MEDwave

Comment
Medwave 2017 Jul;17(6):e6986 doi: 10.5867/medwave.2017.06.6986

Coping with a patient's suicide: the impact on physicians

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Citation: Arancibia M, Martínez-Aguayo JC, Madrid E. Coping with a patient's suicide: the impact on physicians. *Medwave* 2017 Jul;17(6):e6986 doi: 10.5867/medwave.2017.06.6986
Submission date: 29/5/2017
Acceptance date: 4/6/2017
Publication date: 10/7/2017
Origin: not requested
Type of review: not peer reviewed

Despite suicide is the most prevalent cause of death among people who suffer from mental disorders, the reaction of the physician is an uncommonly discussed topic. A great proportion of the more than 30,000 people who commit suicide in the United States each year has received treatment from a mental health professional, and many more have had recent contact with a primary care physician [1],[2], often due to physical complaints that may have disguised mental disorders [3].

Although for younger physicians suicide may constitute a topic that might be easier to deal with, since they have been better trained in personality and depressive disorders, and have more familiarity with clinical guidelines (including questioning about suicidal behavior) than previous generations, they may not be capable of assessing the actual risk of suicide, nor preventing it. This phenomenon may be due to the fact that younger practitioners usually do not believe they have the necessary skills to deal with suicide. Paradoxically, attempting to approach the potential suicide victims has proved to reduce risk [4]. Nonetheless, there are no formal training programs for mental health workers intended to provide tools to face and cope with this issue [4].

The impact of suicide on general practitioners and specialists is associated with many variables, such as the physician's psychological structure (personality features such as obsessive and anxious traits, trend to internalization and depression), the physician-patient relationship and the stage of their professional career. The initial response of the physician is associated with his (or her) own personal reaction to loss and grief, skepticism and negation. All this followed by de-realization, shame, blame, anger (towards him or herself, the patient, or the patient's family), the search for premonitory signals alerting the event, concern or self-doubt about failure to hospitalize a suicidal patient or about the therapeutic decision, and even loss of self-confidence, depressive mood and anhedonia [2],[5].This is especially important when the professional has not been able to previously detect suicidal ideation [3]. The effects on the physician's personal life include irritability, sense of futility to cope with own family problems, and sleeping disturbances. These effects may generate future changes such as becoming aware of suicidal risk and a more defensive approach to potentially vulnerable patients [6]. Other more narcissistic types of response are the negation of guilt for the failure to hospitalize, indifference, or even blaming others [5]. At the same time, a feeling of relief may arise at the end of the obligation of struggling against suicidal ideation and the autolytic threats of the patient, especially after the death of chronic patients with increased levels of suicidality [2].

When coping or confronting suicide, it becomes especially relevant for the clinician to overcome the sense of isolation by restoring behaviors such as the dialogue with close and significant people. Here becomes particularly important the "psychological autopsy" or suicide review, which may contribute to dilute the affective charge and to consolidate the work of the primary care health team [2]. Another intervention that has proved to be beneficial for the physician and for the patient's family is to book a meeting, and conduct it in a comprehensive and empathic manner, without blame or criticism, highlighting the therapeutic efforts done, and emphasizing that everything that could

be done for the patient was actually addressed [7]. A frequent error committed by physicians is avoiding contact with family and relatives. However, this early contact is critical, because a supportive physician has been shown to reduce the displacement of anger onto the professional [5]. Moreover, attending the funeral does not mean assuming responsibility for the suicide, but tends to be appreciated by the family as it facilitates the emotional expression in a group context.

Another measure that might help is taking into account that suicide is a possible predictable outcome in severe psychiatric disorders. As some authors argue, suicide would constitute part of the natural history of mental disorders. This makes it difficult to prevent when the patient does not exhibit ambivalence about the phenomenon, considering modern medicine has no clinical resources effective enough as to predict it with reliability. Nevertheless, such attitudes of the physician might be inadequately used for defensive purposes, promoting "therapeutic nihilism", and avoiding the therapeutic responsibilities inherent to every health professional [2],[8].

General practitioners must find a complex balance when facing suicide, since it could be considered as an inevitable event, in order to self-protect from guilt, but favoring therapeutic nihilism. On the contrary, when considering suicide as a predictable and avoidable event, a guilt culture would develop in the physician. It becomes necessary to encourage education on how to cope with suicide in healthcare professionals, since suicide represents a heavy affective burden. This type of training must not only include the management of physician's and healthcare team emotions, but the suicidal patient's family as well.

Notes

From the editor

The authors originally submitted this article in Spanish and subsequently translated it into English. The Journal has not copyedited this version.

Declaration of conflicts of interest

The authors declare that they have no conflicts of interest related to the subject matter of this editorial.

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