Legislative: Suicide is Painful: We All Count

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April 04, 2023
DOI: 10.3912/OJIN.Vol28No02LegCol01

Column

The statistics on suicide are painful if not enlightening. In the United States, suicide was the 12th leading cause of death in 2020 (CDC, 2021). Physicians and nurses may be at higher risk of suicide than the general population following the intensity of service during the COVI-19 pandemic and other professional and/or personal stressors. Davidson et al. (2019) found nurse suicide was significantly higher than the general population. Further, stressful nursing incidents and workplaces add to the psychological burden (Davidson et al, 2021).

Multiple research studies on situational and occupational nurse stress have been done (Gillespie, Gates, & Berry, 2013; Keller et al., 2022). However, the nursing profession does not easily or effectively address the multitude of facility issues (lack of personal protective equipment, mandatory overtime, toxic workplace, workplace violence, etc.). Nurses are encouraged to stoic responses amid a pandemic. In other situations, nurses are told to "pull their big girl panties up" and work through these situations. Nor do we address the stigma of mental decompensation, illness, or suicide within our own professional ranks. What does this say about our worth as persons and professionals? We have been socialized to not ask for help (Davidson et al., 2021).

Physician suicide is not at any higher risk than nurses or the general population (Ye et al., 2021). And yet, it took a physician taking her own life for a literal act of Congress. Dr. Lorna Breen was an Emergency Department physician in New York City who took her life. Her family sought help for Dr. Breen. But even as she recovered, prior to returning to work, she completed suicide (Knoll, Watkins, & Rothfeld, 2020). We encourage you to read Dr. Breen's story (www.nytimes.com/2020/07/11/nyregion/lorna-breen-suicide-coronavirus.html).

H.R. 1667 – Dr. Lorna Breen Health Care Provider Protection Provider Act

On March 18, 2022, H.R. 1667 – Dr. Lorna Breen Health Care Provider Protection Provider Act (H.R. 1667) became law. H.R. 1667 established a national evidence-based or evidenced-informed education and awareness program to prevent suicide, reduce the stigma of seeking mental health and/or substance abuse assistance, and improve mental health and resilience among health care professionals. Important aspects of H.R. 1667 are:

1. Encourage health care professionals to seek support and care for mental health and/or substance use concerns.
2. Address stigma associated with seeking help with mental health and substance use disorders.
3. Mandatory reporting of activities and outcomes to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives no later than two years after the date of enactment by the Secretary of Health and Human Services.
4. The authorization of $10 million for fiscal years 2022 through 2024 ($30,000,000 plus another $5,000,000 for administration).

Here is where definitions are important. Although H.R. 1667 was named in honor of a health care *provider*, the bill broadens its approach to health care *professionals*. A health care *provider* as defined in the Code of Federal Regulation (Title 29 825.125, 2023) includes a Doctor of Medicine or Osteopathy authorized to practice medicine or surgery by the State or any other person determined capable of providing health care services. Nurse practitioners, nurse midwives, clinical social workers, and physician assistants are included within the scope of their practice under state law. However, a health care *professional* is "an individual licensed, registered, or certified under Federal or State laws or regulations to provide health care services" (42 U.S. Code § 234, 2019).

Under these interpretations, studies regarding registered nurses, public health nurses, or licensed practical nurses, also may be eligible for interventions under HB 1667. Unfortunately, healthcare worker (HCW) is excluded from this language. HCWs are used extensively in many different facilities. Any medical, dental, or other health-related care or treatment done under the supervision of a healthcare profession is a HCW (https://www.lawinsider.com/dictionary/health-care-worker).

In our humble opinion, HCWs should not have been ignored for education on stigma, resiliency, stress reduction, and suicide prevention. It is essential for HCWs to be included in comprehensive and targeted strategies for reducing the risk of suicide. Although each person on this planet has had pandemic impacts (i.e., illness, death of loved one, loss of income), HCWs had these and more exposures related to their employment and lack of resources. Physicians make much more than HCWs and registered nurses.

Suicide: The Driving Forces

In a report by the American Hospital Association (2023), three key drivers were reported in clinician suicide risk. Stigma was cited as the first key driver, followed by inadequate access to behavioral health education, resources, and treatment options. Lastly, job-related stress was listed a key driver in suicide risk. Essentially, health care professionals have two drivers – what can be controlled by stigma and resiliency education; and what health care professionals have no control over – the job stressors created and amplified by health care system issues. Glaringly, the Dr. Lorna Breen Health Care Provider Protection Provider Act has no accountability for health care facility employers to implement changes in systems and cultural issues that amplify HCW, nurse, or physician stress.

We can educate and mitigate stigma and encourage access to behavioral health, along with self-care and resiliency, but health care providers are overwhelmed with mandatory overtime, too much to do in too little of time (job compression), workplace conflict, incivility, bullying, short staffing, and, in case these issues were not enough, the psychological burden of the health care provision itself (Davidson et al, 2021).

Nurses, especially female nurses, are at a higher risk for suicide in America, not physicians (Ye et al., 2020; Davidson et al. 2021). That said, in a study on trends in mental health indictor, 19.8% of nurses had an increased probability of anxiety disorder significantly higher than previous years of data with 34% reporting sadness, depression, or feeling down (Cuccia et al., 2022). In the stressful health care environments, nurses will need to support and uplift each other to thrive. We are stronger together.

Regarding the above gendered suicide result, we have yet to understand the real impact of COVID-19, its isolating factors, and shared occupational trauma on suicide. These statistics are obfuscated on professions or jobs, and only time and energy will illuminate the statistics not yet reported. Meanwhile, United States suicides have increased by four percent from 2020 to 2021 (Curtin, Garnett, & Ahman, 2022).

Conclusion

In conclusion, while we praise the law for the attention and monies dedicated to increasing resilience and stigma research and programs for healthcare providers and professionals, if we could, we would have changed the language of the law to be inclusive of all HCWs. We also would have included accountability measures for employers for the safety and health of their employees for meaningful programs, system, and cultural changes. How we educate and foster mental wellness amongst physicians, nurses, and other HCWs needs to change. Poorly paid aides and other HCWs must be included, not disqualified in the monies distributed by the Act. And, so unashamedly cataloged as a third driver - the job stressors created and amplified by health care system issues and must be addressed aggressively now and in the future.

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Citation: Berry, P.A., Tyson, L., (April 4, 2023) "Legislative: Suicide is Painful: We All Count" *OJIN: The Online Journal of Issues in Nursing* Vol. 28, No. 2.