examiners, the situation with the probationers appeared to be reaching alarming proportions. As one means of action, the

dynamics of the victims. Because of limited resources, the study has been limited to the latter. The board cooperated in this venture, opening its full records—under appropriate professional constraints—for the investigation of the life history of the victims, with particular emphasis on the period immediately before their deaths.

The study was undertaken by a group of six professionals (one psychiatrist, two clinical psychologists, one sociologist, one psychiatric resident, and one medical student) who were brought together by the senior author (R.C.) out of consideration for their interest, compassion, and professional competence. The investigators named themselves the Blachly Group, as a means of honoring a distinguished psychiatrist (Paul Blachly, MD), who had recently met

Table 1.—Annual Percentage of Physicians Placed on Probation

Among Physicians

Ralph Crawshaw, MD; John A. Bruce, I
Marvin Greenbaum, PhD; James E. Lindem

Oregon
s grew
suicide
placed
proba-
89, the
ower of
e regu-
in the
s com-
repre-
graphic
in the
nerally
a list,
Medical
ho are
their

board
proba-
gon is
l mis-
merit
tice is
rein-
ionary

In the spring of 1977, the board had approximately 40 physicians on probation or under investigation for probation (Table 1). Most unusual, however, was the disturbing fact that during the preceding 18 months eight of these physicians had committed suicide, and two were recovering from serious suicidal attempts. The impact on the board members was understandably great.

While it is recognized that the present sample is too limited for statistical analysis, the suicide rate for the general population is about 15 per 100,000, and that of physicians in general is thought to be about 77 per 100,000. The Oregon rate for our sample of probationers, however, if it could be extrapolated to a larger population, would approximate 20,000 per 100,000. In any case, in the eyes of the Board of Medical Examiners, the situation with the probationers appeared to be reaching alarming proportions. As one means of action, the board encouraged the authors to examine the phenomenon and asked

dynami
limited
limited
operate
full rec
fessiona
gation
tims, wi
period
deaths.
The
group o
chiatris
one soci
dent, ar
were br
author (
their in
fessiona
tors nai
Group,
a distin
Blachly,

Tabl
Phy
by Dr

An Epidemic c

Among Physicians on

Ralph Crawshaw, MD; John A. Bruce, PhD; Pat
Marvin Greenbaum, PhD; James E. Lindemann, Phi

IN 1976, the members of the Oregon Board of Medical Examiners grew uneasy with the incidence of suicide among the physicians they had placed under close examination and probation. Since its inception in 1889, the board has acted through its power of licensure as the primary force regulating the medical profession in the state of Oregon. The board is composed of eight members who represent a cross section of the geographic distribution of physicians in the state. Board members are generally appointed by the governor from a list, proposed by the Oregon Medical Association, of physicians who are recognized and respected in their communities.

The disciplinary mode of the board is expressed in its powers of probation. When a physician in Oregon is found culpable of professional misconduct of sufficient weight to merit probation, his license to practice is suspended and immediately reinstated, generally for a probationary period of ten years.

From the University of Oregon Health Sciences Center, Portland (Drs Crawshaw, Bruce, Lindemann and Mr Schmidt); Children's Neurological Unit, Good Samaritan Hospital, Portland (Dr Greenbaum); and Dammash State Hospital, Wilsonville, Ore (Dr Ereker).

Reprint requests to 2525 NW Lovejoy St, Suite 304, Portland, OR 97210 (Dr Crawshaw).

In the spring of 1977, the board had approximately 40 physicians on probation or under investigation for probation (Table 1). Most unusual, however, was the disturbing fact that during the preceding 18 months eight of these physicians had committed suicide, and two were recovering from serious suicidal attempts. The impact on the board members was understandably great.

While it is recognized that the present sample is too limited for statistical analysis, the suicide rate for the general population is about 15 per 100,000, and that of physicians in general is thought to be about 77 per 100,000. The Oregon rate for our sample of probationers, however, if it could be extrapolated to a larger population, would approximate 20,000 per 100,000. In any case, in the eyes of the Board of Medical Examiners, the situation with the probationers appeared to be reaching alarming proportions. As one means of action, the board encouraged the authors to examine the phenomenon and asked for suggestions concerning steps to avoid recurrence.

Ideally, two avenues of investigation are necessary for the phenomenon to be understood in-depth—a study of the social dynamics of the board's processes and structure and the psychosocial circumstances and dynamics of the
limited resource
limited to the
operated in this
full records—un
fessional constra
gation of the lif
tims, with partic
period immedi
deaths.

The study w
group of six pr
chiatrist, two cl
one sociologist,
dent, and one n
were brought to
author (R.C.) out
their interest, c
fessional compet
tors named the
Group, as a n
a distinguished
Blachly, MD), wh

Table 1.—Ann
Physicians Pl
by Oregon Stat
Exa

Year	Total No. of Physicians
1972	3,154
1973	3,949
1974	4,651
1975	3,581
1976	4,120
1977	4,697

1977, the board had physicians on pro- vestigation for pro- Most unusual, how- sturbing fact that ing 13 months eight ns had committed ere recovering from tempts. The impact mbers was under-

cognized that the is too limited for a, the suicide rate pulation is about 15 nat of physicians in to be about 77 per n rate for our sam- rs, however, if it lated to a larger approximate 20,000 case, in the eyes of cal Examiners, the e probationers ap- ing alarming pro- eans of action, the the authors to omenon and asked ncerning steps to

nues of investiga- for the phenome- stood in-depth—a l dynamics of the and structure and circumstances and

dynamics of the victims. Because of limited resources, the study has been limited to the latter. The board cooperated in this venture, opening its full records—under appropriate professional constraints—for the investigation of the life history of the victims, with particular emphasis on the period immediately before their deaths.

The study was undertaken by a group of six professionals (one psychiatrist, two clinical psychologists, one sociologist, one psychiatric resident, and one medical student) who were brought together by the senior author (R.C.) out of consideration for their interest, compassion, and professional competence. The investigators named themselves the Blachly Group, as a means of honoring a distinguished psychiatrist (Paul Blachly, MD), who had recently met

Table 1.—Annual Percentage of Physicians Placed on Probation by Oregon State Board of Medical Examiners

Year	Total No. of Physicians	Total on Probation	% on Probation
1972	3,154	21	0.66
1973	3,349	25	0.75
1974	3,551	34	0.93
1975	3,681	36	0.99
1976	4,120	41	1.00
1977	4,657	43	0.92

drowning and
of his profes-
of physician

Blachly Group
interview the
member of each
y. Of the eight
o the interview.
who would not
the husbands'
o the Midwest
n by telephone
d to talk to any
for her. hus-
ews were per-
mes, except for
interviewer's
ur were wives.
In the latter
knew was not
ives.
ich had been
ychiatric Asso-
icide, was the
the interviews.
eges attended,
and residency,
of the Oregon
s. The remain-
of questions
es: Details of
n of Suicidal
l Communica-
empts, Inten-
und Informa-
n, Psychiatric
ity, Interper-

Table 2.—Risk Factors for Suicide Among Physicians on Probation in Oregon*

Risk Factor	No. of Physicians	Percentage of N
Age, yr		
35-44	4	67
65-74	2	33
M	6	100
Drug abuse history	5	83
Alcohol abuse history	5	83
Divorced	4	67
Isolated or alienated	4	67
Religion a source of support	0	100
Migrants from other states	6	100
Family history of suicide	0	0
Prior suicide attempt	4	67
Prior psychiatric illness diagnosed	6	100
Physical illness	2	33

*Suicides occurred during 13-month period of June 1976 to July 1977 (N=6).

trists met with the study group and gave a helpful and detailed history of the patient; the other psychiatrist declined.

The Blachly Group met regularly to review transcripts and to discuss various approaches to the growing mass of data. The summary of the interviews may be explained from at least two perspectives: the first is a quantitative presentation of selected dimensions of the material contained in the answers to the protocols (Table 2), while the second is a narrative

(amphetamine
ride), and fou
all abused at
altering drugs
None of the
(as is true o
population of
sient, having
positions in di
Four of the six
They were unl
religious attac
socially isolate
more importa
Several had f
goals that they
specialty statu
rejected by pro
minating coope
from positions
contact. Four
craftsman fath
an upwardly m
a family histor
of the six had
their final act o

COMMENT

The most ir
in the data
degree of seri
thological co
before contac
probationers
For most of th
psychopatholo
manifest earl
recurred throu
al lives. Also c

Special Communications

An Epidemic of Suicide Among Physicians on Probation

Ralph Crawshaw, MD; John A. Bruce, PhD; Patricia L. Eraker, MD; Marvin Greenbaum, PhD; James E. Lindemann, PhD; David E. Schmidt

IN 1976, the members of the Oregon Board of Medical Examiners grew uneasy with the incidence of suicide among the physicians they had placed under close examination and probation. Since its inception in 1889, the board has acted through its power of licensure as the primary force regulating the medical profession in the state of Oregon. The board is composed of eight members who represent a cross section of the geographic distribution of physicians in the state. Board members are generally appointed by the governor from a list, proposed by the Oregon Medical Association, of physicians who are recognized and respected in their communities.

The disciplinary mode of the board is expressed in its powers of probation. When a physician in Oregon is found culpable of professional misconduct of sufficient weight to merit probation, his license to practice is suspended and immediately reinstated, generally for a probationary period of ten years.

From the University of Oregon Health Sciences Center, Portland (Drs Crawshaw, Bruce, Lindemann and Mr Schmidt); Children's Neurological Unit, Good Samaritan Hospital, Portland (Dr Greenbaum); and Dammash State Hospital, Wilsonville, Ore (Dr Eraker).

Reprint requests to 2525 NW Lovejoy St, Suite 504, Portland, OR 97210 (Dr Crawshaw).

In the spring of 1977, the board had approximately 40 physicians on probation or under investigation for probation (Table 1). Most unusual, however, was the disturbing fact that during the preceding 18 months eight of these physicians had committed suicide, and two were recovering from serious suicidal attempts. The impact on the board members was understandably great.

While it is recognized that the present sample is too limited for statistical analysis, the suicide rate for the general population is about 15 per 100,000, and that of physicians in general is thought to be about 77 per 100,000. The Oregon rate for our sample of probationers, however, if it could be extrapolated to a larger population, would approximate 20,000 per 100,000. In any case, in the eyes of the Board of Medical Examiners, the situation with the probationers appeared to be reaching alarming proportions. As one means of action, the board encouraged the authors to examine the phenomenon and asked for suggestions concerning steps to avoid recurrence.

Ideally, two avenues of investigation are necessary for the phenomenon to be understood in-depth—a study of the social dynamics of the board's processes and structure and the psychosocial circumstances and dynamics of the victims. Because of limited resources, the study has been limited to the latter. The board cooperated in this venture, opening its full records—under appropriate professional constraints—for the investigation of the life history of the victims, with particular emphasis on the period immediately before their deaths.

The study was undertaken by a group of six professionals (one psychiatrist, two clinical psychologists, one sociologist, one psychiatric resident, and one medical student) who were brought together by the senior author (R.C.) out of consideration for their interest, compassion, and professional competence. The investigators named themselves the Blachly Group, as a means of honoring a distinguished psychiatrist (Paul Blachly, MD), who had recently met

Table 1.—Annual Percentage of Physicians Placed on Probation by Oregon State Board of Medical Examiners

Year	Total No. of Physicians	Total on Probation	% on Probation
1972	3,154	21	0.69
1973	3,349	25	0.75
1974	3,551	34	0.95
1975	3,881	36	0.93
1976	4,120	41	1.00
1977	4,357	40	0.92

an accidental death by drowning and who had devoted much of his professional life to the study of physician suicide.

METHODS

In the spring of 1978, the Blachly Group made arrangements to interview the closest available surviving member of each deceased physician's family. Of the eight cases, six relatives agreed to the interview. Of the two surviving wives who would not agree to a discussion of the husbands' suicides, one had moved to the Midwest and did not want discussion by telephone or letters. The other refused to talk to any physicians, blaming them for her husband's death. The interviews were performed in the survivors' homes, except for one that took place in an interviewer's office. Of the survivors, four were wives, and two were daughters. In the latter group, the information they knew was not as detailed as that of the wives.

A 15-page protocol, which had been devised by the American Psychiatric Association Task Force on Suicide, was the guide for compiling data in the interviews. Factual information, eg, colleges attended, medical school, internship, and residency, was obtained from the files of the Oregon Board of Medical Examiners. The remainder of the form consisted of questions under the following headings: Details of the Suicide, Communication of Suicidal Intent, Response to Suicidal Communication, Previous Suicidal Attempts, Intention and Motivation, Background Information, Psychiatric Information, Psychiatric Symptoms Checklist, Sexuality, Interpersonal-Social Information, Financial Information, Residential Information, Interpersonal-Familial Information, Religious Information, Developmental History, Professional Background and Activities, and Survivors.

To protect survivors, case histories will not be published. Eighty percent of the interviews took place in Oregon and, for the most part, in the Portland metropolitan area and suburbs. One interview was conducted in Eugene, Ore, and one in California. The sessions lasted approximately two to four hours. Each session was tape-recorded. Five of the interviews were conducted with two study group members present, the other with only one interviewer. The same single interviewer was present for five of the interviews. Funds for travel expenses were obtained from the Community Psychiatry Program at the University of Oregon Health Sciences Center Department of Psychiatry. The remainder of the expenses were borne by the Blachly Group interviewers.

Two of the physicians were undergoing psychotherapy at the time of their deaths. Subsequently, one of the treating psychiatrists met with the study group and gave a helpful and detailed history of the patient; the other psychiatrist declined.

Table 2.—Risk Factors for Suicide Among Physicians on Probation in Oregon*

Risk Factor	No. of Physicians	Percentage of N
Age, yr		
35-44	4	67
65-74	2	33
M	6	100
Drug abuse history	5	83
Alcohol abuse history	5	83
Divorced	4	67
Isolated or alienated	4	67
Religion a source of support	0	100
Migrants from other states	6	100
Family history of suicide	0	0
Prior suicide attempt	4	67
Prior psychiatric illness diagnosed	6	100
Physical illness	2	33

*Suicides occurred during 13-month period of June 1976 to July 1977 (N=6).

The Blachly Group met regularly to review transcripts and to discuss various approaches to the growing mass of data. The summary of the interviews may be explained from at least two perspectives: the first is a quantitative presentation of selected dimensions of the material contained in the answers to the protocols (Table 2), while the second is a narrative generalization that is contained in the following profile.

Physician Suicide—A Profile

This profile will attempt to characterize six physicians who took their own lives in Oregon during 1976 and 1977. All were in probation status with the Oregon Board of Medical Examiners. All were men.

In age, the men fit in two groups: four were early middle-aged, from 36 to 48 years of age. Two were in their late 60s. All had a history of serious, formally diagnosed psychiatric disturbance before probation status. Depression was present to some extent in all of them. The two older men appeared to suffer from reactive depression caused by loss, in one case, of spouse, in another, of physical health. The younger group appeared to have serious endogenous emotional problems associated with instability early in their lives. Most were described as introverted and sensitive, with anxiety and depression. Under stress, they frequently showed serious psychopathological conditions, including paranoid thinking or manic-depressive behavior. Five of the six abused drugs (amphetamines or meperidine hydrochloride), and four of the six abused alcohol; all abused at least one of these mind-altering drugs.

None of the men was a native of Oregon (as is true of about 52% of the total population of the state). Most were transient, having held a variety of medical positions in different areas of the country. Four of the six were divorced at least once. They were unlikely to have community or religious attachments. They tended to be socially isolated persons and, perhaps even more important, professionally isolated. Several had failed to reach important goals that they had set for themselves (eg, specialty status), and several had been rejected by professional colleagues by terminating cooperative practices, dismissal from positions, or by withholding social contact. Four of the men had blue-collar craftsman fathers and appear to have had an upwardly mobile work ethic. None had a family history of suicide, although four of the six had attempted suicide before their final act of self-destruction.

COMMENT AND CONCLUSIONS

The most important single element in the data appears to be the high degree of serious diagnosed psychopathological conditions demonstrated before contact with the board by the probationers who completed suicide. For most of these physicians, an overt psychopathological condition was manifest early in their careers and recurred throughout their professional lives. Also of great importance and interrelated with the psychopathology is their abuse of alcohol and other mind-altering drugs.

Case histories disclose that professional status was of singular importance to these men. This goal was embodied by professional achievement (eg, specialty boards and professional ambitions) and personal acceptance by their physician peers. These goals were of such importance that they were frequently pursued at the expense of positive family relationships and community networks. While some of these probationers experienced financial difficulties that probably contributed to their stress, financial problems were not perceived by the survivors or by the study group as having a directly causal relationship with their deaths. All of these physicians were migrants to Oregon, and in most cases their domestic and social lives were characterized by a severe sense of isolation.

Among other things, the findings speak to the importance of medical school screening of future physicians for emotional stability and for guidance of those aspirants with early, serious psychiatric disturbance into less stressful vocations. Furthermore, medical educators should seriously address the destructive side of professional competition, namely, those characteristics of the medical profession that exaggerate independence to the degree that a physician fears to admit that he needs personal help and consequently fails to seek it out or accept it.

Examining boards face a sobering duty in supervising the ethical conduct of medical practice by bringing to public scrutiny those physicians whose activities are judged questionable, for such exposure and disciplinary action itself will—and probably should—increase personal stress in the probationers to express society's disapproval of their unacceptable behavior and to motivate them to seek and to cooperate with competent help. At the same time, close attention must be paid to the possibility of causing even more deviant behavior, including self-destruction. Granted that boards must pursue their duty, it must be carried out in a perceptive and supportive fashion, without diminishing the firmness of its standards and actions. No one should underestimate the difficulty and complexity of such a task.

The following conclusions and suggestions are submitted for the consideration of medical (and other professional) examining boards.

1. When a physician demonstrates questionable practices, the earlier in the person's career that candid recognition and corrective action occurs, the more likely that there will be a constructive response.

2. Corrective action at times might be more effective if it were stronger, more clearly delineated, and closely time-limited. A few months of absolute professional suspension might be more effective in changing behavior, and ultimately easier for the person to handle, than ten years' probation. Probation itself should probably be limited to a few years, to modify the endless (and hopeless) prospect.

3. Comprehensive mental health services (psychiatry, clinical psychology, and psychiatric social work) should be regularly used by all medical licensing boards.

4. There should be a psychosocial evaluation of all probationers at critical points in the preprobation and probation processes.

5. A board should make direct contact with and make itself accessible to close relatives of probationers.

6. A board should carry out its own psychological autopsies of deceased probationers and should maintain detailed records on these cases for a period of years.

In addition to the aforementioned suggestions to examining boards, a few general recommendations may be made.

1. The medical (and especially psychiatric) community should take steps to make access for physicians to mental health treatment easier and more socially acceptable.

2. A physician's widow interviewed during this study strongly urges that laws prohibiting self-prescription of drugs be rigorously enforced.

3. Medical societies should cease the practice of destroying the records of physicians' suicides.

4. To facilitate the study of physician impairment at a national level, it is recommended that a national clearinghouse be established under the aegis of the American Medical Association for the maintenance of statistics regarding all physicians' suicides.

5. It is recommended that the American Psychiatric Association institute a national program of psychological autopsies of physicians' suicides by volunteer psychiatrists and that the resulting data be stored in the AMA clearinghouse.

6. Given the Blachly Group's findings that domestic and especially community isolation, as well as anxiety over professional loss of face, were prominent aspects of most of the suicides in question, the medical profession and others who share this concern should foster groups who can offer support of a regular social (not psychiatric or therapeutic) nature to physicians in need and their families. Awareness of and ability to refer to resources of school, church, recreation, and other community activity should be clearly in the minds of those who seek not only to discipline but also to help the physician-probationer and his family.

Barbara Redmore, MD, James Shore, MD, and Rogers Smith, MD, consulted with the authors.