Isolated, Together

Hsuan-hsiu Annie Chen, MD

I fidgeted with my identification bracelet while waiting to check in with the on-call psychiatrist. Other than the occasional dull buzz from the security doors signaling the arrival of another patient, the unit was quiet. Yet my mind roared with self-loathing thoughts. "I should have tried harder. I am too weak to be a doctor."

I was a second-year medical student when I was hospitalized for major depressive disorder.

As a first-year student, I attributed my irritability and moodiness to the inherent challenges of medical school.[1,2] I felt unqualified among classmates who boasted top examination scores and prestigious publications. I tried to emulate them by doubling my study hours and spending my weekends conducting research. In reality, I could not keep up. I experienced a nervous breakdown 2 months into my second year. Between uncontrollable trembling and heaving, I finally realized that I was severely depressed.

Admitting that I needed help, however, was formidable. Having overheard classmates and attending physicians dismiss mental illness as "annoying" and "made up," I did not want anybody to think that I was unfit to practice medicine. It took me 2 months to bring myself to see a psychiatrist and another month to start on medication. I sobbed in the pharmacy parking lot the day I filled my first prescription, feeling defeated by my diagnosis. Weeks later, I brought myself to a psychiatric hospital. I could not stop thinking about consuming a handful of anxiolytics and jumping off my fifth-floor balcony. I knew I needed help but no longer trusted myself to fight for it.

After my hospitalization, I was determined to hide my depression. I resumed and completed the second-year curriculum by watching lectures online while attending intensive outpatient group therapy. During third-year rotations, I told my supervising residents that I had meetings to attend rather than admitting that I had regular doctor's appointments. Despite managing my illness in secrecy, my mood and energy lifted noticeably over time. I used newly acquired coping skills to challenge irrational, self-defeating beliefs and to maneuver through the stress of clinical rotations, board examinations, and residency applications. Through self-compassion, I began to heal.

I hid my depression until a classmate completed suicide at the end of our third year of medical school. Few knew of his struggles before his death because he, too, hid in fear and shame. Reflecting on his passing, I realized that we are never alone in our despair despite how isolated we may feel.

Living with depression is akin to walking through a pitch-black void with no apparent end in sight. However, if we reach out a little farther into the darkness, we will likely find another human being walking parallel with us, thinking that he or she is alone as well. We

Children's Hospital Los Angeles, Los Angeles, California

Dr Chen certifies that she has participated in drafting and revising this manuscript, and she approves the final manuscript as submitted and agrees to be accountable for all aspects of the work.

DOI: https://doi.org/10.1542/peds.2019-1210

Accepted for publication Apr 18, 2019

Address correspondence to Hsuan-hsiu Annie Chen, MD, Pediatric Residency Office, Children's Hospital Los Angeles, 4650 Sunset Blvd, Mail Stop 68, Los Angeles, CA 90027. E-mail: hsuchen@chla.usc.edu

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

FINANCIAL DISCLOSURE: The author has indicated she has no financial relationships relevant to this article to disclose.

FUNDING: No external funding.

POTENTIAL CONFLICT OF INTEREST: The author has indicated she has no potential conflicts of interest to disclose.

To cite: Chen HA. Isolated, Together. *Pediatrics*. 2019; 144(3):e20191210

suffer in isolation, unable to see that we are actually together in our experiences; but it does not have to be that way. We can change the culture and dismantle the stigma by confronting medicine and medical education's systemic flaws.

Among medical students and resident physicians, nearly one-third of us have depression or experience depressive symptoms, but only 15% of those affected have sought psychiatric treatment.[3,4] We are also more likely to die by suicide than our nonmedical counterparts.[5] As high-achieving individuals, we tend to blame ourselves for feeling overwhelmed, exhausted, or sad. Many of us experience immense guilt for shifting responsibilities onto our colleagues. Consequently, we trudge through 80-hour workweeks as hypocrites, encouraging patients to make lifestyle changes, while silently nearing our own breaking points. We learn to heal others but not ourselves.

Medical schools and residency programs cannot simply tell trainees to "be well." Those who are most in need of "wellness" are often those already grappling with mental illnesses. When significant energy is used just get out of bed for work, there is a limited reserve for self-care. A list of wellness resources is not a cure for the lack of schedule flexibility and support that trainees confront when seeking help.

One of the greatest barriers to receiving mental health care is the inability to take time off from work.[6] Although many institutions offer discounted counseling, these services are often inaccessible to trainees working long shifts and overnight calls. Some institutions now offer late-night and weekend appointments; others have mirrored protected didactic time for education and created protected personal time for appointments with prearranged shift coverage. This guaranteed time off also allows trainees time to connect with community providers who may offer services that better meet individual treatment needs.

Most institutions also have a "jeopardy" system that provides coverage for unplanned absences. However, residents often choose to work despite ongoing illness or crisis because of obligations to patient care, guilt of burdening colleagues, and fear of judgment and penalization.[7] One solution is to increase the baseline physician-to-patient ratio so that even if a resident cannot work, adequate and safe coverage remains without needing to call in another resident. Programs should revise the system to support residents who feel unfit to work because of exhaustion, depression, or stress.[8] Payback and makeup shifts must be minimized and delayed. By pushing for immediate return to work, we further the acculturation of denying our own needs in the service of others. In contrast, by allowing time to grieve, heal, and receive real-time treatment without punitive conditions, we normalize mental health care and prevent debilitating, fatal mental illness crises.

Extended work hours also undermine trainee well-being. In 2017, the Accreditation Council for Graduate Medical Education relaxed its policies on duty hours because previous restriction trials found no changes in patient outcomes or time spent on patient care.[9,10] Proponents of the flexible policies argue that longer shifts improve the continuity of care by minimizing patient handoffs and maintain current residency durations by maximizing learning opportunities. However, residents that worked longer hours reported increased dissatisfaction with their personal lives and health.[9] Because modern medicine focuses on patient outcomes, we overlook the sleep deprivation, chronic stress, and emotional trauma that trainees must endure to meet such quotas.

In an effort to reduce work hours without undermining trainee education, European countries have actively expanded their physician workforce by increasing the number of medical schools and recruiting foreign medical graduates.[11] Administrative assistance and ancillary support have also been increased to ensure that trainees' clinical responsibilities are truly educational. Reduced work hours allow trainees to incorporate self-care, whether it is through sleep, socialization, or exercise. Although redesigning medical training is a daunting task, it is necessary in producing happier physicians who are more likely to remain in practice and deliver high-quality patient care.[6]

We chose medicine because we want to help others. Such privilege should not cost us our lives. This generation's demands for reasonable work hours and conditions are not out of selfishness or laziness but out of desperation to preserve our initial passion for science and humanity. It is not about building resiliency; we are already resilient for holding onto medicine despite its dysfunctional infrastructure. In the wake of the physician suicide epidemic, we need proactive and preventive care instead of regretful condolences. We need institutional changes to allow us to start taking care of ourselves.

Although it brought suffering and pain, my depression has also emboldened me to prioritize and advocate for mental health in medicine and medical education. I hope others find solace in knowing that they are not alone in this dark journey and that asking for help can bring them light. Let us transform the culture by making our voices heard.

ACKNOWLEDGMENT

In loving memory of Sean Michael Petro.

REFERENCES

1. Dunn LB, Iglewicz A, Moutier C. A conceptual model of medical student well-being: promoting resilience and preventing burnout. *Acad Psychiatry*. 2008;32(1):44–53
2. Dyrbye LN, Thomas MR, Shanafelt TD. Systematic review of depression, anxiety, and other indicators of psychological distress among U.S. and Canadian medical students. *Acad Med*. 2006;81(4):354–373
3. Mata DA, Ramos MA, Bansal N, et al. Prevalence of depression and depressive symptoms among resident physicians: a systematic review and meta-analysis. *JAMA*. 2015;314(22):2373–2383
4. Rotenstein LS, Ramos MA, Torre M, et al. Prevalence of depression, depressive symptoms, and suicidal ideation among medical students: a systematic review and meta-analysis. *JAMA*. 2016;316(21):2214–2236
5. Schernhammer ES, Colditz GA. Suicide rates among physicians: a quantitative and gender assessment (meta-analysis). *Am J Psychiatry*. 2004;161(12):2295–2302
6. Holmes EG, Connolly A, Putnam KT, et al. Taking care of our own: a multispecialty study of resident and program director perspectives on contributors to burnout and potential interventions. *Acad Psychiatry*. 2017;41(2):159–166
7. Jena AB, Meltzer DO, Press VG, Arora VM. Why physicians work when sick. *Arch Intern Med*. 2012;172(14):1107–1108
8. Saab FG, Haynes CA, Zen AL, et al. Resident wellness—a chief resident's perspective. *SIGM Forum*. 2018;41(1):1, 10–11
9. Desai SV, Asch DA, Bellini LM, et al; iCOMPARE Research Group. Education outcomes in a duty-hour flexibility trial in internal medicine. *N Engl J Med*. 2018;378(16):1494–1508
10. Bilimoria KY, Chung JW, Hedges LV, et al. National cluster-randomized trial of duty-hour flexibility in surgical training. *N Engl J Med*. 2016;374(8):713–727
11. Temple J. Resident duty hours around the globe: where are we now? *BMC Med Educ*. 2014;14(suppl 1):S8

Isolated, Together

Hsuan-hsiu Annie Chen

Pediatrics 2019;144;
DOI: 10.1542/peds.2019-1210 originally published online August 2, 2019;

PEDIATRICS®
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Isolated, Together

Hsuan-hsiu Annie Chen

Pediatrics 2019;144;
DOI: 10.1542/peds.2019-1210 originally published online August 2, 2019;