President's message

Through the Looking Glass: Reflections

By Frank Guerra, M.D.

"We have met the enemy and he is us." Pogo

As my Presidential term approached and for much of the year that I was your President-Elect, I ruminated over the nature of this column, what I would say, and how I would say it. In the many years that I have been reading this bulletin, I have noted a variety of approaches including reportage, opinion, and essays on the pressing issues of the moment. I suppose that any given President often must write in response to a particular hot issue of the day. In these days there are so many urgent concerns that one hardly knows where to begin.

I have been in medicine for over forty years now. I have practiced both anesthesiology and psychiatry. I have had the opportunity to work closely with surgeons, obstetricians/gynecologists, neonatologists, internists, nurses, social workers, psychologists, insurers, and administrators. As such I have learned a lot, I have seen a great deal of change.

I hope to use the bully pulpit of this column to present my thoughts and observations about the important issues of the day as they occupy my thinking as well as the work of the APA and CPS. I hope that my ideas will provoke discussion, debate, perhaps outrage, and change where possible and necessary.

About seven years ago I submitted a strongly worded letter, quitting the Colorado Psychiatric Society and the APA. I quit because I felt that the Society was not supporting the best interests of patients and physicians. At the time I felt that the Society was embracing the interests of insurers in some ways that I felt were inconsistent with the mission of advocacy for patients and for the profession. It was through the urging of an esteemed colleague that I decided to return to the fold. I accepted the invitation with the idea that I would allow myself time to experience, first hand, whether my impressions were accurate. I was given the opportunity to work within the organization to try to make a difference.

For the last six years I have been privileged to be one of your representatives to the Assembly of the APA. This has given me a chance to speak about the great work the CPS does and continues to do. Now I am your President.

I continue to feel that we are not doing all that we can do to advance the well-being of our patients and ourselves as caregivers and advocates. There are still too many of us who neglect our responsibilities as advocates.

The CPS and the APA are each clearly comprised of a complex membership representing the clinical and political spectrum of psychiatry. The field of psychiatry is so varied and rich that no point of view will ever capture the entirety of who we are. There are, however, certain basics. The most important of these is that we are integrators who are in the unique position in all of medicine to address the subtle interplay of psyche and soma.

We psychiatrists have overstated our case as a medical specialty. In the process of trying to establish and reinforce our medical provenance, the value of training in dynamic psychotherapies has been minimized in many places. New generations of psychiatrists are being trained to be mixers of chemicals. I know that in many institutions the nature of the discourse regarding patients has moved from the biopsychosocial to the biobiobio with a smidgen of social thrown in only insofar as it applies to being able to safely discharge patients from the hospital without incurring liability while representatives of insurance companies, some of whom are colleagues, breathe down our necks.

We psychiatrists sold the farm when we agreed to become medication managers, consigning psychotherapy to social workers and...
Resident's Column

Suicide:
It's Still the Elephant in the Room

By Rachel Davis, M.D.

In psychiatry, suicide might be considered the equivalent of a fatal myocardial infarction (MI) in cardiology or a subarachnoid hemorrhage in emergency medicine. In residency we learn, in great detail, how to assess suicidality. However, we spend little time discussing the aftermath of completed suicide or even the reality that it DOES happen. This is certainly not a shortcoming of psychiatry alone. Medicine doctors also spend much time discussing diagnosis and treatment of disease with the goal of preventing death and little time acknowledging that death does occur. Most of the energy and focus in psychiatry, as in the rest of medicine, is spent attempting to help people improve their quality of life, but there are times when people's illnesses are so severe that they succumb to them. There are also times that people aren't amenable to the treatment that would help them get better, and their illnesses continue to deteriorate to the point where suicide seems, to them, the only option.

I entered psychiatry knowing that suicide was a reality. In particular, that reality sunk in after a month at the County Coroner's office during my fourth year of medical school. After that rotation, an initial question at the back of my mind was, "What do I need to do to keep this from happening to my patients?" Over the course of internship and the second year of my psychiatry residency, I've realized that I can't simply "keep it from happening." Just as with coronary artery disease (CAD), there are certain interventions and treatments I can recommend. I can learn to pick up on warning signs and provide a thorough interview and exam. However, I have no magical power to stop the course of an illness or to make a person adhere to what I think, or even know, would make them better. My responsibility is to be astute, compassionate, and vigilant, but the ultimate mortality will depend on the severity of a person's illness and/or the person's willingness and ability to participate in treatment. Although I can pick up on all the signs of coronary artery disease and recommend appropriate medical and lifestyle interventions, I can't make my patients adhere to these recommendations. Even if they do exactly what is recommended, they may eventually die from a myocardial infarction because their genetic vulnerability is too high and their degree of illness is beyond our capacity to successfully treat.

Statistics from the Center for Disease Control indicate that suicide is the eleventh leading cause of death in the United States.\(^1\) To put this in context, the seventh cause is Alzheimer's disease, the tenth cause is septicemia, and the twelfth is chronic liver disease and cirrhosis.\(^1\) In the United States, 11.1 per 100,000 people killed themselves in 2004.\(^2\) Dong and colleagues found the rate of inpatient suicides to be 269 per 100,000 admissions in Hong Kong.\(^3\) Though statistics vary widely, the 2002 World Report on Violence and Health indicates that those with major or bipolar depression carry a 12-15% risk of death via suicide\(^4\) (referencing Guze et al\(^5\) and Harris et al\(^6\)). Of note, Bostwick and Pankratz, in a review of studies, calculated the rate of suicide to be lower, 4.0% to 8.6% in patients with affective disorders.\(^7\) Those with schizophrenia carry a similar, 10-12% risk of death via suicide\(^8\) (referencing Roy\(^9\)). These sobering risks mean that approximately half of all psychiatrists will lose one or more patients to suicide at some point during their practice.\(^9\) Approximately one-third of these suicides will occur during a psychiatrist's internship or residency.\(^9\) This translates to approximately one in three psychiatry residents experiencing the suicide of a patient during training.\(^10\) An American Journal of Psychiatry article by Hendin and colleagues notes that most therapists perceived adequate support from their peers and colleagues.\(^11\) However, those in training tended to report a more varied, and often disturbing, lack of support.\(^12\) Erick Plakun postulates that a resident may be worried that a patient's suicide reflects inexperience.\(^11\) Residents may be more sensitive to feedback and perceive it as criticism in the context of a patient's death via suicide.

In particular, I've been thinking about suicide in relation to death from other medical illnesses after being the recipient of a thoughtless comment from another physician. While consulting in the emergency department, I spent over an hour discussing treatment options with a young suicidal woman who had recently experienced horrific trauma. We discussed, at length, the benefits and risks of hospitalization versus return to home and reintegration back into her "normal" life. We considered both the short-term and the long-term pictures. In the end, she decided, with the support of her mother, that it was best for her to return home and that she would be safe. I concurred but only after working with her and her mother to develop a thorough plan of how she would spend the next few days and what she would do should the suicidal thoughts return. I went to speak with the consulting physician, only to hear, "Well, let's just hope she doesn't go and kill.
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herself. It took all my willpower not to retaliate with something along the lines of, "Well, let's just hope the man with numerous cardiac risk factors and chest pain who you just sent home doesn't go and die of an MI either." I wanted to talk about imminent risk versus long-term risk. I wanted to ask her why she didn't hospitalize every patient with CAD risk factors to monitor diet and make sure they adhere to treatment. I wanted to point out that physicians send someone home after a work-up for "rule-out MI" because they're not an acute risk, not because they'll never have an MI. I wanted to comment that the patient with increased blood glucose may indeed come back in diabetic ketoacidosis after failing to adhere to treatment and diet recommendations. Instead, I smiled and responded in a tired, middle of the night voice, "please don't say that."

Unfortunately, it's not only other medical professionals who associate suicide with an increased level of blame. If I had to wager a guess, I'd bet that most psychiatrists would be relieved to receive an autopsy report which indicated that a patient had died of a massive MI rather than suicide, despite the fact that many of our medications may contribute to coronary artery disease. At an APA presentation addressing the impact of suicide on mental health providers, numerous psychiatrists discussed the shame and alienation they felt after losing a patient to suicide. They talked about the journey in the aftermath of such tragedy – guilt, self-doubt, lawsuits, fear of treating very ill patients, and isolation. Some of my fellow colleagues-in-training have already lost patients to suicide. Though we're taught how to evaluate suicidality, we're not taught the probability that it will happen to a patient of ours or how to deal with it when it occurs. Due to legal concerns, even the psychiatry M&M's are shrouded in a degree of secrecy different from surgical or medical M&M's.

The stigma associated with suicide is pervasive, but this doesn't mean change cannot be made. We need to talk openly about suicide early in residency. We need to know that it does happen and how often it happens. We need to hear from providers who have lost patients to suicide, including our supervisors and mentors. Most importantly, when a suicide does happen, it should be discussed in an open manner, perhaps among colleagues-in-training. This idea is supported by Plakun and Tillman in their publication, "Responding to Clinicians After Loss of a Patient to Suicide."14 We need to educate other medical professionals about the risk of suicide and that it cannot always be prevented. We need to talk openly with family members about the mortality rate of certain mental illnesses, just as a good oncologist would do with family members of someone with cancer. That way family is not ignorant of the degree of their loved one's suffering or risk. That way they are aware of the level of concern for their family members and that the illness is taken very seriously.

We should never accept that suicide is an option, but we must recognize our limitations and acknowledge that there are many diseases where we fall short of having the science and technology to adequately treat, let alone cure. Medicine will continue to advance, and we can continue to hope that, as new treatments become available, psychiatric morbidity and mortality will continue to decrease.

I would appreciate any thoughts, comments, and experiences to use in a follow-up article. I will keep all names confidential. Please send e-mail to Rachel.Davis@uchsc.edu. The American Association of Suicidology provides support and education for survivors of suicide, both for providers and family. The web address is http://www.suicidology.org/.

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References

JUNE 2007

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