I JORNADAS CLÍNICAS PAIME

Madrid, 25 y 26 de enero de 2013

Fundación Patronato de Huérfanos y Protección Social de Médicos Príncipe de Asturias

OMC
ORGANIZACIÓN MÉDICA COLEGIAL DE ESPAÑA

Fundación Patronato
de Huérfanos y Protección
Social de Médicos
Príncipe de Asturias

PRESENTACIÓN

Respondiendo al compromiso contraído en el IV Congreso PAIME celebrado en Málaga en 2011, la **Fundación Patronato de Huérfanos y Protección Social de Médicos Príncipe de Asturias** ha organizado las *I Jornadas Clínicas PAIME .*

Las jornadas están planteadas desde un punto de vista aplicado y van dirigidas a los profesionales clínicos (psiquiatras, psicólogos, o unidades clínicas colegiales), que intervienen directamente en el tratamiento de los pacientes PAIME.

El objetivo principal de las mismas es facilitar la reflexión, el debate y el intercambio de conocimientos, experiencias y buenas prácticas entre todos los profesionales clínicos actualmente participantes de este Programa.

La parte principal de los espacios programados estará dedicada al desarrollo de tres talleres de temática diferente y metodología aplicada. Cada asistente podrá inscribirse, si así lo desea, a los tres talleres, al estar éstos programados en tres ediciones diferentes y en horarios alternativos.

Juan José Rodriguez Sendín

Presidente de la Fundación

La Fundación Patronato de Huerfanos y Protección Social de Médicos Príncipe de Asturias tiene su origen en 1917 y se creó con la misión de proporcionar protección a los médicos de España y sus familias que por especiales circunstancias así lo requirieran. Desde entonces ofrece su ayuda a más de 3.500 beneficiarios cada año mediante prestaciones y servicios que se recogen en el Catálogo Anual de Prestaciones.

Las naturaleza de estas prestaciones puede ser de distintos tipos: asistenciales, educacionales, prestaciones para la conciliación de la vida personal, familiar y laboral, y prestaciones para la protección, promoción y prevención de la salud del médico. El acceso a estas ayudas es a través de los Colegios Oficiales de Médicos.

Toda la información sobre la Fundación se encuentra disponible en su página web: www.fphomc.es. El contacto directo puede también establecerse a través del correo electrónico: patronato.huerfanos@fphomc.es

La Comisión Técnica Nacional del PAIME está compuesta por un grupo de médicos pertenecientes a distintos colegios de toda España. Tiene como objetivos fomentar la implantación del PAIME en todo el territorio del estado a través de los Consejos Autonómicos de Colegios de Médicos, velar por el buen funcionamiento de éste y garantizar una atención de calidad a los pacientes del Programa mediante la formación adecuada y actualiza de los profesionales que los atienden.

PROGRAMA

Viernes 25 enero 2013

16,00h: Recepción y acreditación de participantes.

16,30h: Bienvenida asistentes e inauguración.

D. Juan José Rodriguez Sendin.
Presidente de la FPSOMC.

16,45h: PONENCIA INAGURAL: *El Programa de Atención Integral al Médico Enfermo. Contexto actual de desarrollo y estructura de funcionamiento.*
Ponente: D. Serafín Romero Agüit.
Secretario General de la FPSOMC

17,15h: TALLERES I.

Taller 1: Análisis del paciente difícil. Propuestas de intervención.

DIRECTORES:

Dr. Eugeni Bruguera. Psiquiatra PAIME-Barcelona.

Dr. Francisco Collazos. Psiquiatra PAIME-Cataluña

Taller 2: Prevención del riesgo de suicidio.

Dra. Dolores Crespo. Psiquiatra.
Coordinadora PAIME -Madrid.

Dr. José Carlos Mingote Adán. Psiquiatra. Coordinador UVOPSE PAISE-Madrid.

Taller 3. Readaptando el trastorno adaptativo para el PAIME.

DIRECTORES:

Dr. Juan Luis Mendivil . Psiquiatra PAIME-País Vasco.

Dra. Mª Dolores Braquehais. Psiquiatra PAIME—Barcelona

19,00h: Fin de la Jornada.

PROGRAMA

Sábado 26 enero 2013

9,00h: Ponencia: *El PAIME; desde el momento actual hacia el futuro necesario. Desafíos y retos a afrontar.*

PONENTES: Dr. Antoni Artemán Jané. Gerente de la Fundación Galatea.
Dr. Miquel Casas Brugué. Psiquiatra Fundación Galatea

9,20h: Talleres II. Repetición

Taller 1: Análisis del paciente difícil. Propuestas de intervención.

DIRECTORES

Dr. Eugeni Bruguera.
Psiquiatra PAIME-Barcelona.

Dr. Francisco Collazos.

Psiquiatra PAIME-Barcelona.

Taller 2: Prevención del riesgo de suicidio.

DIRECTORES

Dra. Dolores Crespo.

Psiquiatra. Coordinadora PAIME -Madrid.

Dr. José Carlos Mingote Adán. Psiquiatra. Coordinador UVOPSE del PAISE-Madrid.

Taller 3. Readaptando el trastorno adaptativo para el PAIME.

DIRECTORES.

Dr. Juan Luis Mendivil . Psiquiatra PAIME-País Vasco.

Dra. Mª Dolores Braquehais. Psiquiatra PAIME-Barcelona

10,50h: Pausa Café

11,15h: Talleres III. Repetición de los tres Talleres.

12,45h: Coloquio—Debate: Temas complejos del PAIME.

Dirige y Modera: Dra. Mar Sánchez. Coordinadora PAIME Castilla La Mancha

13,45h: Conclusiones finales.

14,30h: Clausura

PONENTES

Dr. Serafín Romero
Secretario General de la FPSOMC

Dr. Antoni Arteman
Gerente Fundación Galatea

Dra. Mar Sánchez
Médico. Coordinadora PAIME Consejo Colegios de Médicos Castilla La Mancha

Dr. Miguel Casas Brugué
Psiquiatra PAIME. Fundación Galatea

Dr. Eugeni Burguera
Psiquiatra PAIME. Fundación Galatea

Dr. Francisco Collazos
Psiquiatra PAIME. Fundación Galatea

Dra. Dolores Crespo
Psiquiatra. Coordinadora PAIME Madrid

Dr. José Carlos Mingote
Psiquiatra. Coordinador UVOPSE del PAIMSE—Madrid

Dr. Juan Luis Mendivil
Psiquiatra PAIME—País Vasco

Dra. Mª Dolores Braquehais
Psiquiatra PAIME. Fundación Galatea

Dr. Serafín Romero Agüit

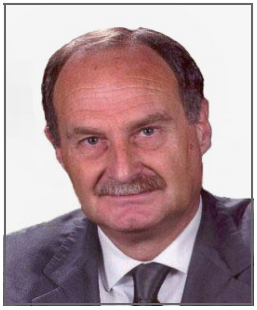
Secretario General del Consejo General de Colegios Oficiales de Médicos.
Secretario General de la Fundación Patronato de Huérfanos y Protección Social de Médicos Príncipe de Asturias.
Licenciado en la Facultad de Medicina de la Universidad de Sevilla
Especialista en Medicina Familiar y Comunitaria (1986).
Secretario General del Iltre. Colegio Oficial de Médicos de Córdoba (febrero 2001)
Secretario de la Fundación del Iltre. Colegio Oficial de Médicos de Córdoba.
Representante del Consejo General de Colegios Oficiales de Médicos ante el Ministerio de Sanidad y Consumo en el Grupo de Trabajo para la elaboración del PAIME.

Dr. Antoni Arteman Jané

Médico. Especialista en medicina preventiva y salud pública. Máster en salud pública. Diplomado ESADE en alta dirección de empresas. Ex-director del órgano técnico de drogodependencias y Gerente de atención psiquiátrica y salud mental del Servicio Catalán de Salud. Gerente de la Fundación Galatea del Consejo de Colegios de Cataluña. Director General Adjunto de la Clínica Galatea, Unidad de Internamiento PAIME de Barcelona.

Dra. Mar Sánchez

Licenciada en Medicina. Coordinadora de la Unidad de Conductas Adictivas, Servicio de Psiquiatría del Hospital de Ciudad Real.
Coordinadora del PAIME en la Comunidad de Castilla La Mancha.



Dr. Miquel Casas Brugué.

Miguel Casas Brugué, catedrático de Psiquiatría de la Autónoma de Barcelona. Jefe del Servicio de Psiquiatría del hospital Vall d´Hebrón.
Pionero en la creación y consolidación del PAIMM desde l1998 en la Fundación Galatea.

Dr. Eugeni Bruguera

Médico psiquiatra. Actualmente es jefe de la Unidad de Conductas Adictivas del Servicio de psiquiatría del Hospital Universitari de la Vall d'Hebron de Barcelona. Miembro fundacional del PAIMM y desde 1998, uno de los jefes clínicos del mismo. Coordinador de programas y responsable de las CCEE y del Hospital de Día del PAIMM. Miembro de la comisión de casos difíciles del programa.

Dr. Francisco Collazos

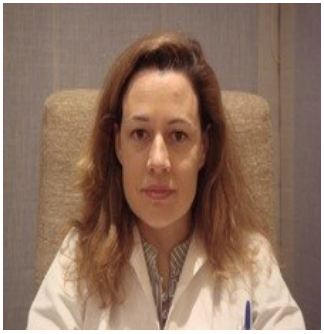
Licenciado en medicina. Especializado en psiquiatría. Psiquiatra adjunto en el Hospital Universitario Vall d´Hebrón de Barcelona responsable del Programa de Psiquiatría Transcultural y en el PAIME. Profesor asociado del Dpto. de Psiquiatría de la Universidad Autónoma de Barcelona. Ha publicado numerosos artículos y capítulos de libros sobre salud mental y participado en diversos proyectos de investigación.

Dra. Dolores Crespo Hervás.
Doctora en Medicina. Psiquiatra. Jefe de los Servicios de Salud Mental de la Comunidad de Madrid. Coordinadora del PAIME en el Colegio Oficial de Médicos de Madrid. Autora de numerosas investigaciones y estudios en salud mental.

Dr. José Carlos Mingote
Doctor en Medicina, especialista en Psiquiatra. Coordinador de la Sección de Psiquiatría de Interconsulta y Enlace en el Servicio de Psiquiatría del hospital Universitario Doce de Octubre de Madrid hasta el año 2000. Actualmente, Coordinador del Programa de Atención integral al Médico Enfermo de la Comunidad de Madrid. Ha realizado diversos estudios en colaboración sobre Riesgos Psicosociales del Trabajo en el ámbito sanitario, como burnout y acoso laboral, así como sus repercusiones en la salud del trabajador (depresión, psicosis, etc.). En 2004 coordinó un protocolo de prevención del suicidio en el hospital General Clínica.

Dr. Juan Luis Mendivil

Doctor en Medicina, Psiquiatra, Director del Centro de Psiquiatría y Psicología tadi (Bilbao), Psicoterapeuta Grupoanalista, Terapéuta del PAIME del País Vasco



Dra. Dolores Braquehais

Psiquiatra. Doctora en Medicina. Licenciada en Filosofía. Jefa de Servicio de la Unidad de Hospitalización de los Programas de Atención Integral al Profesional sanitario Enfermo. Clínica Galatea. Barcelona (España). Psiquiatra en el Departamento de Psiquiatría del Hospital Universitario Valle de Hebrón de Barcelona (España)

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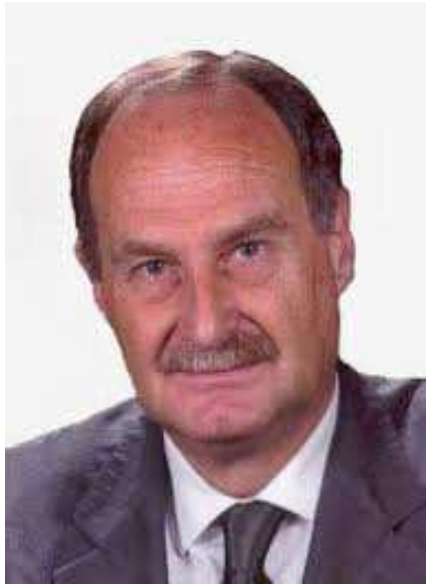
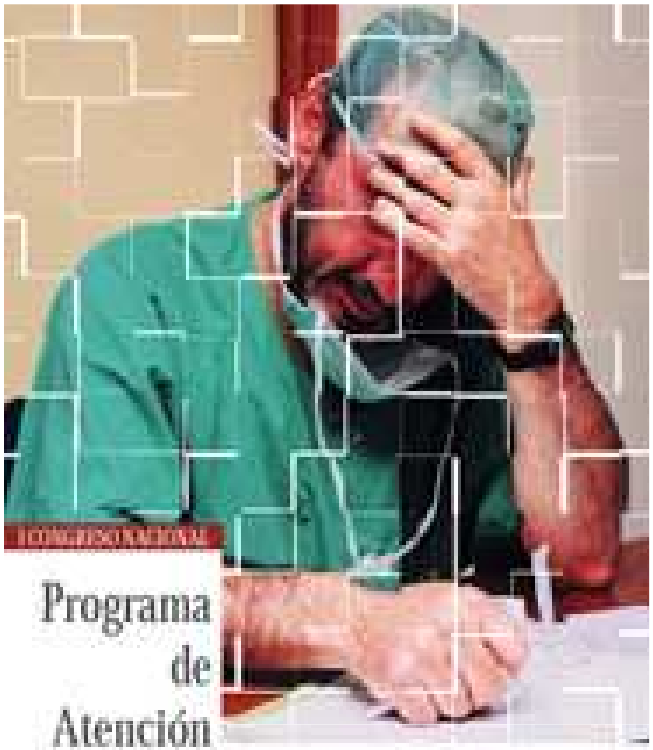
Príncipe de Asturias

PAIME. PRESENTE Y FUTURO

MADRID 25 DE ENERO DE 2013



COL·LEGI OFICIAL DE METGES DE BARCELONA



I CONGRESO NACIONAL

Programa de Atención Integral al

Médico Enfermo

Organizan: Fundación Colegio de Médicos de Córdoba
PAIME - Colegio de Médicos de Barcelona

Con Apoyo de Salarios Científico Sanitario
para la Consejería de Salud de la Junta de Andalucía

Córdoba, 9 y 10 de Octubre de 2003
Palacio de Congresos y Exposiciones

acional PAIN

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646 581 200


XUNTA DE GALICIA


GENERALITAT VALENCIANA
CONSELLERIA DE SANITAT


III CONGRESO NACIONAL PAIME
DEL MÉDICO ENFERMO A LA SALUD DEL MÉDICO
10º ANIVERSARIO PAIME
10 AÑOS AYUDANDO AL PROFESIONAL
12, 13 Y 14 DE NOVEMBRE DE 2008
AUDITORIO DEL COLEGIO DE MÉDICOS
DE BARCELONA


III CONGRESO
NACIONAL PAIME


Junta de
Castilla y León


La Caja de
las Personas
CajaSur

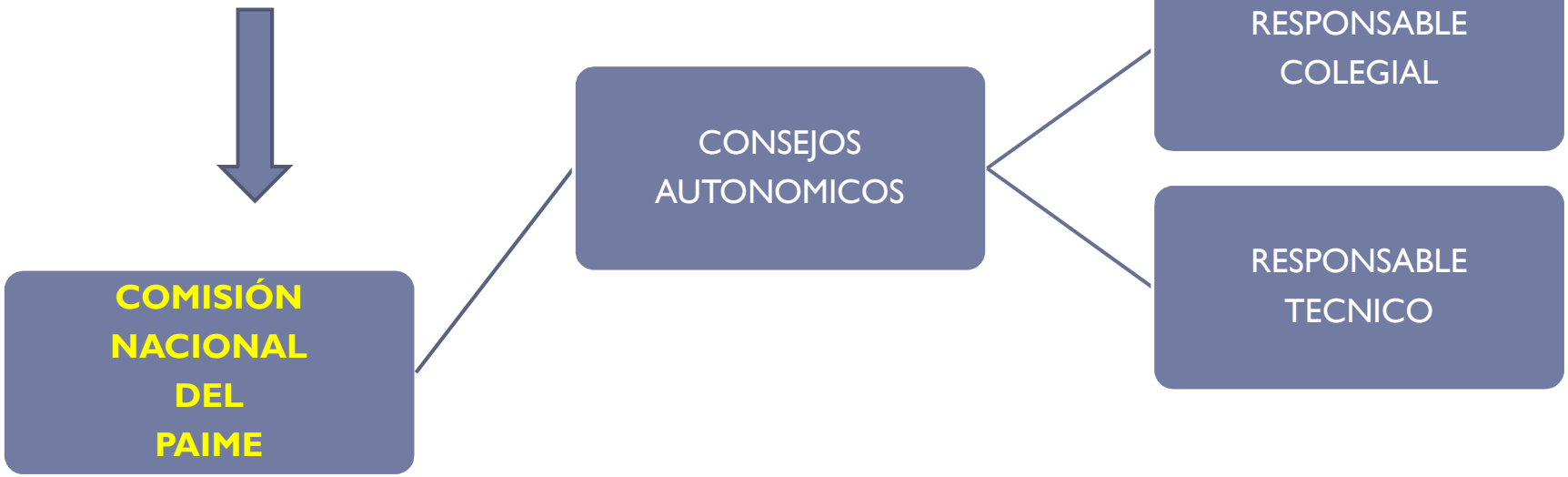
Fundación GALATEA

Fundación Patronato de Huérfanos y Protección Social de Médicos Príncipe de Asturias


IV Congreso
PAIME
Programa de Atención Integral
al Médico Enfermo
Salud de los Médicos, Calidad del Servicio
Málaga, 3 y 4 de marzo de 2011
OMC
commálaga
Colegio Oficial de Médicos de Málaga - C/ Curtidores, 1 - 29006 Mála

COMISIÓN NACIONAL DEL PAIME

Fundación Patronato de Huérfanos y Protección Social de Médicos Príncipe de Asturias



FUNCIONES

- **Desarrollar desde la OMC los criterios que permitan una estandarización consensuada de la actividad- y de la calidad de la misma - de los diferentes Programas existentes, y estableciendo de forma transparente unos criterios comunes de homologación y registro sistemático de los datos de todos los PAIME**

FUNCIONES

- **PROMOVER ACTIVIDADES ENCAMINADAS NO SOLO A LA ATENCIÓN SINO A LA PROMOCIÓNY PREVENCIÓN DE LA SALUD DEL MÉDICO.**

FUNCIONES

- **COORDINAR E IMPLEMENTAR MECANISMOS ENCAMINADOS A LA REHABILITACIÓN Y REINSERCIÓN PROFESIONAL.**

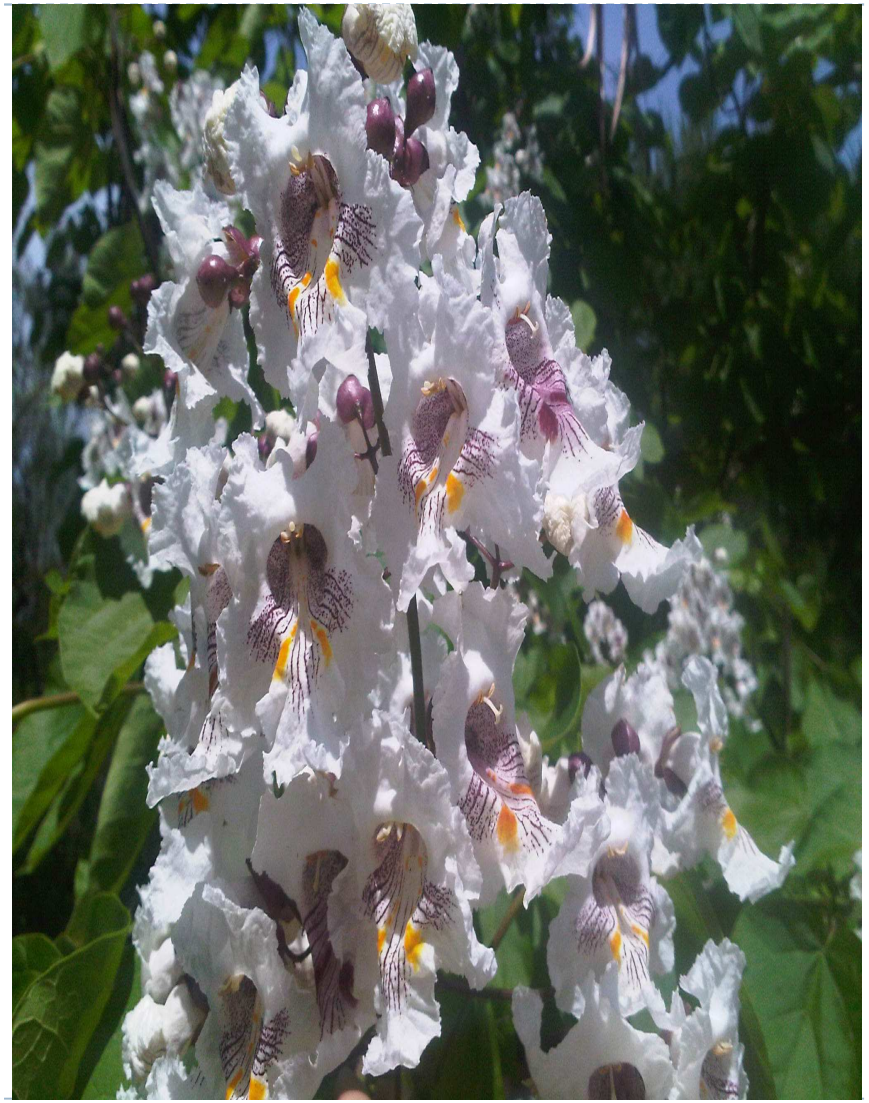
FUNCIONES

- **SISTEMATIZAR RESPUESTAS ANTE SITUACIONES DE RIESGO DE MALA PRAXIS.**

- **PERITACIONES CRUZADAS ENTRE COLEGIOS.**

FUNCIONES

- **ENCAMINADAS A MANTENER LA CONFIDENCIALIDAD, INDEPENDENCIA Y PROFESIONALIDAD DEL PROGRAMA.**



FUNCIONES

- **BUSCAR COMPLICIDADES FUERA DE LAS CORPORACIONES PROFESIONALES (UNIDADES DE PREVENCIÓN, DIRECCIONES DE RECURSOS HUMANOS)**

FUNCIONES

- **ENCAMINADAS A MANTENER Y MEJORAR LA FINANCIACIÓN DEL PROGRAMA Y SUS ACTIVIDADES.**

FUNCIONES

- **PROMOVER LA INVESTIGACIÓN Y EL ESTUDIO EN TODO LO RELACIONADO CON EL ENFERMAR DEL MÉDICO.**

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Príncipe de Asturias

PRESTACIONES

Criterios que regulan la prestación PAIME

Pago total de la parte de los gastos de internamiento que recaiga sobre el colegio o el colegiado, en razón de los siguientes criterios:

a) Ser médico en ejercicio.

b) El colegio de procedencia deberá contar con una unidad de seguimiento ambulatorio.

a) El coste persona/día no será superior al pactado con la Fundación Galatea

Para los reingresos, el criterio a seguir es:

a) Enfermedades mentales: se aceptarán todos.

a) Dependencias: reingreso con intervalo =/> 1 año se analizarán individualmente. Con intervalo inferior a 1 año se desestimarán.

Evolución de la prestación para el PAIME desde su creación.

Años 2004 y 2005		Total años 2004/2005
Número de beneficiarios	10	29.273,50 €
Año 2006		Total 2006
Número de beneficiarios	35	65.038,82 €
Año 2007		Total año 2007
Número de beneficiarios	35	91.303,10 €
Año 2008		Total año 2008
Número de beneficiarios	53	107.050,84 €
Año 2009 (hasta 3.12.09)		Total año 2009
Número de beneficiarios	59	89.719,00 €
Año 2010	61	Total año 2010
		169.014,20

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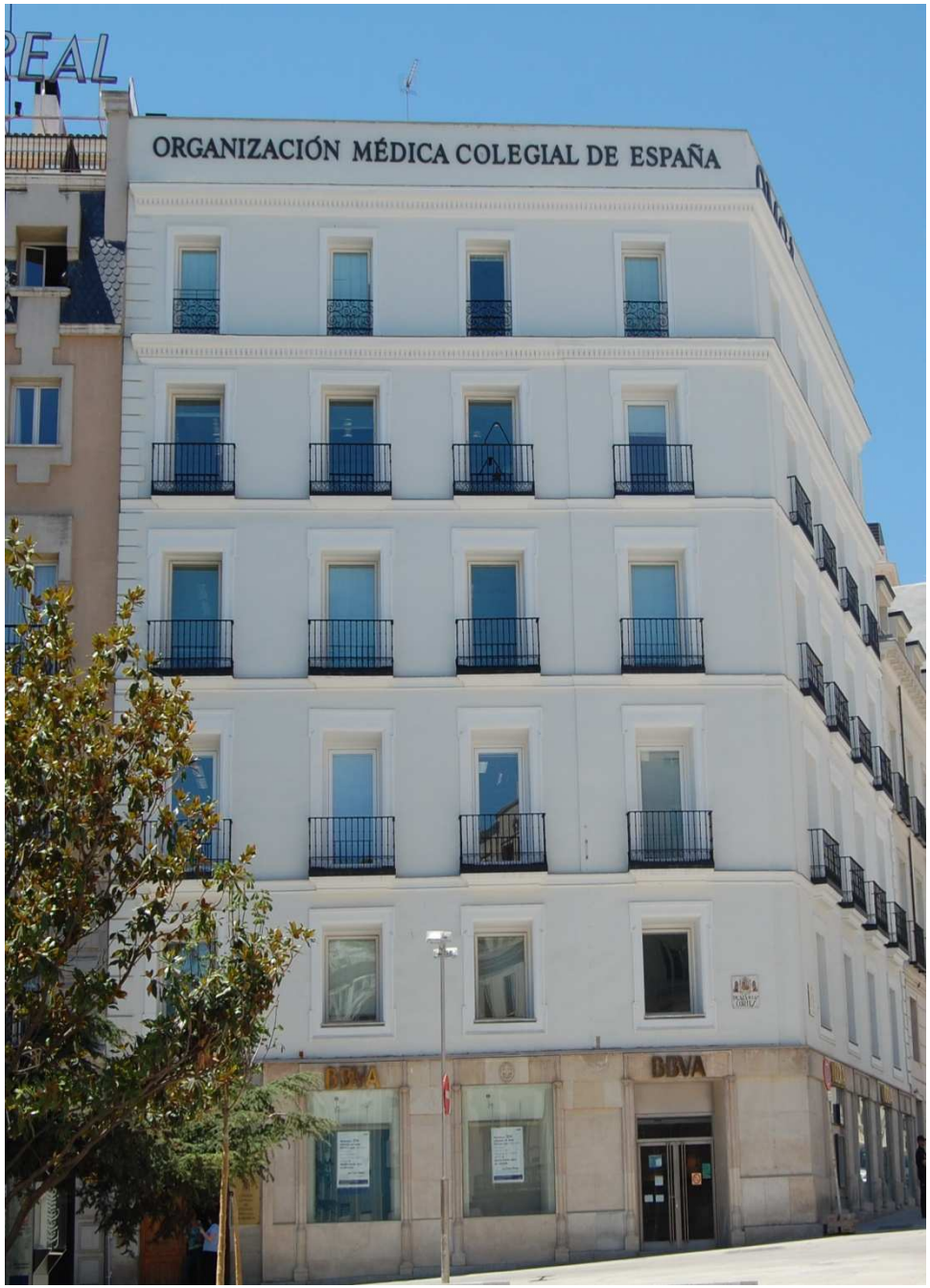
DATOS PAIME

	2011	2012
Nº INGRESOS	49	31
COSTE	149.137,70€	147.491,00€

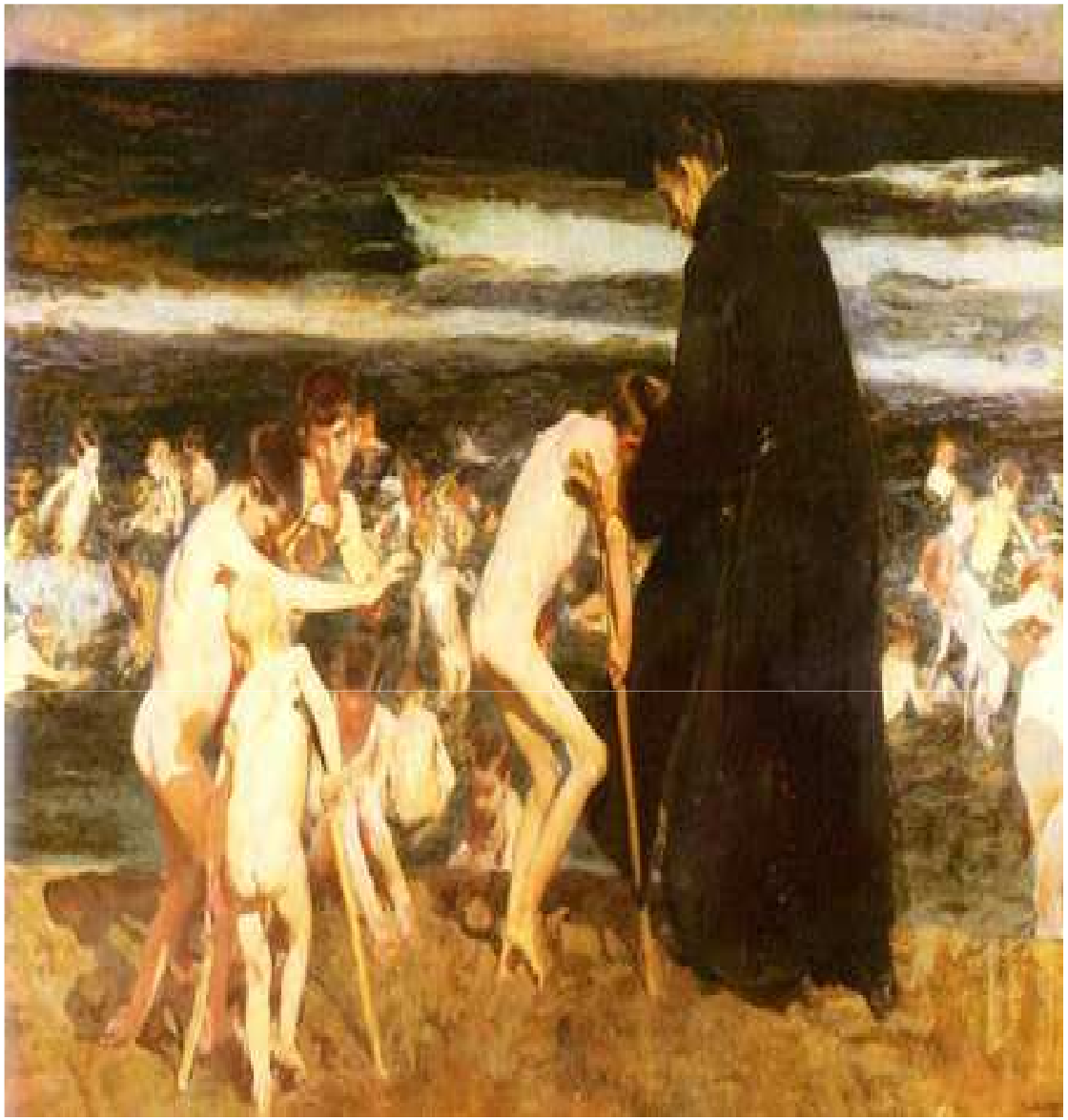

Cantabria
Euskadi
Asturias
Navarra
Galicia
Andorra
La Rioja
Castilla y León
Aragón
Cataluña
C. Madrid
Castilla La Mancha
C. Valenciana
Extremadura
I. Balears
Andalucía
R. Murcia
Islas Canarias
Ceuta
Melilla



ESTUDIO PAIME 2010

El total de casos atendidos por el programa PAIME en el periodo comprendido entre 1998 y 2010 han sido **2.435casos**

Total de ingresos: 748



ACTIVIDADES

COMISIÓN NACIONAL DEL PAIME ACTIVIDADES

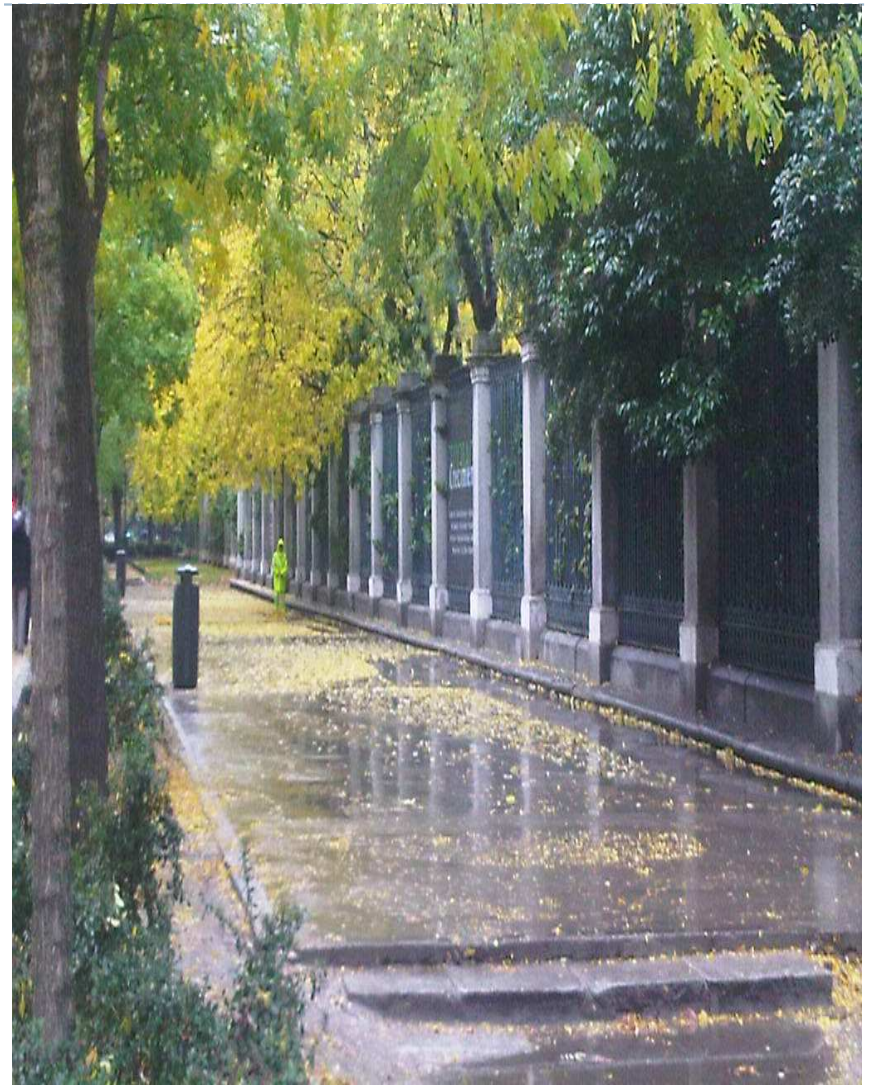
- **ACTUALIZACIÓN DE LISTADOS DE RESPONSABLES COLEGIALES Y TECNICOS DE LOS COLEGIOS, CONSEJOS AUTONOMICOS Y CONSEJO GENERAL DE COLEGIOS DE MÉDICOS.**

COMISIÓN NACIONAL DEL PAIME ACTIVIDADES

- **REUNIÓN CON RESPONSABLES COLEGIALES.**
- **TALLER BASICO DE PUESTA EN MARCHA DEL PAIME EN LOS COLEGIOS DE MÉDICOS.**

COMISIÓN NACIONAL DEL PAIME ACTIVIDADES

- **REUNIÓN CON RESPONSABLES TERAPEUTAS PARA PRESENTACIÓN DEL CONSEJO NACIONAL Y ELABORACIÓN DE PROPUESTAS DE DATOS MINIMOS Y ELABORACIÓN DE PROTOCOLOS ASISTENCIALES.**

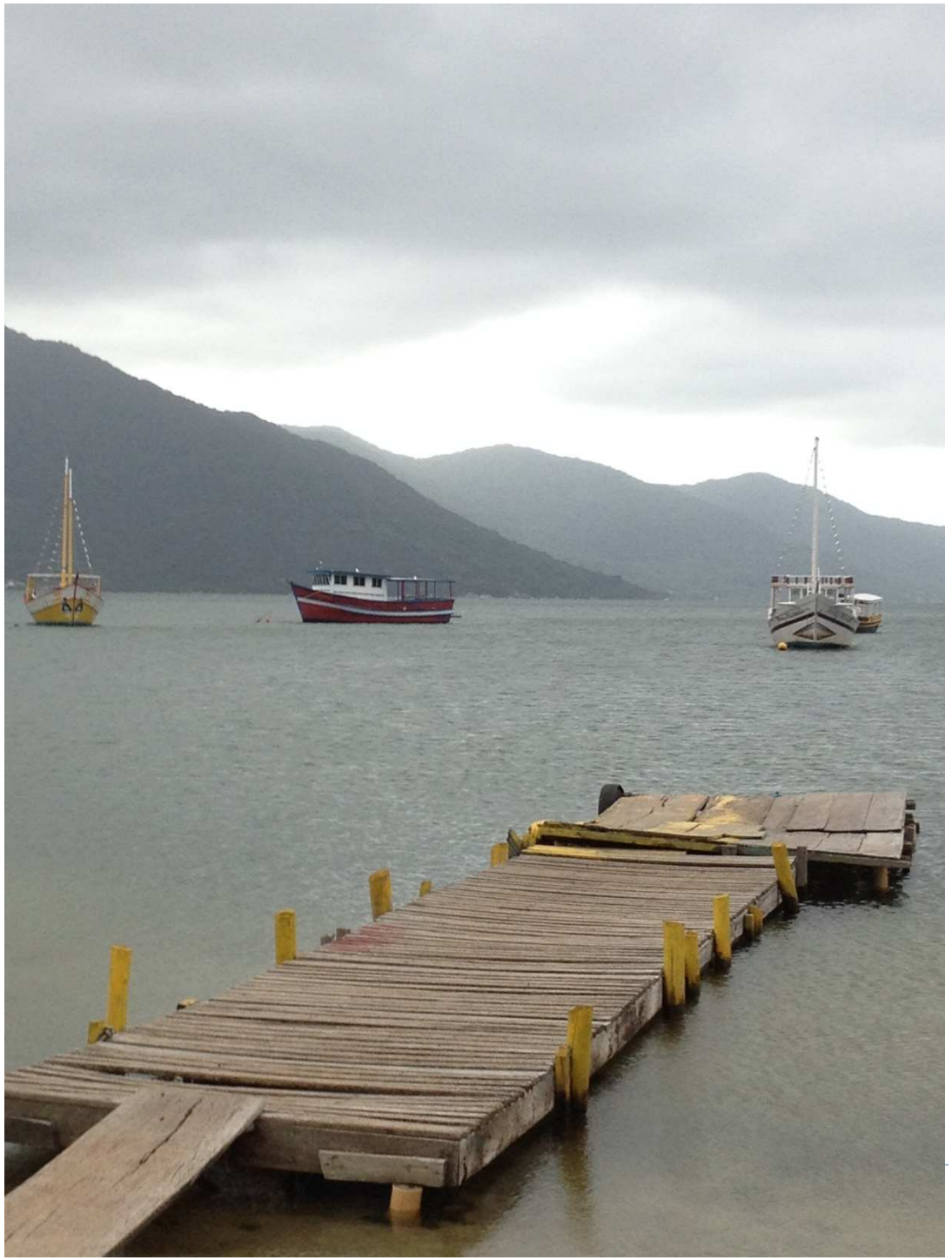


COMISIÓN NACIONAL DEL PAIME ACTIVIDADES

- **CREACIÓN DE UNA BASE COMÚN DE DATOS ESTADISTICOS MINIMOS DEL PAIME TANTO ASISTENCIALES COMO COLEGIALES.**

COMISIÓN NACIONAL DEL PAIME ACTIVIDADES

- **REALIZAR UN ESTUDIO SOBRE EL ESTADO DE SALUD, HABITOS SALUDABLES Y CONDICIONES DE TRABAJO DE LOS MÉDICOS DE ESPAÑA.**



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Príncipe de Asturias

V CONGRESO DEL PAIME
BURGOS
23-24 DE MAYO 2013

Fundación Patronato
de Huérfanos y Protección
Social de Médicos
Príncipe de Asturias

PROGRAMA DE ATENCIÓN INTEGRAL A LA SALUD DEL JUEZ

•ANTECEDENTES.

- Red PAIME
- Trabajos desarrollados por la Fundación Galatea con el CGPJ.
- Demanda al CGCOM por el CGPJ de una propuesta de colaboración:
  - Para atender de forma integral, a la salud de los jueces (PAISJ)
  - En todo el territorio nacional.
  - Incorporando acciones preventivas.
  - Fase Piloto – 2013
  - Valoración Fase Piloto + implementación y consolidación.

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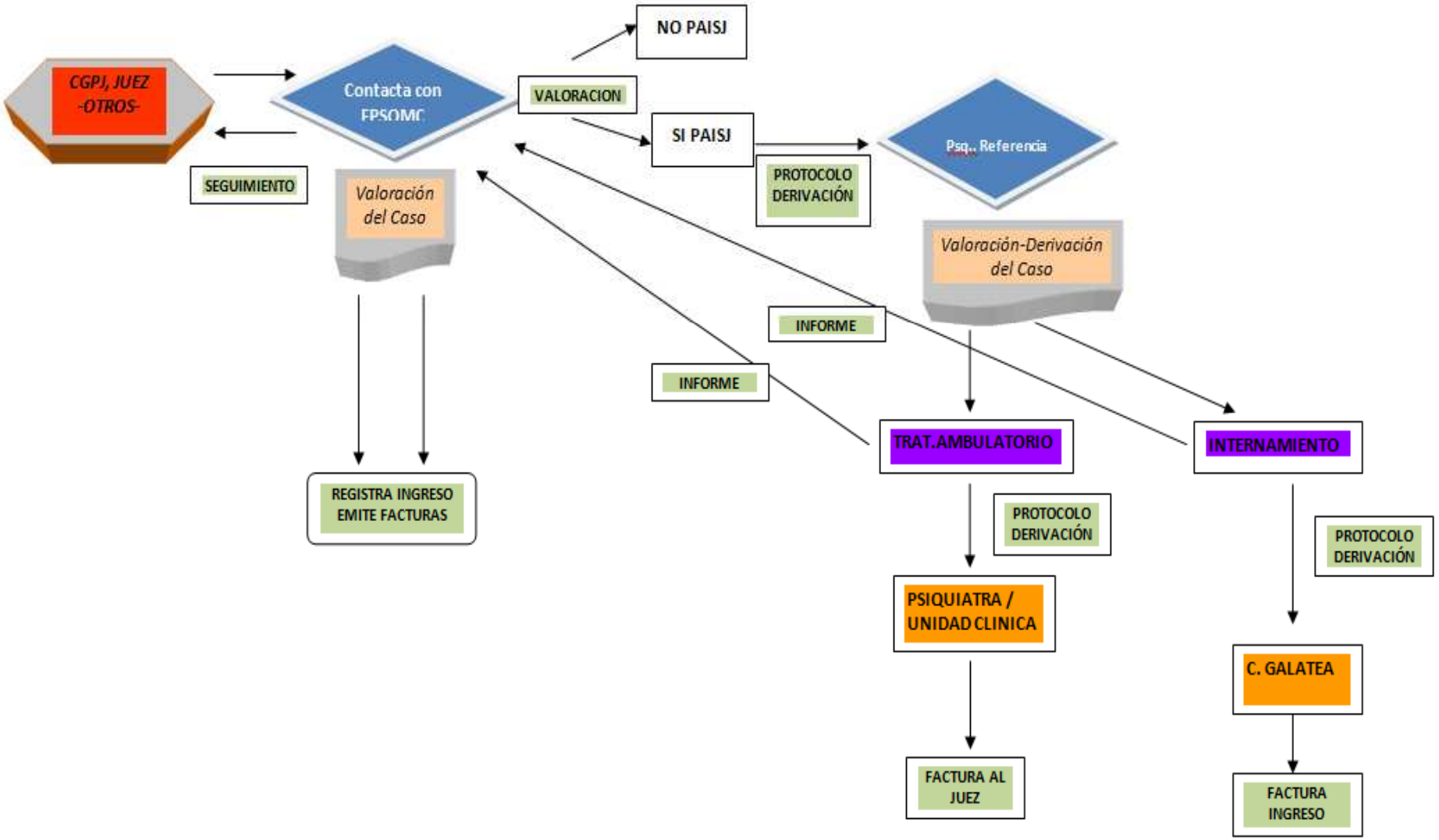
DIAGRAMA FUNCIONAL - PAISJ –



MUCHAS GRACIAS POR SU ATENCIÓN

I JORNADAS CLÍNICAS PAIME

Taller 2: Prevención del riesgo de suicidio

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ORGANIZACIÓN MÉDICA COLEGIAL

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Social de Médicos
Príncipe de Asturias

Psiq Biol. 2012;19(4):127–136

Psiquiatría Biológica

www.elsevier.es/psiquiatriabiologica

Revisión

Suicidio en ancianos☆

Yeates Conwell*, Kimberly van Orden y Eric D. Caine

Department of Psychiatry, University of Rochester Medical Center, Rochester, Estados Unidos

INFORMACIÓN DEL ARTÍCULO

Palabras clave:
Suicidio
Ancianos
Edad avanzada
Prevención

RESUMEN

En este artículo se argumenta que el suicidio a una edad avanzada de la vida debe ser motivo de gran preocupación y justifica que se centre en ello la atención de investigadores, profesionales de la asistencia sanitaria, responsables de la toma de decisiones políticas y sociedad en general. Se revisa la evidencia existente respecto a los factores que sitúan a los ancianos en un riesgo de suicidio o que les protegen de ello. Los autores introducen el concepto de que las intervenciones de prevención del suicidio van dirigidas a individuos o grupos de diferentes niveles de riesgo en diferentes puntos de la trayectoria de desarrollo que lleva a la muerte por suicidio, y ofrecen ejemplos y recomendaciones para su aplicación combinada estratégica con objeto de crear una respuesta efectiva, en el ámbito de la sociedad, frente al problema creciente del suicidio en las personas de edad avanzada.

Suicide in older adults

Keywords:
Suicide
Older adult
Aged
Prevention

ABSTRACT

This article makes the case that late-life suicide is a cause for great concern that warrants ongoing attention from researchers, health care providers, policy makers, and society at large. It reviews the evidence for factors that place older adults at risk for suicide, or protect them from it. The authors introduce the notion that suicide preventive interventions target individuals or groups at different levels of risk at different points on the developmental trajectory toward death by suicide, offering examples and recommending their strategic, combined application to create an effective, community-level response to the mounting problem of suicide in older adults.

Introducción

El suicidio es siempre una tragedia para el individuo, para su familia y amigos y para las comunidades de las que forma parte. A nivel de población, el suicidio constituye también un importante problema de salud pública, que comporta más de 34.500 muertes al año en Estados Unidos[1] y se estima que un millón o más en todo el mundo[2]. El número más elevado de suicidios es el que se produce en adultos jóvenes y de mediana edad, y las muertes por suicidio de jóvenes y adultos jóvenes son las que captan la mayor parte de la atención de los medios de comunicación. Sin embargo, en este artículo se argumenta que el suicidio a una edad avanzada de la vida debe ser motivo de gran preocupación y justifica que se centre en ello la atención de los investigadores, de los profesionales de la asistencia sanitaria, de los responsables de la toma de decisiones políticas y de la sociedad en general. Reconociendo la complejidad y la naturaleza multietiológica de la conducta suicida en los ancianos, el artículo aporta un marco de referencia para determinar en qué basar su prevención. Se revisa la evidencia existente respecto a los factores que sitúan a los ancianos en un riesgo de suicidio o que les protegen de ello. Sin embargo, considerados individualmente, los factores de riesgo aportan una guía relativamente débil para la aplicación de iniciativas eficaces de prevención del suicidio ya que, a escala individual, su capacidad de predecir qué personas morirán por suicidio es muy baja. Los autores adoptan entonces una perspectiva de salud pública para abordar el suicidio como un proceso de desarrollo cuyos factores de riesgo y de protección contribuyen a definir una trayectoria hacia el mismo a lo largo del tiempo. La traducción de la perspectiva de desarrollo en intervenciones preventivas requiere entonces la identificación de las oportunidades de intervención, los lugares o puntos en los que es más posible detectar a estos ancianos, y las intervenciones aplicadas para modificar sus trayectorias conducentes al suicidio. Por último, los autores introducen el concepto de intervenciones

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de prevención del suicidio dirigidas a individuos o grupos de diferentes niveles de riesgo en diferentes puntos de la trayectoria de desarrollo que lleva a la muerte por suicidio, y ofrecen ejemplos de cada uno de ellos y recomendaciones para su aplicación combinada estratégica, con objeto de crear una respuesta efectiva, a nivel de la sociedad, frente al problema creciente del suicidio en las personas de edad avanzada.

Epidemiología del suicidio a una edad avanzada

En la mayor parte de los países de todo el mundo que proporcionan estadísticas de este tipo a la Organización Mundial de la Salud, las tasas de suicidio tienden a aumentar en función de la edad, tanto en los varones como en las mujeres, hasta alcanzar un máximo a edades muy avanzadas[2]. Sin embargo, existe una gran variabilidad al respecto. En Canadá, por ejemplo, las tasas de suicidio alcanzan un máximo a una edad media de la vida tanto en los varones como en las mujeres, y luego se reducen ligeramente. En los últimos años, en Estados Unidos se ha observado el mismo patrón para la población global. Sin embargo, la figura 1 muestra un cuadro más complejo en el que se presentan las tasas en función de la edad, el sexo y la raza. En las mujeres negras y blancas, las tasas aumentan hasta llegar a la edad media de la vida y luego disminuyen; en los varones negros se producen 2 máximos de riesgo: uno en los adultos jóvenes y otro a una edad avanzada. Resulta más sorprendente la tasa más elevada existente en cada momento de la vida en los varones blancos, que aumenta hasta llegar a un máximo en el grupo de mayor edad, con más de 45 suicidios por 100.000 habitantes al año, que corresponde a más de 4 veces la tasa global, ajustada para la edad, del país, que es de 11,5 suicidios por 100.000 habitantes al año[1].

Hay buenas y malas noticias en lo relativo a las tendencias existentes en cuanto al avance de la edad y el suicidio a lo largo del tiempo en Estados Unidos, en donde, tal como se muestra en la figura 2, la tasa global de suicidios se redujo de forma lenta pero constante de 1985 a 2000, tras lo cual ha empezado a aumentar de nuevo de modo marginal[1]. La disminución se debió en gran parte a una reducción de las tasas existentes en los jóvenes, los adultos jóvenes y las personas de más de 65 años de edad. De hecho, desde 1986 las tasas han venido disminuyendo en los adultos ancianos de Estados Unidos en más del 35%, aun cuando las tasas de suicidio han aumentado en casi un 20% a lo largo de los últimos 8 años en las personas de entre 35 y 64 años. Aunque la reducción constante que se ha observado en las tasas de suicidio entre los adultos de edad avanzada es alentadora, el reciente aumento de las tasas en las personas de mediana edad es motivo de gran preocupación. Las cohortes de nacimiento tienden a tener asociada una propensión al suicidio característica a medida que envejecen. La cohorte del *baby boom*, es decir, la de las personas nacidas entre 1946 y 1964, ha tenido unas tasas de suicidio relativamente más elevadas que las de las cohortes de nacimiento previas o posteriores, para cada edad dada. Además, la vanguardia de la cohorte del *baby boom* alcanzará la edad de 65 años en 2011, y ello impulsará un rápido crecimiento del tamaño total de la población de adultos ancianos en los próximos 20 años. Los demógrafos estiman que, al llegar al año 2030, habrá más de 71 millones de ciudadanos de Estados Unidos de una edad igual o superior a 65 años, es decir, el 20% de la población de Estados Unidos[3]. Así pues, al llegar la cohorte del *baby boom*, que es un grupo con unas tasas de suicidio históricamente altas, a una edad avanzada, que es el periodo de tiempo de máximo riesgo, con esas cifras tan elevadas cabe prever que la tasa de suicidios en los varones y mujeres aumentará de nuevo, con incrementos sustanciales del número absoluto de ciudadanos de edad avanzada que causan su propia muerte.

Factores de riesgo y de protección

Para poder diseñar intervenciones destinadas a reducir la morbimortalidad relacionada con el suicidio, es preciso comprender sus causas. Establecer la causalidad de un desenlace complejo, multietiológico, infrecuente y de nefastas consecuencias como el suicidio es una tarea de enormes proporciones. Sin embargo, la identificación de los factores de riesgo y de protección puede orientar las medidas preventivas. Gran parte de lo que se conoce acerca de los factores que sitúan a los adultos ancianos en un riesgo de suicidio o los protegen frente a él procede del análisis retrospectivo de las características, los antecedentes y las circunstancias de las personas que se causan la muerte a sí mismas, un enfoque al que se denomina método de la autopsia psicológica (AP)[4]. Aunque está sujeto a un sesgo de recuerdo y a otras limitaciones inherentes a la obtención retrospectiva de los datos, el enfoque de AP tiene también ventajas, como el hecho de centrarse en el análisis detallado de las personas que fallecen por suicidio. Continúa sin estar claro de qué forma pueden aplicarse las enseñanzas obtenidas del estudio de los pensamientos e intentos de suicidio a una edad avanzada al conocimiento del proceso que lleva al suicidio completado. La realización de estudios de cohorte longitudinales en las que haya un número de suicidios suficiente para permitir la realización de análisis útiles no es viable, dado que el suicidio es un hecho relativamente infrecuente. Además, incluso en los estudios longitudinales, el intervalo de tiempo transcurrido entre la evaluación más reciente de un individuo y el momento de la muerte, que es un periodo crucial para comprender los desencadenantes más inmediatos de la conducta suicida, tendría que analizarse retrospectivamente. Con el respaldo de los estudios que han puesto de manifiesto la validez del método de AP[5,6], diversos investigadores lo han aplicado a estudios de casos y controles que aportan resultados notablemente uniformes[7-21]. Los resultados indican que determinados factores específicos correspondientes a los dominios de enfermedad psiquiátrica, conexión social del anciano con su familia, amigos y comunidad, enfermedad física y capacidad funcional parecen influir en el riesgo de suicidio. Estos factores actúan a su vez con un telón de fondo constituido por la cultura, la personalidad y el medio neurobiológico del individuo. Los autores examinan brevemente la evidencia existente respecto a cada uno de ellos.

Enfermedad psiquiátrica

De entre todos los factores examinados en los estudios de AP de individuos ancianos, la enfermedad psiquiátrica emerge de manera uniforme como el más prominente. En la tabla 1 se indican las tasas de trastornos psiquiátricos y de consumo de sustancias que se han descrito en muestras de individuos ancianos que fallecen por suicidio según diversos estudios. En la tabla 2 se indican los resultados de los estudios de AP que han incluido un grupo control que permite calcular una *odds ratio* (OR) que refleja la intensidad de la asociación entre trastornos psiquiátricos de eje 1 específicos y suicidio en la segunda mitad de la vida. Las enseñanzas son claras. La enfermedad psiquiátrica está presente en el 71 al 97% de los suicidios, y el trastorno afectivo es la patología más frecuente. Concretamente, la depresión mayor es el trastorno con una asociación más estrecha. Los trastornos psicóticos primarios, incluida la esquizofrenia, la enfermedad esquizoafectiva y el trastorno delirante, así como los trastornos de ansiedad, tienden a estar presentes en menor proporción. La prevalencia de los trastornos de consumo de sustancias fue muy variable en estos estudios, y ello refleja las diferencias existentes en los parámetros de valoración utilizados, las poblaciones examinadas y su contexto sociocultural. Así, por ejemplo, las tasas observadas de consumo de alcohol problemático difieren notablemente entre los países orientales[9] y los occidentales[21].

Tabla 1
Diagnósticos de eje 1 realizados mediante la autopsia psicológica en estudios del suicidio a una edad avanzada

Estudio	Ubicación	Edad	Tamaño muestral (con distribución por sexos si se dispone de ella)	Diagnóstico: porcentaje con						
				Depresión mayor	Otros trastornos del estado de ánimo	Trastorno de consumo de alcohol	Otros trastornos de consumo de sustancias	Psicosis no afectiva	Trastorno de ansiedad	Ningún diagnóstico[a]
Barraclough[7], 1971	West Sussex, Reino Unido	≥ 65	n = 30 (no se presenta la distribución por sexos)	87		3		0	–	13
Beautrais[20], 2002	Nueva Zelanda	≥ 55	n = 31 20 (64,5%) ♂ 11 (35,5%) ♀	86		14		–	–	9
Carney et al.[6], 1994	San Diego, California	≥ 60	n = 49 29 (59,2%) ♂ 20 (40,8%) ♀	54		22		–	–	14
Chiu et al.[9], 2004	Hong Kong	≥ 60	n = 70 32 (45,7%) ♂ 38 (54,3%) ♀	53 46,9% ♂ 57,9% ♀	26 34,4% ♂ 18,4% ♀	3 6,3% ♂ 0% ♀	–	9 9,4% ♂ 7,9% ♀	1 0% ♂ 1,4% ♀	14 12,5% ♂ 15,8% ♀
Clark[10], 1991	Chicago	≥ 65	n = 54	54	11	19		0	2	24
Conwell et al.[11], 1996	Condado de Monroe, Nueva York	55-74	n = 36 28 (77,8%) ♂ 8 (22,2%) ♀	47	17	43	3	6	11	8
		75-92	n = 14 9 (64,3%) ♂ 5 (35,7%) ♀	57	21	27	7	0	0	29
Conwell et al.[21], 2009	Condado de Monroe y Onondaga, Nueva York	50-64	n = 33 23 (69,7%) ♂ 10 (30,3%) ♀	49	39	27	18	9	24	3
		65-99	n = 53 40 (75,5%) ♂ 13 (24,5%) ♀	51	26	9	2	2	9	23
Harwood et al.[12], 2001	Inglaterra central	≥ 60	100	63		5	5	4	–	23
Henriksson et al.[13], 1995	Finlandia	≥ 60	43 34 (54,1%) ♂ 39 (45,9%) ♀	44	21	25		5	9	12
McGirr et al[14]., 2008	Quebec, Canadá	50-59	n = 88 71 (80,5%) ♂ 17 (19,5%) ♀	60		45		–	15	–
		60-69	n = 31 25 (80,6%) ♂ 6 (19,4%) ♀	48		24		–	24	–
		> 70	n = 21 19 (90,5%) ♂ 2 (9,5%) ♀	46		39		–	23	–
Waern et al.[15], 2002	Goteborg, Suecia	≥ 65	n = 85 46 (54,1%) ♂ 39 (45,9%) ♀	46	36	27		8	15	5

Los guiones indican que no se dispone de datos.
[a] Incluye casos con datos insuficientes para realizar un diagnóstico.

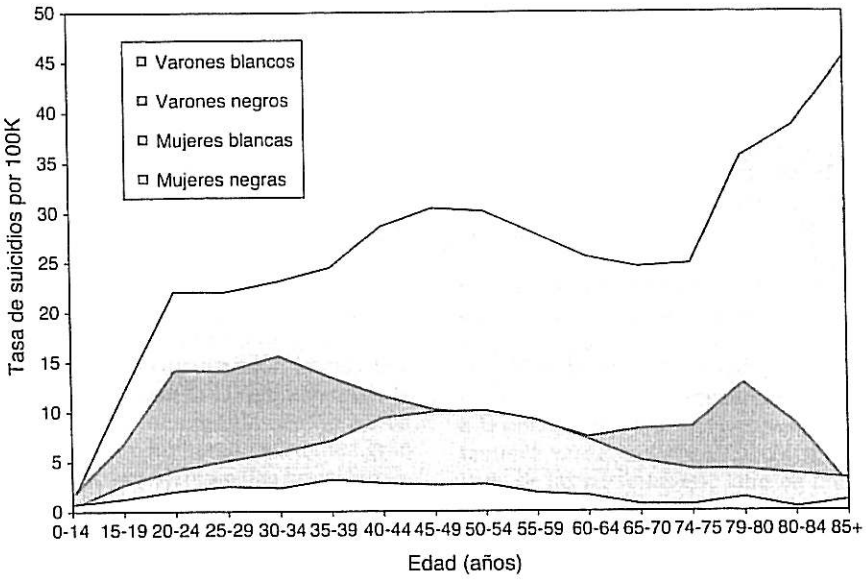

Figura 1. Tasas de suicidios según la edad, la raza y el sexo en Estados Unidos, 2007. (Datos de los *Centers for Disease Control and Prevention*, 2010.)

Tabla 2
Valores de *odds ratios* para el suicidio según el diagnóstico de eje 1 en estudios de autopsia psicológica de casos y controles en ancianos

	Harwood et al.[12], 2001	Beautrais[20], 2002	Waern et al.[15], 2002	Chiu et al.[9], 2004	Conwell et al.[21], 2009
Cualquier diagnóstico de eje I	–	43,9	113,1	50,0	44,6
Cualquier trastorno del estado de ánimo	4,0	184,6	63,1	59,2	47,7
Episodio depresivo mayor	–	–	28,6	36,3	12,2
Trastorno de consumo de sustancias	ns	4,4	43,1	ns	ns
Trastorno de ansiedad	–	–	3,6	ns	5,9
Espectro esquizofrénico	ns	–	10,7	> 1	ns
Demencia/delirium	0,2	–	ns	ns	ns

Los grupos de comparación son los siguientes: Harwood et al. utilizaron ancianos que fallecieron por causas naturales; todos los demás estudios utilizaron controles vivos de la comunidad.
ns: no significativo.

Tal como se indica en la tabla 2, las probabilidades de que un individuo de edad avanzada con algún diagnóstico de eje 1 se suicide son entre 44 y 113 veces mayores que las de los individuos de control de iguales características. Las OR más altas fueron las observadas para los trastornos del estado de ánimo, con valores de OR más bajos y resultados generalmente más variados en los estudios en los que se examinó el abuso y la dependencia de sustancias, la esquizofrenia y los trastornos de ansiedad. Las amplias diferencias existentes entre los estudios en cuanto a la intensidad de las asociaciones observadas puede explicarse también por diferencias metodológicas, entre ellas la forma de elección del grupo control. Por ejemplo, Harwood et al.[12] compararon a los individuos con suicidios completados con controles que fallecieron por causas naturales en el hospital, mientras que en los demás

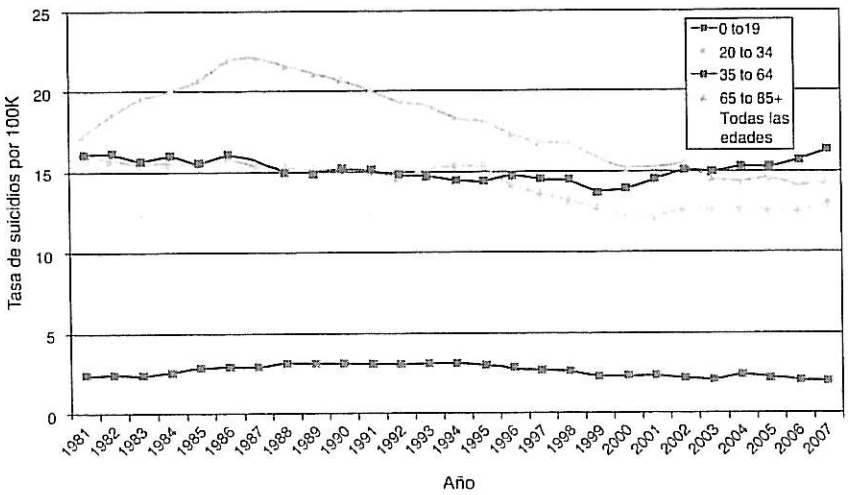

Figura 2. Tasas de suicidios en Estados Unidos por 100.000 habitantes para todas las razas y ambos sexos, 1981-2007. (Datos de los *Centers for Disease Control and Prevention*, 2010.)

estudios mencionados se utilizaron controles vivos de la comunidad. En consecuencia, Harwood et al. observaron, por ejemplo, que el diagnóstico de demencia o de delírium era significativamente menos frecuente en los suicidas que en los controles, una observación que va en contra de lo intuitivo y que no se hizo en los demás estudios; es probable que se explique por las tasas elevadas de trastornos cognitivos y estados confusionales existentes en los individuos ancianos hospitalizados y con enfermedades terminales. El método de AP puede ser poco apropiado para el estudio de la demencia y el delírium, cuyos signos y síntomas, en especial en la fase inicial del curso de la enfermedad —que es cuando el paciente puede tener un riesgo comparativamente superior[22,23]—, es menos probable que sean apreciados en un contexto ambulatorio por los familiares u otros informadores indirectos. Otros datos biológicos[24] y epidemiológicos[22] aportan una evidencia cuando menos preliminar respecto a que también la demencia se asocia a un aumento del riesgo de suicidio en los adultos de edad avanzada.

Salud física y capacidad funcional

Además de la enfermedad psiquiátrica, la enfermedad física y el deterioro funcional contribuyen también al riesgo de suicidio a una edad avanzada. Sin embargo, dado que las tasas generales de enfermedad física y discapacidad son altas en esa población, la utilidad de estos factores para identificar a los individuos ancianos en los que está justificada una intervención es limitada. Por ejemplo, los estudios de vinculación de registros han observado de manera uniforme que los individuos con enfermedades malignas (aparte de los cánceres de piel comunes) tienen un riesgo de suicidio aproximadamente 2 veces superior al de las personas sin estos trastornos[25]. En algunos estudios se ha observado también que otros diversos trastornos —como la infección por el virus de la inmunodeficiencia humana (VIH)/síndrome de inmunodeficiencia adquirida (sida), la epilepsia, la enfermedad de Huntington y la esclerosis múltiple, la nefropatía y la enfermedad ulcerosa péptica, las cardiopatías y las neumopatías, las lesiones de la médula espinal y el lupus eritematoso sistémico— se asocian a un aumento del riesgo de suicidio[25-27]. Los riesgos relativos de suicidio asociados a estos trastornos son entre 1,4 y 4 veces mayores.

Aunque el riesgo relativo de suicidio asociado a cualquier trastorno concreto puede ser bajo, a medida que aumenta el número de trastornos agudos y crónicos que presenta un individuo se incrementa también su riesgo acumulativo. Juurlink et al.[26] vincularon los registros de prescripción de todos los residentes en Ontario (Canadá) de edad igual o superior a 65 años con los informes de suicidios de los forenses de la provincia, en un análisis de casos y controles. Estos autores observaron que los pacientes con 3 enfermedades físicas presentaban un aumento de aproximadamente 3 veces del riesgo relativo estimado de suicidio, en comparación con los sujetos en los que no había ningún diagnóstico, mientras que los ancianos que tenían 7 enfermedades o más tenían un riesgo de suicidio aproximadamente 9 veces superior.

Más allá del número en sí de enfermedades físicas, es probable que el significado percibido de estas enfermedades, sus repercusiones en la función, el dolor y las amenazas percibidas para la autonomía y la integridad personal desempeñen también un papel fundamental. Por ejemplo, en una comparación de casos y controles de los suicidios en individuos de edad superior a 50 años con controles vivos igualados en cuanto a sus características demográficas, el grupo de los autores observó en los análisis multivariados que la presencia de algún deterioro en las actividades instrumentales de la vida diaria mostraba una asociación significativa con el carácter de caso de suicidio, independientemente de los efectos sobre los diagnósticos de trastornos de la salud física o mental[21]. En otra publicación, los autores han señalado que los individuos ancianos que se suicidaban comunicaban con frecuencia a otros la creencia de padecer un cáncer que luego la autopsia no confirmaba. Sin embargo, no había ningún otro indicio de trastorno del pensamiento ni de deterioro cognitivo[28]. Es posible que, en última instancia, el estado de salud percibido resulte ser un factor de mayor importancia respecto al suicidio a una edad avanzada y su prevención que las medidas objetivas, tal como se ha observado también en cuanto a la asociación con las muertes de causa natural y la mortalidad por todas las causas[29].

Aunque la investigación en la que se han examinado las asociaciones entre dolor y suicidio en los adultos de edad avanzada es relativamente escasa, varios estudios han sugerido que puede tratarse de una cuestión de especial importancia en los varones ancianos. Juurlink et al.[26], por ejemplo, señalaron que la asociación entre el dolor intenso y el suicidio fue también más intensa en los varones (OR = 9,9) que en las mujeres (OR = 3,3). De igual modo, Sirey et al.[30] observaron una asociación más intensa entre los pensamientos suicidas y el dolor crónico en los varones ancianos que recibían comidas llevadas a domicilio en comparación con las mujeres, y en su reciente análisis de ancianos con asistencia domiciliaria, Li y Conwell[31] observaron que los varones con dolor intenso y no controlado tenían un riesgo especialmente elevado de pensamientos autolesivos, mientras que no se observó tal asociación en las mujeres.

Los déficits cognitivos a una edad avanzada se han relacionado también con el suicidio. Dombrovski et al.[32], por ejemplo, han descrito que los ancianos con depresiones y tendencias suicidas mostraron peores resultados en las medidas de la función ejecutiva frontal y en los tests de memoria y de atención que los ancianos con depresión pero sin tendencias suicidas. La función ejecutiva frontal puede ser de especial relevancia en cuanto a la conducta suicida en los ancianos, dado su papel en el control efectivo de las circunstancias estresantes. Keilp et al.[33] observaron que los adultos en los que había intentos de suicidio obtenían un mal resultado en los tests ejecutivos frontales en comparación con los controles, y King et al.[34] realizaron una observación similar en individuos de edad avanzada con intentos de suicidio. Los mecanismos cognitivos que subyacen en las relaciones entre control cognitivo, resolución de problemas y conducta suicida continúan sin estar claros. Dombrovski et al.[35] examinaron los componentes más específicos de la toma de decisión para determinar su asociación con la conducta suicida a una edad avanzada, centrándose en especial en el aprendizaje basado en recompensa/castigo, cuyas anomalías se han relacionado con la patología de los circuitos prefrontales ventrales. Su observación de déficits en los individuos con depresión e intentos de suicidio respalda el concepto de que la conducta suicida en una fase avanzada de la vida se asocia en algunos casos a un deterioro de la toma de decisiones como consecuencia de un deterioro de la capacidad de acceso a la experiencia previa y uso de la misma, que a su vez puede estar relacionada con la patología prefrontal ventral subyacente asociada a la edad[36]. Otros estudios respaldan la existencia de una relación entre la conducta suicida en los ancianos y la patología cerebral. Por ejemplo, Ahearn et al.[37] señalaron que los ancianos con depresión que tenían antecedentes de intentos de suicidio a lo largo de la vida presentaban hiperintensidades en la sustancia gris subcortical significativamente mayores en la resonancia magnética, en comparación con los individuos con depresión cuidadosamente igualados en cuanto a sus características pero que no tenían antecedentes previos de intentos de suicidio, lo cual respalda la hipótesis de que la enfermedad vascular subyacente puede predisponer a una enfermedad depresiva y a la conducta suicida a una edad avanzada de la vida[38].

Factores sociales

Los estudios de AP ponen de relieve de manera clara y uniforme el papel que desempeñan los factores sociales en la patogenia —y

por tanto en la prevención— del suicidio también en los ancianos. Dos grandes categorías de este dominio merecen especial atención: los acontecimientos vitales estresantes como factores predisponentes y la conexión social como amortiguador que sirve para reducir el riesgo de suicidio.

Parece claro que los acontecimientos vitales estresantes que preceden a la muerte por suicidio tienden a ser más numerosos y graves en los suicidas que en los controles. Los acontecimientos más relevantes en relación con el suicidio a una edad avanzada son los asociados al envejecimiento (amenazas asociadas a la mala salud y al deterioro funcional como se ha señalado antes, pérdidas a través del duelo o ruptura de las relaciones con la familia y otras fuentes de apoyo). Los problemas de relación y económicos graves diferenciaron a los ancianos suicidas o con intentos de suicidio casi mortales de los controles en Nueva Zelanda[20], y estos resultados fueron reproducidos por Rubenowitz et al.[16] en Suecia. El grupo de los autores ha descrito también que los desacuerdos familiares y el cambio de empleo diferenciaron a los suicidas de los controles en individuos de más de 50 años, incluso después de introducir un ajuste respecto a las características sociodemográficas y los trastornos mentales[18].

Desde un punto de vista tanto teórico como empírico, el constructo de la conexión social puede ser especialmente importante para comprender el suicidio en la fase avanzada de la vida y su prevención. De hecho, los *Centers for Disease Control* han identificado como estrategia clave para la prevención de la conducta suicida en todas las edades «el fomento y refuerzo de las conexiones a nivel personal, familiar y comunitario»[39]. Holt-Lunstad et al.[40], en una revisión metaanalítica de 148 estudios para determinar el grado en que las relaciones sociales influyen en el riesgo de mortalidad, observaron que, globalmente, había un aumento del 50% de la probabilidad de supervivencia en los participantes que tenían relaciones sociales más intensas. Además, estos autores observaron que la influencia de la conexión social sobre el riesgo de muerte es comparable o mayor que la asociada a factores de riesgo claramente establecidos, como el tabaquismo, la obesidad y la inactividad física. Los autores descartaron los estudios en los que se incluyó el suicidio como causa de la muerte; sin embargo, hay otras evidencias que respaldan claramente también esta asociación. Los estudios de AP han puesto de manifiesto que los ancianos que se suicidan tienen una probabilidad significantemente inferior de disponer de un confidente[41], es más probable que vivan solos en comparación con los demás ancianos de la comunidad[7], y es menos probable que participen en actividades comunitarias[19], sean miembros activos de organizaciones o tengan una afición[16]. Además, Turvey et al.[42], en análisis de datos de un estudio de cohorte prospectivo, observaron que el hecho de tener un mayor número de amigos y familiares que puedan actuar como confidentes se asocia a una reducción significativa del riesgo de suicidio en los ancianos.

La teoría interpersonal del suicidio[43] proporciona una forma de comprender la relación de la conexión social con el suicidio. Esta teoría propone que existen 2 causas proximales del deseo de suicidarse (la frustración de la pertenencia y la percepción de ser una carga) y que se produce un nivel especialmente peligroso de deseo de suicidio con la presencia simultánea de ambos factores. En presencia de una capacidad adquirida de suicidio (p. ej., experiencia previa respecto al dolor o modelos cognitivos bien desarrollados sobre la propia muerte), estos estados psicológicos dolorosos pueden ser letales. El constructo de la frustración de la pertenencia deriva de la necesidad fundamental de conexión propuesta por Baumeister y Leary[44] como «necesidad de pertenecer», que se refleja en los índices de aislamiento social que se han relacionado empíricamente con el suicidio a una edad avanzada, como vivir solo, perder al cónyuge, sentimiento de soledad o bajo apoyo social. La percepción de ser una carga es un constructo que se ha explorado de manera menos completa en la investigación, pero es algo que están acostumbrados a oír los clínicos que trabajan con ancianos que perciben que están en riesgo. La teoría propone que tanto el desacuerdo familiar como el deterioro funcional se asocian al suicidio en una fase avanzada de la vida, ya que es probable que ambos factores generen percepciones de ser una carga para los demás. En cambio, las conexiones con otras personas y con la comunidad pueden ser útiles para proteger a la persona anciana frente a la aparición del deseo suicida ante las circunstancias de la vida causantes de estrés. Sin embargo, según esta teoría, tan solo las conexiones que contribuyen a satisfacer la necesidad de pertenencia de los individuos (conexiones que crean interacciones positivas y sensaciones de ser atendidos) tendrán efectos protectores. Así pues, las relaciones caracterizadas por la percepción de ser una carga o por otras formas de desacuerdo interpersonal no protegerán frente al suicidio. La espiritualidad y la religiosidad se han citado a menudo como factores protectores frente a la aparición de la depresión y las tendencias suicidas[19,45], relación esta que podría entenderse como dependiente de la conexión a nivel espiritual o instrumental (p. ej., apoyo prestado a un anciano aislado por su comunidad de fe.) De igual modo, las diferencias existentes en el riesgo de suicidio en función del sexo y de la raza/origen étnico en los individuos ancianos podrían explicarse, en parte, por los lazos de apoyo de otros más intensos que son capaces de establecer las mujeres y algunas minorías en comparación con los varones y los grupos raciales blancos en general[46]. La teoría interpersonal propone que los factores de riesgo para el suicidio, incluida la enfermedad psiquiátrica, elevan el riesgo de suicidio al causar o exacerbar la frustración de la pertenencia, la percepción de ser una carga y/o la capacidad adquirida. La investigación futura deberá examinar de forma empírica esta hipótesis.

Otros factores

Los factores de riesgo en los dominios psiquiátrico, físico-funcional y social actúan mediante interacciones complejas frente a un trasfondo con matices que dependen de la propia cultura, de los rasgos de la personalidad e incluso de la constitución neurobiológica. Se ha caracterizado a los ancianos suicidas como individuos tímidos y recluidos[47], y como personas hostiles, rígidas y con un estilo de vida independiente[47,48]. Con el empleo de medidas estandarizadas y una metodología de AP de casos y controles se observó que los rasgos anancásticos (obsesivos) y ansiosos diferenciaban de manera significativa a los suicidas de los ancianos de control con una muerte de causa natural en un estudio[12], mientras que en otro, los rasgos de la personalidad del test *Big-Five* correspondientes a «apertura a la experiencia» (AAE) baja y neuroticismo alto[49] diferenciaron a estos grupos[50]. La AAE baja se asocia a respuestas hedónicas y afectivas mudas, una amplitud de intereses limitada y una intensa preferencia por lo que resulta familiar frente a lo novedoso. Duberstein[51] planteó la hipótesis de que los ancianos con un nivel bajo de AAE tienen un riesgo de suicidio porque no están tan bien equipados social y psicológicamente para abordar los retos que supone el envejecimiento, y es menos probable que se detecte que están en una situación de dificultad y necesidad de intervención, lo cual es otra manifestación de la baja conexión social.

Se han publicado numerosas descripciones de asociaciones entre la conducta suicida y diversos parámetros neurobiológicos en estudios de muestras de adultos de diversas edades o de adultos jóvenes[52]. Estos datos plantean la atractiva posibilidad de que anomalías de procesos del sistema nervioso central de base genética predispongan a los individuos a actuar de manera impulsiva y agresiva ante la disforia, la desesperanza y la aparición de pensamientos suicidas en el estado de depresión. Además, sugieren la posibilidad de que los cambios asociados a la edad en estos sistemas puedan explicar en mayor medida el aumento de las tasas de suicidio en una fase posterior de la vida, en especial si se demostrara que esas

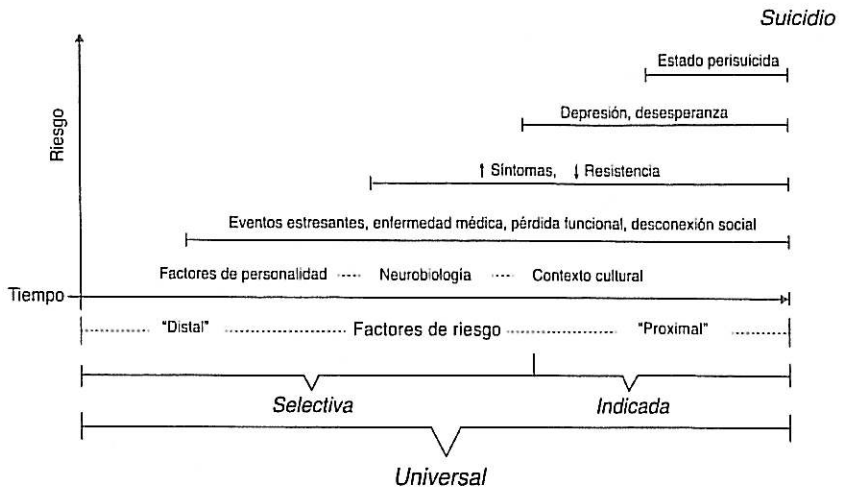

Figura 3. Modelo de desarrollo del suicidio en fase avanzada de la vida.

diferencias son más pronunciadas en los varones que en las mujeres. Sin embargo, son pocos los estudios que han examinado los sistemas neurobiológicos en ancianos que se suicidan, dado que las altas tasas de uso de medicación y de comorbilidad médica existentes en los ancianos que se suicidan o intentan hacerlo complican la interpretación de los resultados de estos estudios. Serán necesarias nuevas investigaciones sobre el papel que desempeñan los factores neurobiológicos en el suicidio en una fase avanzada de la vida, al igual que respecto a los factores de otros dominios, y lo que tal vez sea más importante: su interacción en la determinación del riesgo.

Trayectorias de desarrollo

El conocimiento de los factores que aumentan o reducen el riesgo de suicidio en los ancianos es necesario pero no suficiente para un diseño efectivo de intervenciones preventivas. Resulta insuficiente porque los factores son muy ineficientes, tanto de forma individual como de forma combinada, para predecir los resultados en un determinado individuo. El elevado número de resultados falsamente positivos obtenidos con su uso generalizado conduciría a intervenciones innecesarias, intrusivas y costosas en personas que no las necesitan, mientras que los muchos resultados falsamente negativos dejarían a ancianos en riesgo sin detectar ni proteger. Las limitaciones que tienen los factores de riesgo y los factores de protección como instrumentos para predecir y prevenir el suicidio están relacionadas en parte con el hecho de que los estados de riesgo son dinámicos: oscilan en periodos de tiempo breves. Así pues, el suicidio puede entenderse mejor como un proceso de desarrollo que evoluciona a lo largo de periodos de tiempo más prolongados. En la figura 3 se intenta capturar ese proceso y relacionarlo con un marco de referencia de la salud pública para la prevención. El eje x corresponde a la dimensión temporal. Sobre una base constituida por las características de la personalidad, los factores neurobiológicos individuales y el contexto cultural, cada individuo anciano hace frente a episodios causantes de estrés. En la lucha frente a las enfermedades médicas agudas y crónicas y frente al deterioro funcional, algunos individuos experimentan una desconexión social. El riesgo relativo aumenta en los individuos con menos resistencia y que desarrollan síntomas iniciales de enfermedad psiquiátrica. Algunos desarrollan una depresión y desesperanza manifiestas, y los más vulnerables de ellos entran en un estado perisuicida. Los riesgos se van incrementando con el tiempo, como consecuencia de la acumulación de factores de riesgo progresivamente más proximales o de una pérdida de los amortiguadores protectores. Los individuos con pensamientos activos y capacidad de quitarse la vida llevan a cabo su deseo suicida y muchos de ellos mueren.

El concepto de que los procesos suicidas se despliegan a lo largo del tiempo tiene consecuencias importantes para la prevención. Aunque, por un lado, esto comporta un nivel de complejidad de enormes proporciones, también indica oportunidades de intervenir en múltiples puntos y de muy diferentes formas. Los autores centran ahora su atención en considerar esas oportunidades de intervención.

Enfoques de prevención

Un modelo médico o un enfoque basados en el alto riesgo para prevenir el suicidio tenderían a centrarse en la parte final del proceso de desarrollo, a la derecha del diagrama de la figura 3, que es cuando loa ancianos tienen un mayor riesgo. Un enfoque de salud pública vería oportunidades en la intervención preventiva en todo el proceso continuo. De hecho, propondría que las intervenciones dirigidas a factores y etapas más distales e intermedias del proceso podrían salvar más vidas que las centradas únicamente en los individuos de mayor riesgo[53,54]. Esta premisa puede ser más directamente aplicable a los adultos ancianos que a los grupos de menor edad, ya que la conducta suicida en los ancianos es mucho más letal. Los estudios realizados estiman que se producen intentos de suicidio en hasta 200 adultos jóvenes por cada persona que llega a quitarse la vida[55]. En los ancianos, los intentos son mucho menos frecuentes y la proporción es tal vez de 4 intentos por cada suicidio completado[56]. Sea por el mayor aislamiento de los ancianos y las menores posibilidades de rescate, la mayor fragilidad y por tanto la probabilidad de muerte como consecuencia de cualquier lesión autoinfligida, o bien por la tendencia de la población anciana a utilizar métodos más letales de forma inmediata y con una mayor planificación y determinación[57], las consecuencias de ello son claras. Las intervenciones destinadas a prevenir la aparición del estado suicida son de especial trascendencia en este grupo de edad.

El *Institute of Medicine* ha recomendado el uso de una terminología que describe las intervenciones preventivas a 3 niveles: indicadas, selectivas y universales[58]. En la tabla 3 se presentan definiciones y ejemplos de cada una de ellas.

Las intervenciones preventivas indicadas son las que van dirigidas a individuos que tienen síntomas detectables y otros factores de riesgo proximales para el suicidio. Su objetivo es habitualmente diagnosticar y tratar el trastorno psiquiátrico para prevenir la manifestación de la conducta suicida. Los lugares en los que suelen aplicarse las intervenciones preventivas indicadas son los

Tabla 3
El lenguaje de la ciencia de la prevención aplicado al suicidio a una edad avanzada

Prevención Enfoque	Destinatarios	Objetivos	Ejemplos de posibles medidas de prevención	Lugares de aplicación Destinatarios
Prevención indicada	Individuos con síntomas detectables u otros factores de riesgo proximales para el suicidio	Tratar a los individuos con signos y síntomas precursores con objeto de prevenir el desarrollo del trastorno o la expresión de la conducta suicida	Formar a los profesionales de la asistencia inicial en el reconocimiento de la depresión y las tendencias suicidas Vincular los servicios de asistencia inicial y de alcance a los servicios globales de evaluación y salud en un abanico continuo de asistencia Aplicar estrategias para proporcionar una asistencia de salud mental más accesible, aceptable y asequible a los ancianos Aumentar los exámenes de detección/tratamientos en el contexto de atención primaria para los ancianos con depresión, ansiedad o uso inadecuado de sustancias	Asistencia de salud mental Atención médica primaria y de especialidad Servicios de urgencias
Prevención de selección	Individuos o grupos asintomáticos o presintomáticos con factores de riesgo distales para el suicidio o que tienen un riesgo superior al medio de desarrollar trastornos mentales debido a la presencia de factores de riesgo más distales	Prevenir la morbilidad y la mortalidad asociadas al suicidio abordando características específicas que sitúan a los ancianos en riesgo	Fomentar los programas comunitarios y de iglesias para el contacto y apoyo a los ancianos aislados Orientar los servicios médicos y sociales a reducir la discapacidad y potenciar la función independiente Aumentar el acceso a la asistencia domiciliaria y los servicios de rehabilitación Mejorar el acceso al tratamiento del dolor y los servicios de cuidados paliativos	Servicios de rehabilitación y asistencia a largo plazo Clínicas del dolor Farmacias Asistencia domiciliaria Servicios sociales de la comunidad Comunidades de fe
Prevención universal	Toda la población, no identificada en función del riesgo individual	Aplicación de iniciativas de amplia difusión para la prevención de la morbilidad y la mortalidad asociadas al suicidio mediante la reducción de factores de riesgo y la potenciación de factores protectores	Educación sanitaria del público general, el clero, los medios de comunicación y los profesionales de la salud respecto al envejecimiento normal, la edad avanzada y los estigmas asociados a la enfermedad mental, el tratamiento del dolor y la discapacidad, la depresión y las conductas suicidas Limitar el acceso a medios letales como las armas de fuego	Medios de comunicación Legislación Decisiones políticas

Tabla elaborada en colaboración con Kerry Knox, PhD, y Eric D. Caine, MD.

contextos de atención primaria y de salud mental. Sin embargo, dado que los ancianos son reacios a solicitar asistencia en centros ambulatorios o consultas de salud mental, es probable que las intervenciones aplicadas en el ámbito de la atención primaria sean más eficaces[59].

El diagnóstico y tratamiento efectivos de la depresión son los ejemplos citados con mayor frecuencia de intervenciones preventivas indicadas, dada la estrecha asociación existente entre la enfermedad afectiva y el suicidio en los individuos ancianos. Hay varias líneas de evidencia que refuerzan la importancia de este enfoque. En 2009, Stone et al.[60] publicaron un análisis de datos privados presentados a la *Food and Drug Administration* (FDA) de Estados Unidos correspondientes a 372 ensayos aleatorizados, doble ciego y controlados con placebo de fármacos antidepresivos en individuos adultos. El análisis se llevó a cabo por la preocupación existente respecto a la posibilidad de que la administración de un antidepresivo pudiera intensificar, de hecho, el riesgo de suicidio en algunos pacientes. Estos autores observaron que el riesgo relativo de pensamientos o de conducta suicidas aparecidos durante el tratamiento antidepresivo era, ciertamente, elevado en los individuos de menos de 25 años, no difería del existente con placebo en los de 25 a 64 años, y se reducía significativamente en los de más de 65 años tratados con medicación antidepresiva.

Sin embargo, es frecuente que la enfermedad afectiva no sea detectada y que sea tratada de manera insuficiente en el contexto de atención primaria. En consecuencia, 2 grupos llevaron a cabo ensayos aleatorizados en los que se estudió a pacientes de atención primaria de edad avanzada a los que se asignó aleatoriamente la asistencia habitual o una intervención multidisciplinaria escalonada en la que intervenían expertos en salud mental, formación médica y educación sanitaria del paciente/la familia sobre la depresión, uso de algoritmos de tratamiento e instrumentos de apoyo a la toma de decisiones[61,62]. Aunque había diferencias en los detalles de cada intervención (p. ej., los antidepresivos y las intervenciones psicosociales proporcionados), ambos estudios mostraron reducciones significativamente superiores de los síntomas depresivos y los pensamientos suicidas en los ancianos con depresión del grupo de intervenciones experimentales[63,64]. Sin embargo, dadas las limitaciones del tamaño muestral, ninguno de los dos ensayos pudo evaluar la efectividad de la intervención respecto a la conducta suicida, y los porcentajes relativamente elevados de mujeres incluidas dejan abierta la cuestión de cuál es su grado de eficacia para reducir los intentos de suicidio y los suicidios completados en los individuos de máximo riesgo a una edad avanzada, que son los varones.

Las intervenciones preventivas selectivas van dirigidas a individuos o grupos asintomáticos o presintomáticos con más factores de riesgo distales, tal como se indica en la parte media e izquierda de la figura 3. Puede tratarse, por ejemplo, de individuos ancianos con trastornos crónicos, dolorosos y causantes de limitaciones funcionales, o de personas que han quedado socialmente aisladas

o que se perciben a sí mismas como una carga para los demás. Los lugares en los que podrían aplicarse de manera más efectiva y eficiente las intervenciones preventivas selectivas en individuos ancianos son, pues, más amplios que los de las intervenciones indicadas. Podrían utilizarse, por ejemplo, en el domicilio de las personas ancianas al que acuden una enfermera visitadora, un servicio de ayuda domiciliaria o la entrega de comidas a domicilio, o en los organismos que prestan servicios sociales a la comunidad. Los ejemplos de intervenciones preventivas selectivas orientadas al suicidio son muy escasos, aunque los autores proponen que los ensayos diseñados para prevenir la depresión incidente en los ancianos con un riesgo elevado del trastorno alcanzarían el mismo fin. El servicio Telehelp/Telecheck descrito por DeLeo et al.[65] constituye un ejemplo poco común de prevención selectiva en la que el resultado abordado fueron los suicidios completados en individuos ancianos. El servicio Telehelp/Telecheck, aplicado en Padua (Italia), proporcionaba acceso telefónico y servicios de evaluación y apoyo a más de 18.000 ancianos de una media de edad de 80 años. Más del 84% eran mujeres. Durante los 11 años de funcionamiento del servicio hubo en los clientes un número de suicidios significativamente inferior al esperado en la población anciana de esa región. En análisis más detallados se observó que el efecto solamente era significativo en las mujeres, debido posiblemente al bajo número de varones incluidos en el programa y/o a que estos eran reacios a aceptar intervenciones de alcance social de esta naturaleza.

Por último, las intervenciones preventivas universales van destinadas al conjunto de la población, con independencia de la situación de riesgo de cada individuo o grupo. Por consiguiente, los lugares de aplicación de la prevención universal son los que permiten una amplia difusión de mensajes de salud pública, o el empleo de foros de política legislativa para modificar los niveles de exposición en toda la población.

Aunque no existen ensayos controlados y aleatorizados de la prevención universal del suicidio, los estudios ecológicos y los experimentos naturales aportan un cierto respaldo a su eficacia en la fase avanzada de la vida. Hawton et al.[66] describieron que, tras la aplicación de la legislación que limitaba el tamaño de los envases de paracetamol y salicilatos de venta sin receta en el Reino Unido, la morbilidad y la mortalidad por sobredosis de estas medicaciones se redujeron significativamente. Otro ejemplo, en Estados Unidos, es el de la aprobación de la ley *Brady Handgun Violence Prevention Act* en 1994. Ludwig y Cooke[67] observaron que, en los años siguientes a la aplicación de esta ley, hubo una reducción de los suicidios con pistolas significativamente mayor en las personas de más de 55 años en los estados que empezaron a aplicar nuevas verificaciones básicas y periodos de espera para la adquisición de armas de fuego, en comparación con los estados en los que no fueron necesarios cambios en los procedimientos.

Dado que los métodos de prevención universales, selectivos e indicados van dirigidos al proceso suicida a niveles diferentes, es probable que el programa de prevención más eficaz para el suicidio a una edad avanzada sea el que incorpore elementos de todos ellos. El mejor ejemplo de un programa de prevención con la inclusión de múltiples aspectos del que tienen noticia los autores es el de una serie de 5 estudios casi-experimentales combinados en un metaanálisis por Oyama et al.[68]. Aunque los detalles diferían en cierta medida en los distintos estudios, cada uno se realizó en una región rural distinta de Japón con una tasa elevada de suicidios en los individuos ancianos (> 160 suicidios por 100.000 habitantes). Las intervenciones, aplicadas a lo largo de periodos de 5 a 10 años, consistieron en un examen sistemático de cribado a nivel de la comunidad, la derivación a atención primaria o de salud mental según estuviera indicado y, en diversos grados, programas de educación sanitaria y de socialización para individuos ancianos. Los autores examinaron los cambios del riesgo relativo o los cocientes de riesgo de incidencia correspondientes al suicidio en los ancianos antes y después de la aplicación del programa y en comparación con regiones de referencia próximas de un tamaño y características similares. En general, el riesgo se redujo significativamente en los varones y las mujeres cuando el seguimiento fue realizado por un psiquiatra, pero solamente en las mujeres cuando el seguimiento lo realizaban médicos generales. Nuevamente, los varones ancianos fueron comparativamente más resistentes a los efectos de la intervención preventiva.

Conclusión

Los rápidos aumentos que se prevén en el tamaño de la población de individuos ancianos, impulsados por el envejecimiento de la cohorte de población del *baby boom* que ha tenido durante toda su vida una propensión al suicidio superior a la de cohortes de nacimiento anteriores y posteriores, requiere una atención urgente y la asignación de recursos para el desarrollo y estudio de métodos destinados a la prevención del suicidio que sean especialmente adecuados para los ancianos. Los modelos sobre la forma en que actúan estos factores de manera variable y a través de interacciones complejas a lo largo del tiempo, situando a los ancianos vulnerables en riesgo, informados por el conocimiento de los factores de riesgo y de protección, son la base de esta labor.

La importancia de la depresión como factor patogénico en el suicidio de la fase avanzada de la vida hace que su detección y su tratamiento eficaz sean de capital importancia. La asistencia multidisciplinaria prestada por profesionales de atención primaria que cuentan con el apoyo de expertos de salud mental ha producido resultados prometedores como intervención preventiva indicada, si bien su efecto en la reducción del suicidio en los varones ancianos está aún por determinar. Los resultados del metaanálisis de Oyama plantean nuevas dudas sobre si la intervención de atención primaria por sí sola será suficiente, al menos en los varones ancianos, que son con mucho el grupo de mayor riesgo en Estados Unidos. La incorporación de métodos de prevención selectivos adicionales, destinados a los adultos de una amplia variedad de contextos de la comunidad, deberá desarrollarse en mayor medida y deberá evaluarse como componente de todo plan de prevención de suicidios global en los ancianos en la comunidad, haciendo especial hincapié en el mantenimiento de la conexión con las familias, amigos y comunidades. Por último, deben considerarse los métodos de prevención universal, como la limitación del acceso a medios muy letales en los ancianos en riesgo y los cambios de actitudes y sesgos que les hacen ser reacios a acudir a una asistencia de salud mental accesible y eficaz.

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Aspectos clínico-epidemiológicos del suicidio consumado en pacientes con esquizofrenia

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El suicidio es una de las principales causas de muerte entre los pacientes con esquizofrenia, siendo la caracterización del fenómeno del suicidio la mejor aproximación que puede realizarse para predecir y prevenir el acto suicida. Los pacientes identificados como de alto riesgo precisan una monitorización y una intervención más intensivas. El objetivo de esta revisión es caracterizar desde el punto de vista clínico-epidemiológico el fenómeno del suicidio consumado en la esquizofrenia. Presentamos una revisión sistemática de los estudios más relevantes publicados entre 1994 y 2009, identificados mediante una búsqueda en la base de datos internacional Medline y en las referencias bibliográficas de las revisiones previas.

Las tasas de mortalidad en la esquizofrenia son más elevadas que en la población general, especialmente debido al suicidio. Los sujetos que se suicidan son principalmente varones y jóvenes, con un riesgo mayor al inicio de la enfermedad y en torno a la hospitalización. Los intentos autolíticos previos son un importante factor de riesgo. El riesgo de suicidio también se asocia a síntomas psicóticos positivos, síntomas afectivos, depresión y abuso de sustancias. Un adecuado cumplimiento terapéutico actúa como factor protector. El método de suicidio utilizado es frecuentemente violento.

La prevención del suicidio debería centrarse en el abordaje de los síntomas y síndromes afectivos, en la mejora de la adherencia al tratamiento y en la vigilancia intensiva de los pacientes con más factores de riesgo, especialmente en torno a los ingresos hospitalarios. Se recomienda proseguir el estudio específico del suicidio consumado por sus características diferenciales con otras conductas suicidas.

Palabras clave: Esquizofrenia, Suicidio, Mortalidad, Causas, Factores de riesgo

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Clinical and epidemiological aspects of suicide in patients with schizophrenia

Suicide is a major cause of death among patients with schizophrenia. Suicide phenomenon's characterization is the best available approach for improved prediction and prevention of suicide. Patients at high risk for suicide need a more intensive monitoring and intervention. The aim of this review is to characterize, from a clinical-epidemiological point of view, the phenomenon of completed suicide in schizophrenia. We performed a systematic review to identify the most relevant studies published between 1994 and 2009, by searching on the international database Medline and among previous reviews' references.

Patients with schizophrenia experience higher mortality rates than the general population, especially due to the suicide. Most patients with schizophrenia who commit suicide are likely to be young and males, with a higher risk around illness onset and hospitalization periods. Previous suicide attempts are an important risk factor for completed suicide. Suicide risk is associated to psychotic positive symptoms, affective symptoms, depression and substance abuse. Treatment adherence is as protective factor. Patients with schizophrenia are likely to commit suicide by violent means.

Suicide prevention should focus on treating affective symptoms and syndromes, improving treatment compliance and providing intensive monitoring to those patients at high risk of suicide, specially aroung hospitalization periods. Further studies are needed to clarify differential characteristics between suicide behaviour and completed suicide.

Key words: Schizophrenia, Suicide, Mortality, Causes, Risk factors

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INTRODUCCIÓN

La población con patología psiquiátrica constituye un grupo de elevado riesgo de suicidio y el exceso de mortalidad por este tipo de muerte no natural adquiere especial relevancia en una patología como la esquizofrenia, asociada a una disminución en la esperanza de vida[1]. Hawton encontró un riesgo 30-40 veces mayor de suicidio en pacientes con esquizofrenia que en población general, señalando que un 4-10% se suicidan[2].

A pesar de ello, mientras que las conductas suicidas son un aspecto bien estudiado en esquizofrenia, existe un número mucho menor de estudios sobre el fenómeno de suicidio consumado. La caracterización de este fenómeno tiene implicaciones en la predicción y prevención del suicidio, ya que permite una mejor evaluación y manejo del riesgo y del comportamiento suicida, lo que se traduciría en una reducción de las tasas de suicidio en la esquizofrenia.

Considerando que la conducta suicida y el suicidio consumado son fenómenos íntimamente relacionados pero diferenciados, presentamos una revisión de la bibliografía publicada entre los años 1994 y 2009 sobre las características epidemiológicas y clínicas del suicidio consumado en pacientes con diagnóstico de esquizofrenia.

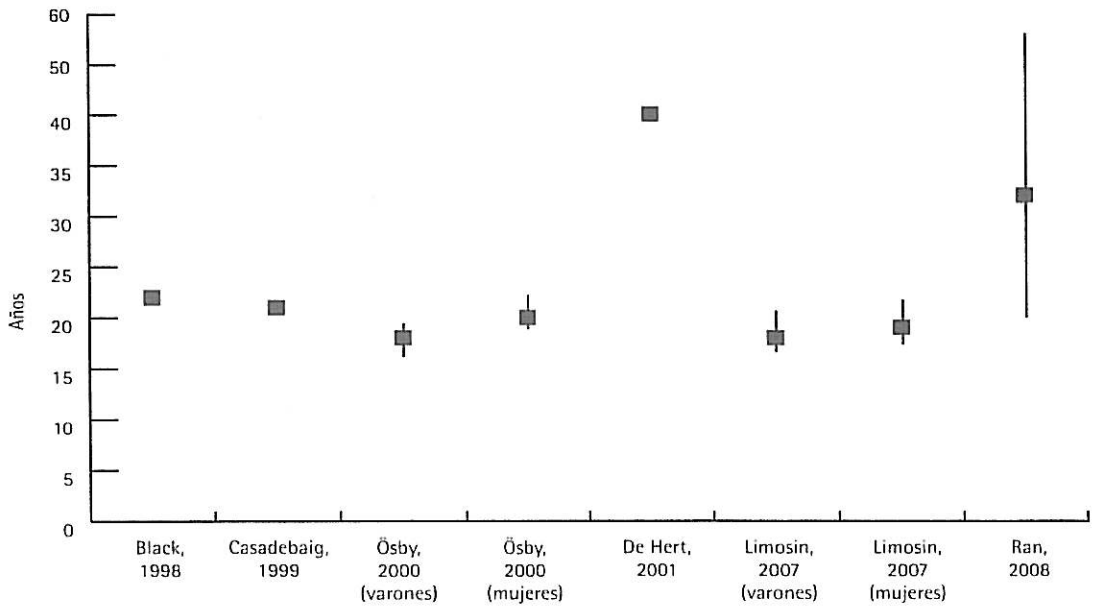
METODOLOGÍA

Se realizó una búsqueda electrónica en la base de datos Medline de estudios publicados entre los años 1994 y 2009, en castellano, inglés, italiano o francés, con las palabras clave "*schizophrenia*" y "*suicide*" en el título o resumen. Esta búsqueda arrojó 623 resultados, 103 de los cuales se consideraron potencialmente relevantes tras revisar los títulos y resúmenes. Se revisó el texto completo de los 103 artículos inicialmente seleccionados y se examinaron las referencias de los estudios relevantes para identificar trabajos no detectados mediante la búsqueda electrónica. Un total de 69 artículos (Tabla 1) cumplieron los criterios de inclusión en la revisión: estudios que investigaban aspectos clínico-epidemiológicos del fenómeno del suicidio consumado en la esquizofrenia así como referentes al acto suicida, con muestra de sujetos adultos y diseño de cohortes o de caso-control. Se extrajeron de los estudios seleccionados los datos sobre las variables referentes a datos epidemiológicos y socio-demográficos, datos clínicos y características del acto suicida. En aquellos trabajos que estudiaban un espectro mayor de patologías, se seleccionaron únicamente los datos referentes al subgrupo de pacientes afectos de esquizofrenia.

RESULTADOS

Datos epidemiológicos y sociodemográficos

Desde el estudio de Earle et al.[3], son muchos los trabajos que señalan a los trastornos de humor como la patología psiquiátrica más frecuentemente asociada a los suicidios analizados[4-13]. Sin embargo, otros autores identifican entre los sujetos que se suicidan una proporción mayor de pacientes con esquizofrenia, fundamentalmente en muestras de pacientes ingresados[14-22].



* Las Tasas de Mortalidad Estándar se disparaban en dos de los estudios seleccionados (Menezes et al. en 1996 apuntaban un SMR de 317,9 y Hiroeh et al. en 2001, un SMR 1073-1080) por lo que fueron excluidos de la figura.

Figura 1 | *Tasas de mortalidad estándar (SMR)*

Tabla 1 Estudios seleccionados

Autor	Diseño	Sujetos	Criterios Diagnósticos	Suicidios (n)	Controles (n)
Earle, 1994.[3] (USA)	IV	93 de 104 pacientes ambulatorios que cometieron suicidio entre 1988 y 1991.	NS	93	16139
King, 1994.[4] (UK)	IV	245 suicidios y 41 muertes indeterminadas ocurridas entre 1974 y 1981.	ICD-9	245	Población NS
Roy, 1995.[14] (Canada)	III	37 pacientes ingresados que cometieron suicidio comparados con 37 pareados por sexo y edad con controles ingresados en el mismo hospital.	ICD	37	37
Menezes, 1996.[66] (Brasil)	I	124 pacientes psiquiátricos ingresados en 1991, edad 18 a 44 años, diagnóstico de esquizofrenia, psicosis paranoide u otra psicosis funcional, seguidos hasta 1993.	ICD-9	5	
Wieselgren, 1996.[48] (Sweden)	I	120 pacientes con esquizofrenia ingresados en una unidad especial para pacientes jóvenes con psicosis. Seguimiento de 5 años.	DSM-III y III-R	7	
Fenton, 1997.[61] (USA)	I	295 pacientes con esquizofrenia o trastornos del espectro esquizofrénico. 6 a 23 años de seguimiento.	DSM-III o Feighner	19	
Proulx, 1997.[5] (Canada)	II	3079 suicidios durante un periodo de 5 años.	DSM	3079	
Rossau, 1997.[38] (Denmark)	III	508 pacientes que cometieron suicidio, individualmente pareados con 10 controles, de una cohorte de 9156 pacientes ingresados en hospitales psiquiátricos con diagnóstico de esquizofrenia.	ICD-8	508	5080
Heilä, 1997.[39] (Finland)	II	92 pacientes con esquizofrenia de 1397 víctimas de suicidio durante un periodo de 1 año. Autopsias psicológicas.	DSM-III-R ICD-8	92	
Shah, 1997.[15] (UK)	IV	60 pacientes ingresados que cometieron suicidio comparados con grupo control pareado.	ICD-9	60	60
Sharma, 1998.[6] (UK)	III	44 pacientes ingresados que cometieron suicido durante el ingreso entre 1969 y 1995, comparado con un grupo control de pacientes ingresados pareados.	DSM-IV	44	44
Wiersma, 1998.[49] (Holland)	I	Cohorte incidente entre 1978 y 1979 de 82 casos de reciente debut de psicosis no afectiva con síntomas positivos, seguimiento de 15 años.	ICD-10 y DSM-IV	9	
Ruschena, 1998.[24] (Australia)	II	188 pacientes psiquiátricos que cometieron suicidio.	ICD-9	188	Población
Lecomte, 1998.[7] (France)	I	392 suicidios de sujetos jóvenes entre 1989 y 1996.	NS	392	
Lee, 1998.[60] (China)	II	100 pacientes con debut de esquizofrenia entre 1977 y 1978 seleccionados de manera randomizada entre 797 historias de pacientes. Seguimiento de 15 años.	ICD-9	10	
Black, 1998.[50] (USA)	II	356 pacientes con esquizofrenia ingresados entre 1972 y 1981.	ICD-9	NS	Población
Heilä, 1998.[67] (Finland)	II	Autopsias psicológicas de 86 víctimas de suicidio con diagnóstico de esquizofrenia comparadas con 1109 víctimas sin evidencia de psicosis, correspondientes a un periodo de un año.	DSM-III-R	86	1109
Stephens, 1999.[51] (USA)	II	Seguimiento entre 4 meses y 26 años de 1212 sujetos con esquizofrenia (aquellos con datos disponibles de entre los 1357 sujetos con esquizofrenia dados de alta hospitalaria).	NS	28	
Häfner, 1999.[62] (Alemania)	II y I	232 casos de primer episodio de esquizofrenia estudiados restrospectivamente desde el debut al primer ingreso. 115 estudiados prospectivamente durante un periodo de 5 años y comparado con 114 controles pareados por sexo y edad.	DSM-III	8	114

Tabla 1 Continuación

Autor	Diseño	Sujetos	Criterios Diagnósticos	Suicidios (n)	Controles (n)
Casadebaig, 1999.[34] (France)	I	3470 pacientes con esquizofrenia, seguimiento a tres años.	ICD-10	60-71	Población
Steblaj, 1999.[16] (Slovenia)	III	32548 pacientes psiquiátricos ingresados, 79 suicidios. 59 pacientes con esquizofrenia o psicosis afectiva se compararon con un grupo control (edad, sexo y diagnóstico).	ICD-9	36	36
Baxter, 1999.[25] (UK)	II	7921 pacientes psiquiátricos, seguimiento máximo de 18 años.	ICD-8 y 9	171	Población
Heilä, 1999.[53] (Finland)	III	Autopsias psicológicas de 72 pacientes con esquizofrenia con datos disponibles sobre eventos vitales pareados con 216 sujetos sin diagnóstico de esquizofrenia, de un total de 1397 víctimas de suicidio durante un periodo de 1 año.	DSM-III-R ICD-8	72	216
Heilä, 1999.[54] (Finland)	II	88 autopsias psicológicas de sujetos con esquizofrenia que cometieron suicidio entre 1987 y 1988 con tratamiento conocido: 25 ingresados, 28 con alta en los últimos 3 meses y 3 pacientes ambulatorios.	ICD-9	88	
Saarinen, 1999.[43] (Finland)	II	Autopsias psicológicas de 17 casos de 108 suicidios ocurridos entre 1987 y 1988.	DSM-III-R	108	
Funahashi, 2000.[52] (Japan)	III	80 pacientes ingresados y ambulatorios diagnosticados con esquizofrenia, trastorno esquizoafectivo o trastorno esquizotípico de la personalidad, que cometieron suicidio y 0 pacientes vivos pareados.	DSM-II-R	80	80
Ösby, 2000.[30] (Sweden)		7784 sujetos dados de alta con diagnóstico de primer episodio de esquizofrenia entre 1973 y 1995.	NS	380	Población
Martin, 2000. [8] (USA)	II	276 pacientes psiquiátricos que cometieron suicido entre 1966 y 1997.	NS	276	
Deisenhammer, 2000.[9] (Austria)	II	44 suicidios en sujetos con diagnóstico psiquiátrico, periodo de observación de 8 años.	ICD-9	44	
Bralet, 2000.[60] (France)	I	150 pacientes con esquizofrenia crónica, seguidos durante 8 años.	*Critères Spitzer*	3	
De Hert, 2001.[46] (Belgium)	III	63 sujetos con esquizofrenia que cometieron suicidio, pareados con 63 pacientes que no.	DSM III-R	63	63
Hiroeh, 2001.[10] (UK)	II	72208 pacientes psiquiátricos ingresados entre 1973 y 1993, fallecidos antes de 1994.	ICD-8 y 10	12977	Población
Spie l, 2002.[17] (Germany)	II	21062 pacientes psiquiátricos ingresados, estudiados durante un periodo de 11 años.	ICD-9/10	30	
Kreyenbuhl, 2002.[57] (USA)	IV	115 suicidios, 15 con diagnóstico de esquizofrenia.	DSM-IV	15	100
Kua, 2003.[37] (Singapore)	I	402 pacientes, seguimiento durante 20 años (re-evaluaciones cada 5 años).	ICD-9	39	
Yim, 2004.[18] (China)	III	73 pacientes psiquiátricos dados de alta entre 1996 y 1999 y fallecidos por suicidio durante el mismo periodo, pareados según sexo, edad y diagnóstico con 73 pacientes de alta que no se suicidaron.	NS	73	73
Jarbin, 2004.[23] (Sweden)	I	88 sujetos con debut de psicosis en la adolescencia, seguidos durante 10.6 ± 3.6 años.	DSM-IV	4	Población
Kim, 2004.[65] (Canada)	II	115 varones que cometieron suicidio, evaluados psiquiátricamente y valorando diferencias estacionales.	DSM-IV	115	

Tabla 1 Continuación

Autor	Diseño	Sujetos	Criterios Diagnósticos	Suicidios (n)	Controles (n)
Kelly, 2004.[58] (USA)	II	Autopsias psicológicas de 97 sujetos con esquizofrenia fallecidos entre 1989 y 1998.	DSM-IV	15	82
Philips, 2004.[32] (China)		19223 residentes chinos, 892 suicidios entre 1995 y 1999. 74 suicidios con diagnóstico de esquizofrenia.	ICD-9 y DSM-IV	892	
Sinclair, 2004.[55] (UK)	III	Pacientes que cometieron suicidio en los 12 meses post-alta entre 1988 y 1997, hasta 2 controles por paciente.	ICD-9 y 10	59	114
Kuo, 2005.[42] (Taiwan)	III	4237 pacientes con esquizofrenia ingresados entre 1985 y 2000, seguidos hasta 2001 con link al Sistema de Certificados de Defunción. 78 fallecidos por suicidio pareados con controles vivos (edad, sexo y año de ingreso).	DSM-III, II-R y IV	78	78
Heilä, 2005.[33] (Finland)	II	811920 fallecidos, 16940 sujetos con esquizofrenia, periodo entre 1980 y 1996.	ICD-8, 9 y 10	2042	
Qin, 2005.[56] (Denmark)	III	21169 suicidios entre 1981 y 1997, 423128 sujetos control de la población general.	ICD-8, ICD-10	21169	423128
Dong, 2005.[19] (China)	III	Pacientes ingresados que cometieron suicidio entre 1997 y 1999, comparados con controles (sexo e ingreso).	ICD-10	93	92
McGirr, 2006.[47] (Canada)	III	81 sujetos diagnosticados con esquizofrenia o un trastorno psicótico crónico. Autopsia psicológica de 45 fallecidos por suicidio con 36 controles pareados.	DSM-IV	45	36
Bickley, 2006.[28] (UK)	II	131 sin-techo que cometieron suicidio en los12 meses posteriores al contacto con servicios de salud mental, comparados con el resto de suicidios entre 1996-2000.	ICD-10	131	
Hunt, 2006.[11] (UK)	II	4859 suicidios registrados en Inglaterra y Gales entre 1996 y 2000.	ICD-10	4859	
Ward, 2006.[63] (Canada)	I	41754 y 3291 sujetos con esquizofrenia que recibieron al menos 1 prescripción de risperidona, olanzapina o quetiapina, seguidos desde 1999 a 2004.	ICD-9		
Kan, 2007.[20] (China)	III	97 suicidios en los 60 días post-alta de hospital psiquiátrico entre 1997 y 1999, pareado con controles.	ICD-10	97	97
Pirkola, 2007.[12] (Finland)	II	Pacientes psiquiátricos que cometieron suicidio durante el año post-alta, grupo control de pacientes dados de alta, durante dos periodos: 1985-1991 y 1995-2001.	ICD-10	1978 - 1863	163236 - 191764
Shields, 2007.[40] (USA)	II	2864 casos de suicidio durante el periodo entre 1993 y 2002.	NS	29	
Karvonen, 2007.[59] (Finland)	II	1877 muertes pos suicidio durante el periodo entre 1988 y 2003.	ICD-8, 9 y 10	1877	
Limosin, 2007.[41] (France)	I	3470 sujetos con esquizofrenia seguidos durante 10 años. 443 fallecidos, 141 por suicidio.	ICD-10	141	
Rockett, 2007.[13] (USA)	IV	Suicidios y fallecimientos por lesiones no intencionales entre 1999 y 2003.	ICD-10	151183	488574
Bertelsen, 2007.[45] (Denmark)	I	547 sujetos con primer episodio de un trastorno del espectro de la esquizofrenia, seguimiento de 5 años.	ICD-10	7	
Ran, 2007.[26] (China)	I	500 pacientes con esquizofrenia de población rural, seguidos durante 10 años.	ICD-10	21	
McGirr, 2008.[44] (Canada)	II	Autopsia psicológica de 527 suicidios consecutivos.	DSM-IV	527	
Capasso, 2008.[35] (USA)	II	319 sujetos con diagnóstico de esquizofrenia o trastorno esquizoafectivo seguidos durante una media de 23.5 años.	DSM-IV-TR	4	

Tabla 1 | **Continuación**

Autor	Diseño	Sujetos	Criterios Diagnósticos	Suicidios (n)	Controles (n)
Osborn, 2008.[27] (UK)	II	Cohorte de 46136 sujetos con trastorno mental severo y 300426 sin, de la base de datos de investigación de atención primaria, entre 1987 y 2002, seguimiento medio de 4.7 años.	NS	215	
Silverton, 2008.[29] (USA)	I	208 hijos de mujeres con esquizofrenia, seguimiento de 43 años.	"definición amplia"	7	
Haukka, 2008.[69] (Finland)	II	18199 pacientes ingresados por intento de suicidio entre 1996 y 2003.	ICD-10	1021	
Thong, 2008. [21] (Singapore)	III	123 pacientes psiquiátricos que cometieron suicidio entre 2003 y 2004, comparados con 123 supervivientes controles pareados.	DSM-IV	123	123
Loas, 2008.[36] (France)	I	150 pacientes con esquizofrenia crónica incluidos entre 1991 y 1995, re-evaluados en 2005, seguimiento de 14 años.	*Spitzer research diagnostic criteria*	8	
Li, 2008.[22] (China)	III	77 fallecidos por suicidio durante la hospitalización en el periodo entre 1956 y 2005: 64 pacientes con esquizofrenia, comparados con 64 controles pareados.	ICD-10	64	64
Reisch, 2008.[64] (Switzerland)	II	17482 suicidios entre 1990 y 2003; 1830 fallecidos por precipitación (283 desde puentes).	ICD-10	17482	
Tidemalm, 2008.[70] (Sweden)	II	713 pacientes con esquizofrenia ingresados por intento autolítico entre 1973-1982, seguidos hasta 2003, comparados con sujetos sin diagnóstico psiquiátrico durante un año post-intento de suicidio.	ICD-8	229	27004
Ran, 2008.[31] (China)	I	Seguimiento de 10 años desde 1994 de una cohorte de 500 pacientes con esquizofrenia, comparando sujetos geriátricos y jóvenes.	ICD 10	21	
Carlborg, 2008.[71] (Sweden)	I	385 pacientes ingresados entre 1973 y1987 con diagnóstico del espectro de la esquizofrenia. Seguimiento medio de 26 años.	DSM-III-R y IV	26	

Estudios identificados por el primer autor y año
Diseño del estudio: I (prospectivo de cohortes), II (retrospectivo de cohortes), III (caso-control anidado), IV (caso-grupo control)
ICD *(International Classification of Diseases)*, DSM *(Diagnostic and Statistical Manual of Mental Disorders)*. NS (no especificado)

Respecto a la patología psiquiátrica que presenta un mayor riesgo de suicidio, los estudios también difieren, siendo para la mayoría las psicosis afectivas[23] o la esquizofrenia[14, 24-26]. Por subgrupos, King[4] señaló un mayor riesgo de suicidio en hombres con esquizofrenia, mientras que en mujeres el riesgo sería mayor para la psicosis afectiva. Osborn et al.[27] encontraron el máximo riesgo en los trastornos bipolares de su muestra de 215 suicidas, sin embargo para la franja de edad entre 18 y 30 años el riesgo de suicidio era mayor para la esquizofrenia. Bickley et al.[28] hallaron una mayor proporción de esquizofrenia entre los sujetos sin domicilio y de trastornos afectivos entre aquellos con domicilio, siendo en conjunto más frecuentes los trastornos afectivos en su muestra de suicidios de pacientes en contacto con salud mental en el último año. En un grupo de sujetos considerados de elevado riesgo, constituido por hijos de madres con esquizofrenia, Silverton et al.[29] observaron un riesgo mayor de suicidio en los sujetos con diagnóstico de esquizofrenia que en los sujetos sin patología psiquiátrica o con otras patologías psiquiátricas.

Las tasas de mortalidad en general de los sujetos con esquizofrenia superan ampliamente a las de la población general, especialmente las debidas a suicidio (Figura 1). El suicidio es la causa que de manera independiente contribuye más al exceso de mortalidad en ésta enfermedad, como coinciden en señalar todos los estudios revisados[3-71]. La Tasa de Mortalidad Estándar (SMR) en esquizofrenia se incrementa si los estudios se centran en subgrupos de sujetos jóvenes. Así, Ösby et al.[30] encontraron en jóvenes una SMR de 102,7 en varones y 175,6 en mujeres y Ran et al.[31] encontraron una gran variación del riesgo de suicidio entre franjas de edad con un SMR de 10.1 (6.6-18.2) para pacientes geriátricos, de 52.2 (40.2-84.1) para sujetos de edad media y de 94.5 (82.1-185.5) en la franja de 14 a 40 años. Los estudios revisados muestran un Riesgo Relativo (RR) de suicidio en individuos con esquizofrenia invariablemente elevado en los sujetos más jóvenes: King[4] RR de 44, Phillips et al.[32] RR de 23.8, Heilä et al. [33] RR ajustado por edad de 9.9, Casadebaig et al.[34] RR de suicidio del doble en los sujetos menores de 35 años). La edad del fallecimiento por suicidio en la Esquizofrenia, se sitúa en torno a la treintena (Figura 2), siendo ésta menor que en otras patologías o en población general[34, 35].

El porcentaje de sujetos con esquizofrenia que cometen suicidio a lo largo de su vida varía de forma notable. Cen-

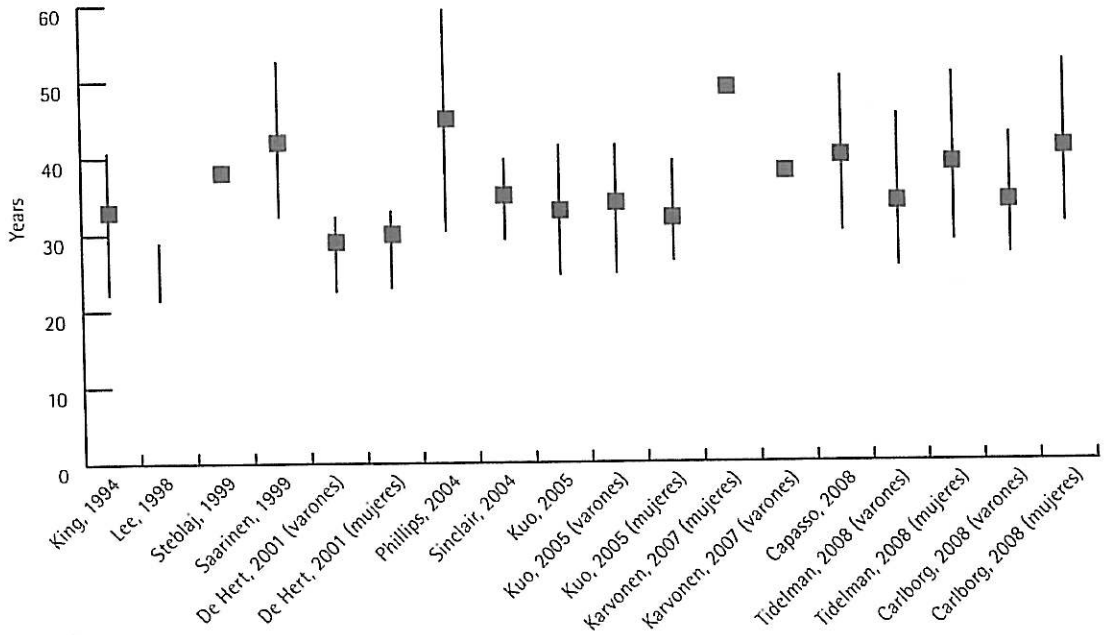


Figura 2 | *Edad en el momento del suicidio*

trándonos en los estudios de seguimiento a más largo plazo, Loas et al.[36] observaron una tasa de suicidio del 5.3% con un seguimiento a 14 años en Francia, mientras que Kua et al.[37] encontraban un 9.7% en su muestra con un seguimiento de 20 años en Singapur.

El riesgo de suicidio en esquizofrenia ha sido asociado repetidamente con el sexo masculino[8, 17, 23, 31, 34, 38-40]. Para Limosin et al.[41] ser varón es un factor de riesgo independiente para el suicidio, con una Hazard Ratio de 2.03 (95%, CI 1.34-3.07). Existen estudios, fundamentalmente en población asiática, que aportan datos contrarios a este hallazgo, así el porcentaje de mujeres que cometieron suicidio en el trabajo de Phillips et al.[32] fue del 70% y en el de Kuo et al.[42] del 51%.

Tradicionalmente, se ha considerado un mayor riesgo de suicidio en general, en varones, jóvenes, solteros y desempleados y diferentes estudios reproducen este perfil entre su muestra de suicidios[4]. Hunt et al.[11] encontraron un porcentaje mayor de solteros en población psiquiátrica. Factores del entorno como una relación no satisfactoria con la familia[23], el encontrarse desempleado[39] o incapacitado[4, 43], se han relacionado con un mayor riesgo de suicidio. Sin embargo, Phillips et al.[32], en su extensa muestra de Asia, encontraron que un 9% de los suicidas con diagnóstico de esquizofrenia vivía solo y un 54% estaban casados.

McGirr et al.[44] en 2008 señalaron que eran más frecuentes los estudios universitarios en los sujetos esquizofrénicos que en el resto de su muestra de suicidios. Sin embargo Kua et al.[37], en población asiática, encontraron mayor riesgo de suicidio consumado en sujetos con educación primaria o menor nivel de escolarización.

Datos clínicos

Si bien el estudio de Bertelsen et al.[45] no encontró relaciones significativas entre las variables clínicas y el suicido consumado en su muestra de pacientes con esquizofrenia, el resto de estudios analizados sí aportan datos que pueden considerarse relevantes.

La historia familiar de esquizofrenia constituye un factor de riesgo de suicidio en los estudios de Kua et al., De Hert et al. y McGirr et al.[37, 46, 47]. Se ha observado un Cociente Intelectual (CI), valorado mediante el WAIS *(Wechsler Adult Intelligence Scale)*, superior al grupo control de esquizofrenia en jóvenes con esquizofrenia que cometieron suicidio (De Hert et al.[46]). El momento de inicio de la enfermedad se considera de especial riesgo de suicidio, siendo el periodo en que se acumula un mayor porcentaje de los casos[5, 30, 33, 37, 39, 48-51]. Funahashi et al.[52] y De Hert et al.[46] encontraron diferencias significativas respecto a estresores vitales o pérdidas recientes respecto al grupo control, mientras que Heilä et al.[53] en 1999 no hallaron diferencias significativas respecto a eventos vitales en los últimos 3 meses en comparación con los controles anidados de su muestra.

El número de admisiones previas y por año ha sido descrito como un factor de riesgo[22, 38, 39, 46, 54]. Heilä et al.[39] en

Tabla 2 | **Método de suicidio utilizado**

Autor	Precipitación	Sumersión	Ahorcamiento	Sobreingesta medicamentosa / Envenenamiento	Arma de fuego	Arma blanca	Otros / Desconocidos	Total
Lee, 1998.	4	3	1	1	0	0	1	10
Stephens, 1999.	10	1	-	9	6	1	1	28
Casadebaig, 1999.	14	1	12	13	10	-	10	60
Funahashi, 2000.	25	1	27	5	-	3	18	79
Spießl, 2002.	13	-	8	-	-	-	-	21
Kreyenbuhl & Kelly, 2002, 2004.	6	2	1	4	1	1	0	15
Phillips, 2004.	-	-	22	4	-	-	48	74
Kuo, 2005.	25	10	16	18	0	6	3	78
McGirr, 2006.	5	3	23	-	-	5	9	45
Shields, 2007.	1	2	4	6	14	-	2	29
Limosin, 2007.	32	8	27	39	20		15	141
Loas, 2008.	-	3	1	2	1	-	1	8
Carlborg, 2008.	6	4	3	10	0	0	3	26
Total	**141**	**38**	**145**	**111**	**32-52**	**16-36**	**111**	**614**

- Sin especificaciones respecto a la cifra de fallecidos por este método

1997 observaron un número significativamente mayor de ingresos en las mujeres que en los varones esquizofrénicos que cometían suicidio. De Hert et al.[46] encontraron un riesgo de suicidio 17 veces mayor en los sujetos ingresados de manera involuntaria. Sinclair et al.[55] señalaron como factor independiente de riesgo de suicidio la participación de la policía en el ingreso y observaron que los sujetos con esquizofrenia que se suicidaban, en comparación con otros suicidas, además de precisar la intervención de la policía, eran ingresados involuntariamente con más frecuencia y realizaban más fugas durante el ingreso. Los permisos, salidas o fugas en una hospitalización[38, 46], así como el periodo post-alta hospitalaria[16, 24, 46, 52], son momentos de especial riesgo de suicidio. Qin et al.[56] en una muestra de 1658 suicidios en sujetos con esquizofrenia hallaron que el riesgo de suicidio se incrementaba tras el ingreso y tras el alta (6 meses), y declinaba rápidamente tras el tratamiento y la recuperación. Heilä et al.[39] encontraron que, entre los sujetos que consumaron el suicidio, un porcentaje elevado había contactado con los Servicios de Salud Mental recientemente (51% en los últimos 4 días) y en la muestra de Saarinen et al.[43] un tercio de los sujetos habían contactado con un terapeuta el día del suicidio.

Se han señalado repetidamente como factor de riesgo los intentos autolíticos previos[16, 17, 22, 34, 41, 42, 46, 55, 57, 58]. Karvonen et al.[59] observaron un mayor porcentaje de intentos previos en mujeres que en varones con esquizofrenia que se habían suicidado. De Hert et al.[46] y Kreyenbuhl et al.[57] describieron la existencia de amenazas previas de suicidio como un factor de riesgo, si bien King[4] encontró una menor proporción de pacientes que realizan estas amenazas entre los sujetos que cometen suicidio con diagnóstico de esquizofrenia que con otros diagnósticos psiquiátricos. Asimismo, Kreyenbuhl et al.[57] describieron en su muestra de pacientes con esquizofrenia un porcentaje menor de planificación del acto que en el resto de patologías psiquiátricas. Aunque Heilä et al.[54] (1999) hallaron en sus casos de suicidio en pacientes con esquizofrenia un mayor porcentaje de sujetos con intentos previos o amenazas, ideación y planes autolíticos que en el grupo de controles sin psicosis, los porcentajes se igualaban si se estudiaban estas variables en los últimos tres meses y los hallazgos de este estudio no alcanzaron nivel de significación estadística tras el análisis de regresión logística.

Se ha descrito que existe un mayor riesgo de suicidio mientras haya sintomatología activa[32, 39, 46, 60]. McGirr et al.[47] (2006) refieren que sufrir sintomatología psicótica severa o moderada es un factor de riesgo para el suicidio en esquizofrenia. Heilä et al.[54] (1999) encontraron un riesgo elevado relacionado con la presencia de síntomas positivos prominentes (Odds Ratio (OR) 6.6; CI 95% 1.9-22.7). Loas et al.[36] en casos de suicidio en pacientes con esquizofrenia encontraron una proporción significativamente mayor de sujetos clasificados como "positivos" conforme a la puntuación en la PANSS *(The Positive and Negative Syndrome Scale)*, mien-

tras que la puntuación de síntomas negativos era menor, sin alcanzar este hallazgo significación estadística. La presencia de síntomas negativos y de síndrome deficitario ha sido asociado con un menor riesgo de suicidio en esquizofrenia[46, 61].

Fenton et al.[61] también asociaron la sintomatología positiva con un riesgo más elevado de suicidio, señalando dos síntomas concretos: la suspicacia y los delirios. En esta misma línea, Saarinen et al.[43] hallaron en su muestra que los síntomas paranoides representaban el rasgo clínico dominante en un 88% de los sujetos. Se ha asociado el subtipo paranoide de esquizofrenia con un mayor riesgo de suicidio[16, 61], si bien Heilä et al.[53] (1999) encontraron esta asociación únicamente en pacientes no ingresados. Funahashi et al.[52] relacionaron el riesgo de suicidio con un curso grave de la enfermedad, con una asociación significativa con la presencia de ideación suicida, la ansiedad por miedo a la desintegración mental y las alucinaciones auditivas imperativas de suicidio. Asimismo, identificaron en su muestra una asociación significativa con 6 ítems de la PANSS: hostilidad, ansiedad, sentimientos de culpa, tensión, depresión y pobre control de los impulsos y unas puntuaciones significativamente menores en embotamiento afectivo, retraimiento emocional y trastorno de volición, respecto al grupo no suicida con esquizofrenia. De Hert et al.[46] apuntaban a un riesgo elevado en aquellos pacientes con esquizofrenia con tendencia al "*acting out*".

McGirr et al.[47] en 2006 consideraban la presencia comórbida de otros diagnósticos del eje I como factor de riesgo de suicidio en esquizofrenia, sin embargo en 2008 el mismo autor encontraba un porcentaje menor de trastornos comórbidos en los sujetos con esquizofrenia que en el resto de los suicidios estudiados (n=527)[44]. La presencia de sintomatología depresiva (sentimientos de culpa, ideación suicida, desesperanza, etc.) o el diagnóstico de un trastorno depresivo presente o pasado, se consideran factores de riesgo para el suicidio en la esquizofrenia[16, 21, 32, 38, 39, 42, 43, 46, 47, 49, 54, 55, 57, 60, 62]. Karvonen et al.[59] encontraron un mayor porcentaje de síntomas depresivos en mujeres que en varones con diagnóstico de esquizofrenia que se suicidaban, pero consideraba que la sintomatología depresiva podía ser un factor discriminante dentro del grupo de varones, ya que consumaban el suicidio inmediatamente tras el alta. Los sentimientos de culpa han sido señalados como factor de riesgo para el suicidio y Li et al.[22] hallaron una OR de 11.095 (CI 95% 1.429-86.163) en su estudio de casos-control, así como una OR de 4.788 (CI 95% 1.591-14.414) para la hipotimia. El único estudio que arroja datos en contra de la relación sintomatología depresiva-suicidio es el realizado por McGirr et al.[44] en 2008, en el que los sujetos con esquizofrenia cumplían con menor frecuencia los criterios para trastorno depresivo presente o pasado (OR 0.2; CI 95% 0.09-0.449 y OR 0.18; CI 95% 0.08-0.40, respectivamente).

El abuso de sustancias en general, más concretamente el de alcohol, han sido repetidamente señalados como un factor de riesgo[11, 34, 39, 41], si bien Heilä et al.[54] (1999) no encontraron diferencias significativas respecto al consumo de alcohol con los sujetos controles de su estudio. Karvonen et al.[59] señalaban que el abuso de alcohol era más frecuente en esquizofrénicos varones que cometían suicidios que en mujeres.

Sólo se identificaron dos estudios que hicieran referencia directa a los rasgos de personalidad en relación al fenómeno del suicidio. Mc Girr et al.[47] en 2006 encontraron una menor proporción de sujetos con rasgos de personalidad cluster A y C en el grupo suicida, señalando la presencia de rasgos cluster C como un factor protector. McGirr et al.[44] en 2008 describieron una menor prevalencia de rasgos cluster B y C en los sujetos con esquizofrenia que consumaban el suicidio respecto al resto de suicidas estudiados, con puntuaciones menores en persistencia según el TCI ("*Temperament and Character Inventory*"), si bien también recogían que obtenían mayores puntuaciones en evitación del daño.

Respecto al tratamiento, De Hert et al.[46] señalaron que el tratamiento con base en la atención ambulatoria y un buen nivel de funcionamiento diario resultan factores protectores. Hunt et al.[11] encontraron en los sujetos con diagnóstico de esquizofrenia que cometieron suicidio, un tiempo más prolongado de enfermedad sin asistencia y un mayor incumplimiento terapéutico comparado con otros diagnósticos. Los pacientes con esquizofrenia que consumaron el suicidio, en el estudio de Loas et al.[36] llevaban un tratamiento neuroléptico más intensivo. Heilä et al.[54] en 1999 encontraron que el 57% de los individuos con esquizofrenia que se suicidaron no tomaban el tratamiento o la toma era irregular, siendo la proporción de sujetos ingresados con una actitud indiferente o negativa hacia el tratamiento muy elevada. Ward et al.[63], en la mayor de sus muestras de estudio sobre los efectos del cumplimiento adecuado del tratamiento, identificaron la variable del adecuado cumplimiento farmacológico como un factor protector ante el suicidio, si bien en la muestra de menor tamaño, que los autores consideran más representativa de su población de pacientes con esquizofrenia, se mostraba una tendencia que no alcanzaba significación estadística.

Acto suicida

Para De Hert et al.[46] los sujetos con esquizofrenia tienen una mayor propensión a la utilización de métodos claramente letales en el suicidio y la historia de intentos previos con métodos de alta letalidad se consideró que multiplicaba por 11 el riesgo de completar el suicidio.

En la muestra de pacientes hospitalizados de Spiessl et al.[17] los suicidios en esquizofrenia se produjeron invariablemente mediante métodos violentos. Karvonen et al.[59] señalaban que la tendencia a usar métodos violentos era mayor en varones que en mujeres con esquizofrenia. Heilä et al.[39] registraron que los sujetos jóvenes diagnosticados de esquizofrenia tendían más a utilizar métodos violentos de suicidio,

Tabla 3 **Elementos característicos de los casos de suicidio consumado en sujetos con esquizofrenia**

Especial riesgo	Factores protectores
Varones	Predominio de síntomas negativos o síndrome deficitario
Jóvenes	Adecuada adherencia y vinculación terapéutica
Predominio del subtipo paranoide	Personalidad clúster C
Al inicio de la enfermedad	
Peri-ingreso hospitalario	
Presencia de sintomatología activa, predominio de síntomas psicóticos positivos	
Comorbilidad, especialmente síntomas o trastornos depresivos	
Mala adherencia al tratamiento, alto número de hospitalizaciones	

si bien el método suicida más frecuente en su estudio era la sobreingesta medicamentosa, especialmente en mujeres, lo que se reproducía en el estudio de Saarinen et al.[43].

La precipitación es un método violento de suicidio repetidamente señalado por su frecuencia en los sujetos con esquizofrenia[17, 51, 58, 60]. Hunt et al.[11] confirmaron una mayor proporción de precipitaciones en sujetos con esquizofrenia. Kreyenbuhl et al.[57] encontraron que su utilización era significativamente mayor en la esquizofrenia que en otras patologías psiquiátricas, y hallaron en su muestra una menor tendencia al uso de armas de fuego en comparación con la población general. Reisch et al.[64], en un estudio específico sobre precipitación, encontraron que los sujetos que utilizaban este método tenían una probabilidad 2-6 veces mayor de sufrir esquizofrenia que los que usaron otros métodos. Ösby et al.[30] observaron que los métodos más utilizados en su muestra eran el ahorcamiento en varones y el envenenamiento en mujeres, al igual que en la población de referencia, en cambio identificaron que la precipitación era utilizada en mayor proporción en los varones y mujeres con esquizofrenia en comparación con la población de referencia. En la muestra de población asiática de Phillips et al.[32] el método suicida más utilizado fue la ingesta de pesticidas, seguido del ahorcamiento, con un elevado porcentaje (30%) clasificado como "otros métodos". Los métodos de suicidio más frecuentemente observados en los diferentes estudios han sido recogidos en la Tabla 2.

Por último, respecto a las variaciones estacionales del fenómeno del suicidio, sólo dos estudios en esta revisión contemplaban de manera directa este aspecto, apuntando a una menor tasa de suicidio en primavera. Kim et al.[65] estudiaron exclusivamente varones encontrando una diferencia significativa con los trastornos depresivos mayores, puesto que un 87,5% de los suicidios en sujetos con esquizofrenia de su muestra ocurrían en otoño/invierno. En la muestra de Shields et al.[40] el 55% de los suicidios registrados ocurrieron en otoño/invierno y sólo un 13,7% en primavera.

DISCUSIÓN

La presente revisión aporta datos de relevancia respecto al fenómeno del suicidio en esquizofrenia, si bien los hallazgos que se presentan están sujetos al habitual sesgo de publicación y limitados por la heterogeneidad de los estudios en cuanto al tipo de variables analizadas, los criterios diagnósticos utilizados, la condición de paciente ingresado o ambulatorio, el tiempo de evolución, la población de procedencia (sesgo cultural con diferencias sustanciales Oriente-Occidente), la metodología de reclutamiento de la muestra (al ingreso hospitalario, mediante el registro forense, inclusión/exclusión de actos letales que no alcanzan el suicidio consumado, etc.) o por el posible registro erróneo de la causa y mecanismo de la muerte a través de distintas fuentes (certificado de defunción, consulta forense, registros nacionales, autopsias psicológicas, etc., así los suicidios en sujetos con esquizofrenia podrían ser clasificados de manera errónea en el certificado de defunción con más frecuencia que en población sin patología psiquiátrica, 20% *vs* 6%[32]). Predominan los trabajos retrospectivos, con limitaciones metodológicas intrínsecas especialmente reseñables en el estudio de determinadas variables como por ejemplo los rasgos de personalidad. Igualmente, consideramos que las diferentes variables interaccionan entre sí en su relación con el suicidio siendo recomendable ajustar estadísticamente por posibles confusores, lo que no sucede en muchos de los estudios revisados. Por último, cabe resaltar que el suicidio es un evento relativamente infrecuente por lo que la identificación de factores de riesgo requiere muestras de gran tamaño y seguimientos prospectivos a largo plazo, por lo que su predicción resultará siempre complicada.

Pese a la variabilidad entre estudios y las consiguientes dificultades en la comparación de resultados existen hallazgos consistentes respecto a determinadas variables y todos los trabajos revisados señalan al suicidio como el factor independiente más relevante respecto al exceso de mortalidad en sujetos con esquizofrenia. Existen variaciones en el riesgo de suicidio según la edad de los sujetos, el sexo, el momento evolutivo de la enfermedad, la sintomatología o la condición de paciente ingresado o ambulatorio.

El cálculo del riesgo de suicidio a lo largo de la vida precisa estudios prospectivos a largo plazo de primeros episodios en esquizofrenia, siendo además susceptible de cambio con las mejoras de tratamiento y las variaciones sociales a lo largo del propio periodo de estudio, pero parece razonable concluir que el porcentaje real no alcanzaría el 9,7% señalado por Ran et al[31].

Los estudios en población europea informan de una mayor proporción de varones entre sus muestras de suicidio, mientras los estudios realizados en Asia registran mayores proporciones de mujeres, lo que apunta la posibilidad de diferencias interculturales[32].

La edad en el momento del fallecimiento fue menor que en otras patologías psiquiátricas[34, 42], lo que concuerda con la tendencia mayor al suicidio al inicio de la enfermedad. Sin embargo, los datos referentes a esta variable evolutiva resultan complicados de valorar puesto que muchos estudios la utilizan como factor para emparejar casos con controles y las franjas de edad analizadas difieren entre estudios.

Otras variables como la historia familiar de suicidio y de esquizofrenia fueron variables escasamente analizadas como factor de riesgo en los estudios, por lo que los hallazgos han de interpretarse con precaución[37, 46].

Sin embargo, si debe considerarse que existe consistencia entre los estudios respecto a la relación con el suicidio de la presencia síntomas activos o la comorbilidad con trastornos afectivos. Diferentes variables que reflejan peor funcionamiento psicosocial, han sido señaladas como factor de riesgo para el suicidio (estar soltero, desempleado o incapacitado), si bien podrían interpretarse como secundarias a la gravedad de la patología, resaltando nuevamente la importancia de los factores clínicos. Así variables relacionadas con la clínica que se apuntan como factores de riesgo de suicidio, como el elevado número de ingresos previos[22, 38, 39, 46, 54], los ingresos involuntarios, la participación de la policía en el ingreso[46, 55] y la realización del acto suicida durante las fugas de un ingreso[30, 46], podrían explicarse por la intensa presencia de síntomas positivos (hostilidad e impulsividad, suspicacia, delirios y alucinaciones imperativas)[38, 43, 52, 54] y el predominio del subtipo paranoide de esquizofrenia[16, 38, 54]. Por otro lado, los hallazgos de algunos estudios sobre el CI y el nivel educacional elevados podrían relacionarse con la aparición de síntomas depresivos ante una buena capacidad de insight y temor al deterioro mental[46, 47].

Conforme a nuestra revisión se puede establecer una asociación entre abuso de alcohol y suicidio, así como para el trastorno por uso de otras sustancias[11, 34, 39, 41], si bien estimamos que resulta un aspecto insuficientemente estudiado.

Por último, cabe destacar que existe una alta proporción de utilización de métodos violentos de suicidio en la esquizofrenia, especialmente la precipitación[17]. Este dato es compatible con los hallazgos de una menor proporción de amenazas previas y planificación del acto que en otras patologías, así como una mayor impulsividad en los pacientes con esquizofrenia que cometen suicidio[4, 44, 46, 47, 52, 57] aunque también se hayan descrito mayores puntuaciones en evitación del daño en ellos[44, 47].

La esquizofrenia demostró un patrón estacional diferente al de los trastornos afectivos[40, 65]. La menor fluctuación estacional puede ser interpretada como una contribución menor a la supuesta inicialmente, de los síntomas afectivos al riesgo de suicidio en la esquizofrenia o bien como una característica específica de los sujetos con depresión y esquizofrenia que cometen suicidio.

CONCLUSIONES

Los pacientes con esquizofrenia son un grupo de alto riesgo de suicidio, por lo que su abordaje debe tener en cuenta este aspecto específicamente e incluir la evaluación de los diferentes factores señalados en esta revisión (Tabla 3). Se debe extremar la vigilancia en aquellos pacientes con factores de riesgo sociodemográficos, especialmente en periodos de acontecimientos vitales relevantes. Resulta especialmente necesaria una valoración rigurosa del riesgo autolítico previa a la autorización de permisos o salidas durante los ingresos y asegurar una atención continuada a los pacientes postalta. Debe prestarse atención al diagnóstico y tratamiento adecuados de la depresión en la esquizofrenia[72] y a la realización de un buen diagnóstico diferencial entre la sintomatología negativa, que podría resultar un factor protector, y los síntomas depresivos, factor de riesgo. La prevención del suicidio en esquizofrenia implica la mejora en la adherencia terapéutica, por lo que debemos trabajar la conciencia de enfermedad y valorar el uso de antipsicóticos de liberación prolongada[11, 54, 63]. El consumo de tóxicos en estos pacientes no debería considerarse un criterio de exclusión para determinados programas asistenciales, subrayándose el imprescindible tratamiento integral de la patología dual también en lo referente al suicidio. Por último, debemos resaltar la necesaria coordinación entre las entidades asistenciales y los Institutos de Medicina Legal[73, 74], dada la relevancia de los datos de origen forense[75], en la realización de estudios prospectivos a largo plazo que permitan la investigación del espectro de la conducta suicida en toda su extensión, identificando rasgos diferenciales del fenómeno del suicidio consumado.

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43. ESCALA DE IDEACIÓN SUICIDA (A. Beck)

I. Características de la actitud ante la vida o la muerte

1. Deseo de vivir:

- O Moderado a fuerte (0)
- O Débil (1)
- O Ninguno (2)

2. Deseo de morir:

- O Ninguno (0)
- O Débil (1)
- O Moderado a fuerte (2)

3. Razones para vivir/morir

- O Más razones para vivir que para morir (0)
- O Igual unas que otras (1)
- O Más razones para morir que para vivir (2)

4. Deseo de intentar activamente el suicidio

- O Ninguno (0)
- O Débil (1)
- O Moderado a fuerte (2)

5. Intento de suicidio de forma pasiva

- O Tomaría precauciones para salvar la vida (0)
- O Dejaría al azar el vivir/morir (p.e. cruzar sin cuidado una calle muy transitada) (1)
- O Evitaría los medios necesarios para salvar o conservar la vida (p.e. un diabético que deja de ponerse la insulina) (2)

Si en los 4 códigos de los ítems 4 y 5 la puntuación es 0, sáltese las secciones II, III, IV, puntuando "8" (no aplicable) en cada uno de los espacios codificados en blanco "( )".

II. Características de la Ideación/Deseo suicida

6. Duración de la ideación/deseo suicida

- O Breve, períodos pasajeros (0)
- O Amplios períodos (1)
- O Continuo (crónico), casi continuo (2)

7. Frecuencia de la ideación/deseo suicida

- O Raro, ocasional (0)
- O Intermitente (1)
- O Persistente o continuo (2)

8. **Actitud hacia la ideación/deseo suicida**

- O Rechazo (0)
- O Ambivalente, indiferente (1)
- O Aceptación (2)

9. **Control sobre el acto suicida: acting-out/deseo**

- O Tiene sentido del control (0)
- O Control incierto (1)
- O No tiene sensación de control (2)

10. **Disuasores ("frenos") para hacer un intento activo** (familia, secuelas si no se consuma)

- O No quería el suicidio por el "freno" que tiene (0)
- O Alguna preocupación por los "frenos" (1)
- O Mínima o ninguna preocupación sobre los "frenos" (Indicar "frenos" si procede_____) (2)

11. **Razones para el Intento planeado**

- O Manipular el ambiente, atraer la atención, venganza (0)
- O Combinación de 0 y 2 (1)
- O Escapar, resolver problemas (2)

III. Características del Intento de suicidio planeado

12. **Método: especificidad/planificación**

- O No considerado (0)
- O Considerado pero sin resolver los detalles (1)
- O Detalles resueltos, bien formulados (2)

13. **Método: disponibilidad/oportunidad**

- O Método no disponible, no oportuno (0)
- O Método que requeriría tiempo, esfuerzo/no oportuno (1)
- O Método y oportunidad disponibles (2a)
- O Oportunidad futura o disponibilidad del método anticipada (2b)

14. **Sensación de "capacidad para realizar el Intento"**

- O No coraje, demasiado débil, temeroso, incompetente (0)
- O Inseguro de tener coraje, competencia (1)
- O Seguro de su competencia, coraje (2)

16. **Expectativa/Anticipación del Intento actual**

- O No (0)
- O Incierta (1)
- O Si (2)

IV. Realización del intento de suicidio

18. **Preparación real**

- O Ninguna (0)
- O Parcial (p.e.: empezar a recoger comprimidos) (1)
- O Completa (p.e.: tener comprimidos, navaja afeitar, arma cargada) (2)

19. **Nota suicida**

- O Ninguna (0)
- O Iniciada pero no terminada, solo ideas sobre ella (1)
- O Completada, depositada (2)

20. **"Últimos arreglos" para preparar la muerte** (seguros, testamento, donaciones, etc.)

- O Ninguno (0)
- O Ideas sobre o hacer algunos arreglos (1)
- O Ha realizado o completado los arreglos (2)

21. **Engaño/Ocultación de la tentativa planeada**

- O Revela las ideas abiertamente (0)
- O Contiene su revelación (reticente)(1)
- O Intenta ocultar, engañar, mentir (2)

V. Antecedentes

22. **Intentos de suicidio previos**

- O Ninguno (1)
- O Uno (2)
- O Más de uno (3)

23. **Intención de morir relacionada con el último intento** (si no es aplicable puntuar "8")

- O Baja (0)
- O Moderada, ambivalente, insegura (1)
- O Alta (2)

VI. Estimación clínica de la fiabilidad

Fiabilidad del paciente (a lo largo de la entrevista):

- O Incertidumbre (0)
- O Pobre (1)
- O Adecuada, limpio, justo (2)
- O Buena (3)

Recomendaciones finales del taller suicidio realizado en la I jornada clínica Paime

Madrid 25 y 26 enero 2013

1. Plantear un estudio epidemiológico previo sobre el riesgo de suicidio entre los médicos en España

2. Hacer un estudio revisando las estadísticas con que contemos actualmente, sobre los casos de intentos o suicidios que conozcamos

3. Realizar un Protocolo nacional de la prevención del suicidio en los médicos, a través de los paimes y elaborado por grupo de expertos .(Hay solo un protocolo español para prevención del suicidio en los presos, de Instituciones Penitenciarias)

4. Implicar a otros estamentos no médicos

5. Formar a los médicos a detectar(identificar a los medicos que atienden médicos regularmente). Derivar, Intervenir y asimilar el problema. Realizar talleres de formación para medicos para la prevención de la depresión, adicciones y suicidio desde los Paimes con grupos de expertos locales, a través de confeccionar material básico desde la OMC Fundacion

6. Organizar un grupo de trabajo del Paime para colaborar e incidir en la Estrategia de salud mental del Ministerio de Sanidad

7. Hacer diferenciación por especialidades e implicar a las sociedades científicas

8. Elaboración de material para los objetivos Protocolos de detección e intervención .Recomendaciones de auto cuidado (video)

9. Considerar el suicidio en el acoso laboral

10. Trabajar conjuntamente con comisiones deontológicas, comisión de agresiones físicas y denuncias.

11. Atención o asesoramiento a medicos jubilados e incapacitados

12. Responsabilidades deontological legales

13. Evaluar los médicos atendidos en centros de salud mental consultas privadas etc.

14. Proponer a al Ministerio de sanidad y al INE que se exija el cumplimiento estricto del certificado de defunción en cuanto a la causa fundamental o etiológica ,la profesión y el compromiso de comunicar el suicidio al responsable sanitario del area igual que en el caso de los homicidios y accidentes de trafico

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Desafíos y retos a afrontar

Antoni Arteman y Miquel Casas

1as JORNADAS CLÍNICAS PAIME
Fundación Patronato de Huérfanos y Protección Social de Médicos
Príncipe de Asturias
Madrid, 25 y 26 de Enero de 2013

Debilidades

- Juntas de Gobierno de los COM cambiantes. Empezar de nuevo.
- Diferentes grados de implicación colegial.
- Escaso interés del Ministerio de Sanidad. No es una prioridad en la agenda del Consejo Inter-territorial del SN de Salud.
- Débil estructuración de la red asistencial PAIME.
- Poca coordinación con SPRL, inspección sanitaria y médicos de familia.

Fortalezas

- Soporte de la FPHPSPA. La fuerza de los COM.
- Podemos ser una de las razones de ser de los COM. El control de la práctica médica para garantizar la seguridad del paciente.
- Experiencia de 14 años. Procedimientos y circuitos establecidos.
- Especialización de los equipos clínicos. Método.
- Experiencia y conocimiento amplio e integrador del proyecto Galatea (fundación y clínica).

Amenazas

- La crisis económica. Los servicios regionales de salud están contraídos.
- A los COM les cuesta afrontar y gestionar debidamente los casos de ME difíciles.
- Quedarnos solamente atendiendo a los médicos cuando están enfermos y no desarrollar la prevención y la promoción de la salud.

Oportunidades

- Los ME existen y pueden poner en riesgo la salud de sus pacientes.
- Todo el mundo tiene algún ME cerca en algún momento…
- Es un campo de trabajo totalmente virgen y muy oportuno.
- Hay que incidir en la prevención de estas enfermedades y en la promoción de la salud de los médicos. A nivel individual, de equipo y en las instituciones sanitarias.
- Una buena salud mental de los médicos es un factor protector de la salud de los pacientes.

Tendencias internacionales

- Ámbito anglosajón:
  - Consolidación de los programas asistenciales para ME.
  - Incidir en el bienestar de los profesionales sanitarios en las instituciones sanitarias.
  - Prevención en etapas formativas de los médicos: estudiantes de medicina y residentes.
- Ámbito latino:
  - Escaso desarrollo, salvo España con el PAIME, la FPHPSM y el proyecto Galatea.
- La EAPH y la IAPH.

Concluyendo

- Trabajando en este ámbito se tiene la sensación de estar creando algo trascendente y con mucha proyección de futuro.
- Los resultados son palpables y obtienen reconocimiento.
- Busquemos aliados, creemos complicidades, cooperemos en un proyecto único, novedoso y muy necesario.

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o conoces a alguien que lo padezca,

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1.- El término "Médico Enfermo"

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1.- El término "Médico Enfermo"

2.- Protocolos de Actuación Consensuados

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1.- El término "Médico Enfermo"

2.- Protocolos de Actuación Consensuados

3.- Actualización de la Información PAIME

El PAIME
desde el momento actual
hacia el futuro necesario.
Desafíos y retos a afrontar

1.- El término "Médico Enfermo"

2.- Protocolos de Actuación Consensuados

3.- Actualización de la Información PAIME

4.- Proyección Internacional

El PAIME
desde el momento actual
hacia el futuro necesario.
Desafíos y retos a afrontar

1.- El término "Médico Enfermo"

2.- Protocolos de Actuación Consensuados

3.- Actualización de la Información PAIME

4.- Proyección Internacional

5.- Reconceptualización del PAIME

PAIME

	Marco Teórico	*Pacientes*
1995	Drogodependencias Demencias, etc.	Problemas legales “Malapraxis”
2000	Drogodependencias Psicopatología	“Malapraxis” T. Personalidad
2005	Drogodependencias Pat. Psiquiátrica	Drogodependencias Pat. Psiquiátrica
2010	Pat. Psiquiátrica Patología Dual	Paciente Psiquiátrico Paciente Dual

PATOLOGIA DUAL

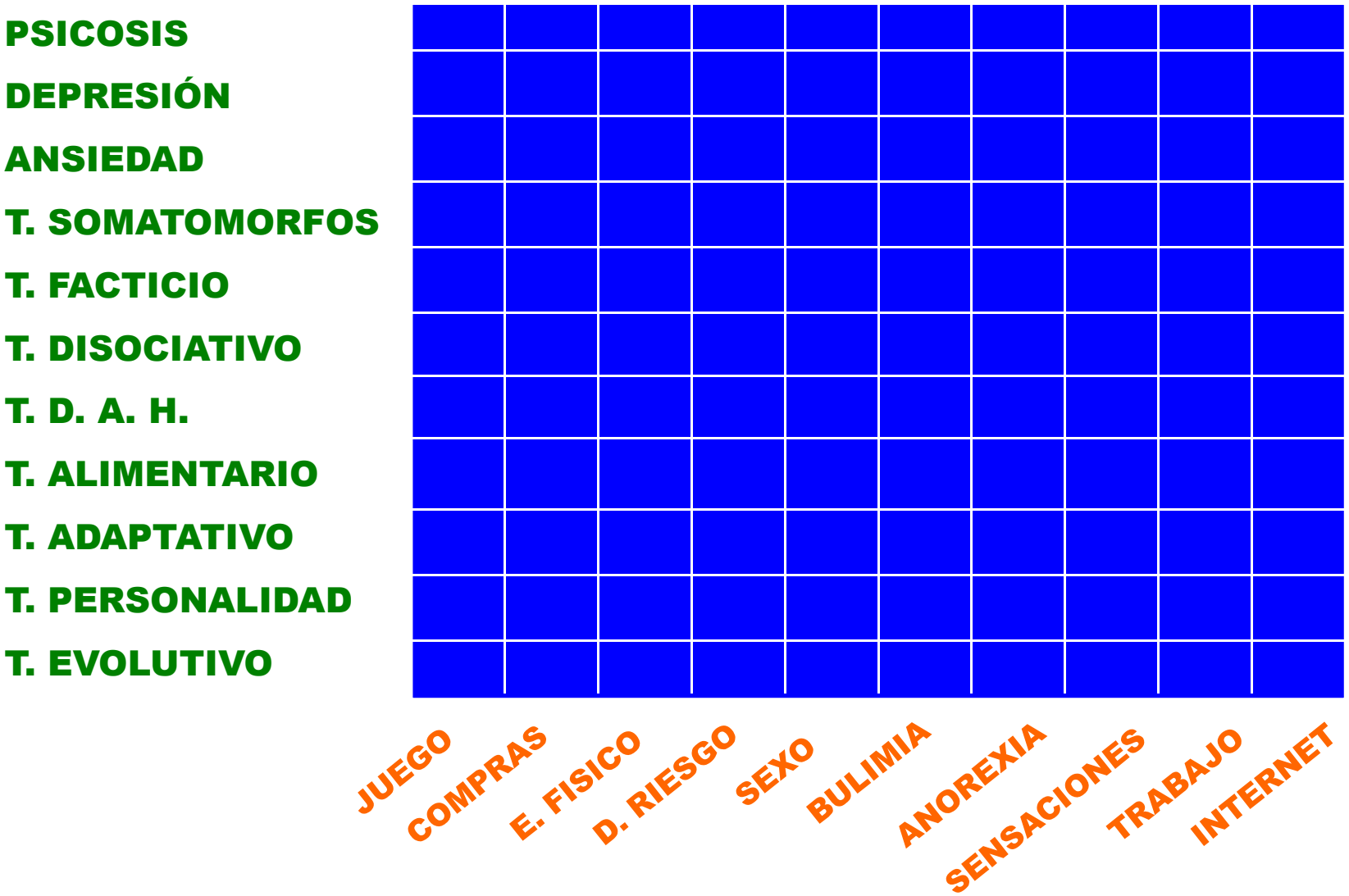
Patología Psiquiátrica

+

Conductas Adictivas

PATOLOGIA DUAL

PATOLOGIA DUAL



PATOLOGIA DUAL

HIPOTESIS

de la

AUTOMEDICACIÓN

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- **Dual Diagnosis**
- **Dual Disorders**
- **Comorbid Disorders**
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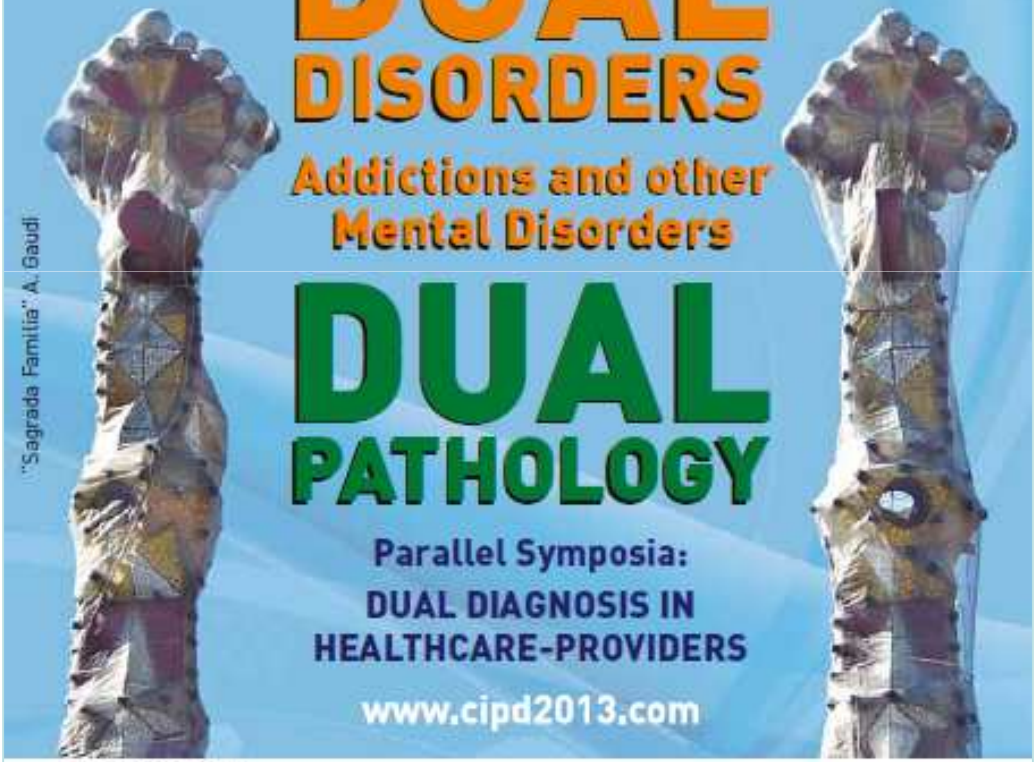
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2.- Protocolos de Actuación Consensuados

3.- Actualización de la Información PAIME

4.- Proyección Internacional

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3.- Actualización de la Información PAIME

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Príncipe de Asturias

Madrid, 25 y 26 de Enero de 2013

Substance abuse in anaesthetists

Roser Garcia-Guasch[a,b], *Jaume Roigé*[b,c], *and Jaume Padrós*[d]

Purpose of review
Anaesthesiologists have a significantly higher frequency of substance abuse by a factor of nearly 3 when compared with other physicians. This is still a current problem that must be reviewed.

Recent findings
Many hypotheses have been formulated to explain why anaesthesiologists appear to be more susceptible to substance abuse than other medical professionals (genetic differences in sensitivity to opioids, stress, the association between chemical dependence and other psychopathology or the second-hand exposure hypothesis). Environmental exposure and sensitization may be an important risk factor in physician addiction. There is a long debate about returning to work for an anaesthetist who has been depending on opioid drugs, and recent debates are discussed. Institutional efforts have been made in many countries and physician health programmes have been developed.

Summary
As drug abuse among anaesthesiologists has continued, new studies have been conducted to know the theories about susceptibility. Written substance abuse policies and controls must be taken in place and in all countries.

Keywords
anaesthesiologists, drug addiction: opioids, recovery, relapse, substance abuse

INTRODUCTION

Addiction among anaesthesiologists has been considered as a result of access to drugs of abuse and efforts to prevent diversion have been intense over the past decades.

Although many efforts have been made to control or lessen the number of addicted anaesthesiologists, the problem of anaesthesiologists as substance abuse and addiction patients has continued.

EPIDEMIOLOGY

Whenever the demographics of physicians with addictive behaviours are reported, anaesthesiologists are usually overrepresented. Twenty-five percent of physicians followed for substance abuse/dependence are anaesthesiologists.

The prevalence of substance abuse among trainees is 2% [1]. Eighty percent of US anaesthesiology residency programmes identified at least one resident with chemical dependence (2.1 ± 1.8 resident per programme), with a prevalence of 0.87%, and 19% reported at least one pretreatment fatality (drug overdose or suicide) [2].

Many surveys have been conducted in different countries, along with USA [3,4], Australia [5], France [6], Catalonia (Spain) [7,8] showing different prevalences of impaired physicians and anaesthesiologists.

When comparing specialities of the physicians who reported fentanyl as their primary drug, 94.4% were anaesthesiologists or surgeons [9].

The prevalence of self-reported substance abuse or dependence for alcohol and/or other drugs was highest for psychiatrists (14.3%) and emergency medicine physicians (12.4%). Psychiatrists were more likely to have used benzodiazepines. Family practice and obstetric/gynaecology physicians were more likely to use minor opiates and there was a suggestion that anaesthesiology, emergency and chronic pain physicians were more likely to use

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KEY POINTS

- The prevalence of substance abuse among staff and training anaesthesiologists is still high and dangerous.
- New theories have been described to explain dependence of anaesthetic drugs: second-hand exposure.
- Surveillance of drug transactions using drug-dispensing systems must be introduced in all hospitals.
- There is no agreement about returning to work after having been dependent on opioid drugs.
- It is essential that each health organization has written policies in place regarding the country laws with respect to the dependent anaesthetist who can prevent disastrous medical and legal outcomes.

mayor opiates. Residents followed the same pattern [10].

A recent study supports the finding that anaesthesiologists have a significantly higher rate of substance abuse by a factor of 2.7 when compared with other physicians. Anaesthesiologists were significantly less likely than their peers to enrol in a physician health programme because of alcohol abuse and much more likely to enrol because of abuse of opioids [11▪▪].

TYPE OF DRUG

Opioids were implicated in 66% of cases overall. The next most frequent were anaesthesia induction agents (20%) and benzodiazepines (15%). Alcohol accounted for 12% followed by inhalation anaesthetic agents 5%. Recreational drugs were implicated in only 7% of reports [5]. The literature concerning abuse of remifentanil is limited.

The incidence of propofol abuse among all anaesthesia personnel was 0.10%. Propofol was often the final drug used in a pattern of controlled substance abuse often initiated with opiate abuse and followed by propofol abuse after one or more relapses. This pattern may be because of the ease of obtaining propofol, short duration of symptoms and a lack of routine testing [12].

Although nitrous oxide (N_2O) has found clinical utility, professionals who have ready access to substance (dentists, medical students and hospital staff) are at elevated risk for N_2O misuse, abuse and dependence. However, new methods to access N_2O have been described and have become a significant drug of abuse among US adolescents [13▪▪] and university students [14]. Nevertheless, N_2O is about to be withdrawn from many hospitals because of its secondary effects and the scarce potency. Abuse among anaesthetists will not probably be a problem in the near future.

Little is known about the incidence of volatile anaesthetic abuse among anaesthetists. A number of individuals abusing inhalational agents were found to be abusing more than one agent at the same time. Nearly half (47%) of the inhalational anaesthetic abuse cases involved N_2O. The remaining cases involved isoflurane (19%), halothane (19%) and desfluorane (9.5%) [15].

Inhalational agent abuse is very difficult to detect, with the abuse being discovered when the abusing individual is found to have died from an overdose [12].

Surprisingly, there are no publications on the misuse of ketamine among anaesthesiologists except for some case reports [16]. Anyway, it continues to gain popularity in the drug abuse scene of 'rave wave' of all nightclubs. This increasing abuse has led the drug-testing laboratories to consider adding ketamine screening to their random urinalysis programme [17]. Sometimes, consumers are identified by urinary bladder ulceration. A high level of urine ketamine active metabolites might result in bladder irritation [18].

THEORETICAL IMPLICATIONS

Many hypotheses have been forwarded to explain why anaesthesiologists appear to be more susceptible to substance abuse than other medical professionals, including ease of access to the drugs, self-medication, the demands of the job and the psyche of the anaesthesiologist.

As there is empirical evidence that the disorders of substance abuse are prevalent within multiple generations of some families, it makes sense that there should be some associated genetic component [19▪]. The overwhelming majority of physicians with opioid abuse or dependence have a family history of substance abuse [20].

There is also considerable association between chemical dependence and other psychopathology. The observation that individuals with the same personality traits tend to self-administer drugs from the same class (opioids for anxiety and depression and amphetamines for attention deficit and hyperactivity states) lends credence to this theory [19▪].

Stress, chronic fatigue and depression are probably important factors [21,22▪]. Stress can lead to isolation and cause physicians to acquire maladaptive strategies, including alcohol or drug abuse [23]. Stress leads to state-related changes in brain reward circuits resulting in a greater sensitivity to the reinforcing properties of the drugs, and thereby

enhancing the reinforcing efficacy of drugs, particularly in those vulnerable to drug abuse [24]. Ready access to opioids and other drugs, together with a detailed knowledge of their pharmacodynamics and pharmacokinetics, must surely play an important role in the onset of substance misuse among anaesthetists [21,25]. The second-hand exposure hypothesis has been postulated. The exposure in the workplace sensitizes the reward pathways in the brain and promotes substance use. Sensitized neurons can be triggered by low doses of the drug which can be assumed to change the brain and the person [26].

A sensitive assay to measure the intravenous anaesthetic and analgesic agents, propofol and fentanyl in air using liquid chromatography–mass spectrometry and gas chromatography–mass spectrometry methods has been developed. The highest concentrations are close to the patients' mouth in which anaesthesiologists work for hours [9]. We could think that exposure to fentanyl, propofol or other drugs in the operating room might be the factors in anaesthesiologists' relapses and the frequency of dependency on opioids such as fentanyl [27▪▪], although in other studies, norfentanyl and fentanyl were not detected in the air during two cardiovascular surgeries [28].

BEHAVIOUR OF THE ADDICTED ANAESTHESIOLOGIST

Those anaesthetists who are dependent upon drugs present a set of subtle changes which occur over a period of months or even years. These may include deteriorating professional performance and health, social withdrawal or financial problems, which, if they occur over long periods, may go unnoticed [29].

MORTALITY

Death, or a nearly fatal overdose, has been the presenting symptom in 7–18% of physicians' substance abusers [3]. There is an increased risk of suicide, especially drug-related suicide in anaesthesiologists compared with internists [30]. Among all anaesthesia-based providers found to be abusing inhalational anaesthetics, the overall mortality rate was 26% (8/31). Among residents, the mortality rate was 36% [15]. The risk of death from inhalational anaesthetics abuse is similar to the overall mortality of misusers of propofol (28%) and the mortality rate was 38% among residents found to be abusing propofol [12], which is similar to the rate of suicide in anaesthetists [30]. In addition, a 2.8-fold increased risk in drug-related deaths in anaesthesiologists compared with internists may represent additional suicides because suicide may have been concealed [30]. However, the finding of a 34% excess risk of death of accidental poisoning compared with the risk of the general population did not reach statistical significance [31].

HARM TO PATIENTS

A drug infraction was two to four times more likely to be reported than an alcohol infraction [32]. The stigma which is attached to these problems will discourage referral by the individual or indeed by friends or colleagues until a catastrophe is either imminent or occurs such as the atypical outbreak of hepatitis C virus detected in Spain in 1998 whose source was an anaesthetist, a morphine addict for many years [33]. Failure to report an impaired colleague may be considered negligence and leaves the individuals and institutions involved in the case if harm comes to any patient [19▪]. There are not many claims involving substance abuse among anaesthesiologists [34]. Some other studies have not found any evidence of patient harm [35,11▪▪].

INSTITUTIONAL EFFORTS

Most countries, anaesthesiology societies and governments have developed specific treatment centres designed just for them or for other physicians. In Europe, the first project to ensure appropriate care for physicians suffering from addictions to legal and illegal drugs was put forward in Catalonia (Spain) in 1998. The programme was called: integral programme for sick physicians (PAIMM; catalan acronym) http://paimm.fgalatea.org/eng/home_eng.htm and the idea has been spread all over Spain [36,37] and appeared to be successful 2 years later [38,39].

A low-threshold facility for seeking help with such problems has been developed in Norway, [40] Great Britain and Ireland Task Force [29]. An American Society of Anaesthesiology Task Force on Chemical Dependency and a model drug abuse and addiction can be found on the American society of anesthesiologists website at www.ASAhq.org/profinfo/curriculum.htm. Nineteen percent of Australasian departments have substance abuse policies in place [5]. Programmes to prevent and/or detect substance use in this relatively high-risk group would therefore seem especially justified [11▪▪].

In spring 2010, the Professional Wellbeing Work Party of the World Federation of Societies of Anaesthesiologists (WFSA) carries out research involving 120 member societies from across the world to identify the incidence of occupational

health problems www.anaesthesiologists.org/committees/working-parties, www.anaesthesiologists.org/guidelines/professional-wellbeing-recommended-reading.

It is essential that each health organization, regardless of its size, has written policies in place specific to the country laws [41].

CONTROLS AND TESTS

Documented diversion of controlled substances from the operating room by anaesthesia care providers has a reported incidence of 1% for faculty and 1.6% for residents [3]. Recent technologic advances, including surveillance of drug transactions via anaesthesia drug-dispensing systems, may allow earlier detection of diversion by analysis of abnormal patterns of usage. These practices are not yet widely adopted [42]. In general, propofol is not under pharmacy control. Lack of control of propofol was significantly associated with positive diversion/abuse [12]. Some programmes of preplacement and postemployment random urine testing of all residents in anaesthesiology have been introduced in an attempt to decrease the incidence of substance abuse [43▪]. Unlike intravenously abused drugs, securing inhalational agents is much more of a logistical challenge given the dispensing and storage characteristics of inhalational agents [15].

TREATMENT

Early diagnosis and prompt treatment are important and the support of family members, general practitioners and former colleagues will be vital in achieving a satisfactory outcome [21]. At the end of a 5-year follow-up period, 71% of anaesthesiologists and 64% of nonanaesthesiologists had completed their contracts and were no longer required to be monitored [11▪▪].

Treatment involves detoxification, monitored abstinence with periodic urine and hair toxic tests, intensive education, exposure to self-help groups and psychotherapy. Urine testing is still the cornerstone for monitoring and documenting abstinence in the recovering addict. An alternative method developed to detect chronic exposure to these drugs of abuse is the analysis of hair samples obtained from the individual. Hair can serve as a marker of chronic exposure because drugs of abuse or their metabolites are incorporated into the structure of the hair follicle over time as the hair grows [19▪].

Naltrexone, like naloxone, is a relatively pure μ-receptor antagonist. It is highly effective orally, and still remains part of the treatment for anaesthesiologists returning to the operating room.

RELAPSING

The risk of relapse with substance use is markedly increased in healthcare providers who use a major opioid, have a coexisting psychiatric illness or a family history of substance abuse [35]. With aggressive follow-up and monitoring, clinicians can expect similar relapse and recovery rates for anaesthesiologists as with others [44].

Death as the initial relapse symptom occurred in 16% of the parenteral opioid abusers who were allowed to re-enter anaesthesiology training [1].

Relapse is most common in the early period of recovery. Although relapse does not necessarily foretells long-term failure, it has been shown that in the setting of re-entry into anaesthesia, relapse is associated with significant mortality [2]. A period away from clinical practice after treatment may reduce the rate of relapse, during which most of the relapses occur [45].

RETURN TO WORK

Of major importance is the question of whether an anaesthetist who has been dependent on opioid drugs should be allowed back to practise anaesthesia wherein such drugs are integral to basic anaesthetic practice.

Among a group of residents receiving treatment for drug abuse, 42–46% successfully re-entered and completed training in anaesthesia [1,2]. With inhalational anaesthetic abuse, there is a lack of successful return to work without relapse. In the study of Wilson, only 22% of those initially found to be abusing inhalational anaesthetics were able to return to anaesthesia practice successfully [15].

Many programme directors will probably feel that re-entry into anaesthesia, with the expectations that fully two-thirds of the re-entrants will relapse into opioid abuse, represents too high a risk. Based on previous studies on mortality [1,12,15,19▪], multiple studies have debated the outcome of anaesthesiologists who have returned to the operating room after some form of treatment for chemical dependency [46]. Berge *et al.* [47▪▪], in his editorial, is extremely pessimistic and clearly believes that a default 'one strike, you are out' policy should replace the current default position of assuming a return to the workplace.

This idea has been shared by others who admit that the substance-related deaths after treatment is a reminder of the risks and mortal consequences of an ill-advised return to the specialty [48]. But some authors disagree [49–53], thinking that with an aggressive follow-up and monitoring, individualized diagnosis and treatment plan, clinicians can expect similar relapse and recovery rates for

anaesthesiologists as others. Each case must be evaluated on an individual basis. A graded reintroduction into the clinical practice of anaesthesia may not be better at reducing the incidence of relapse than the reintroduction after a short period of treatment [19▪].

CONCLUSION

Addiction remains an occupational hazard for anaesthesiologists because of the highly addictive agents that are readily available in the operating room and it is essential to learn to recognize the signs and symptoms of addiction. Successful completion of a treatment programme is not a guarantee against relapse and careful thought is needed to be given to what constituted a sufficient reason to allow an addictive physician to return to the practice of anaesthesiology [19▪,35].

Sick doctors may fear being stigmatized as weak or inadequate and may also have concerns about confidentiality, claims and losing patients' respect [54].

Hospitals and institutions must identify anaesthesiologists whose performance may endanger patients with an objective, fair and responsive system. Assessment and treatment programmes must be available for management of all underlying causes of substandard performance: substance abuse, psychiatric problems, behavioural problems and dyscompetencies. Serious consideration should be given to implementing annual physical examinations and random drug testing for all physicians. Institutions and medical organizations must have policies which can help prevent disastrous medical and legal outcomes for the affected physician, for his or her colleagues or employer and for the physician's patients [41].

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Conflicts of interest

No grant or fund has been received for this work. There are no conflicts of interest.

REFERENCES AND RECOMMENDED READING

Papers of particular interest, published within the annual period of review, have been highlighted as:

- ▪ of special interest
- ▪▪ of outstanding interest

Additional references related to this topic can also be found in the Current World Literature section in this issue (pp. 000–000).

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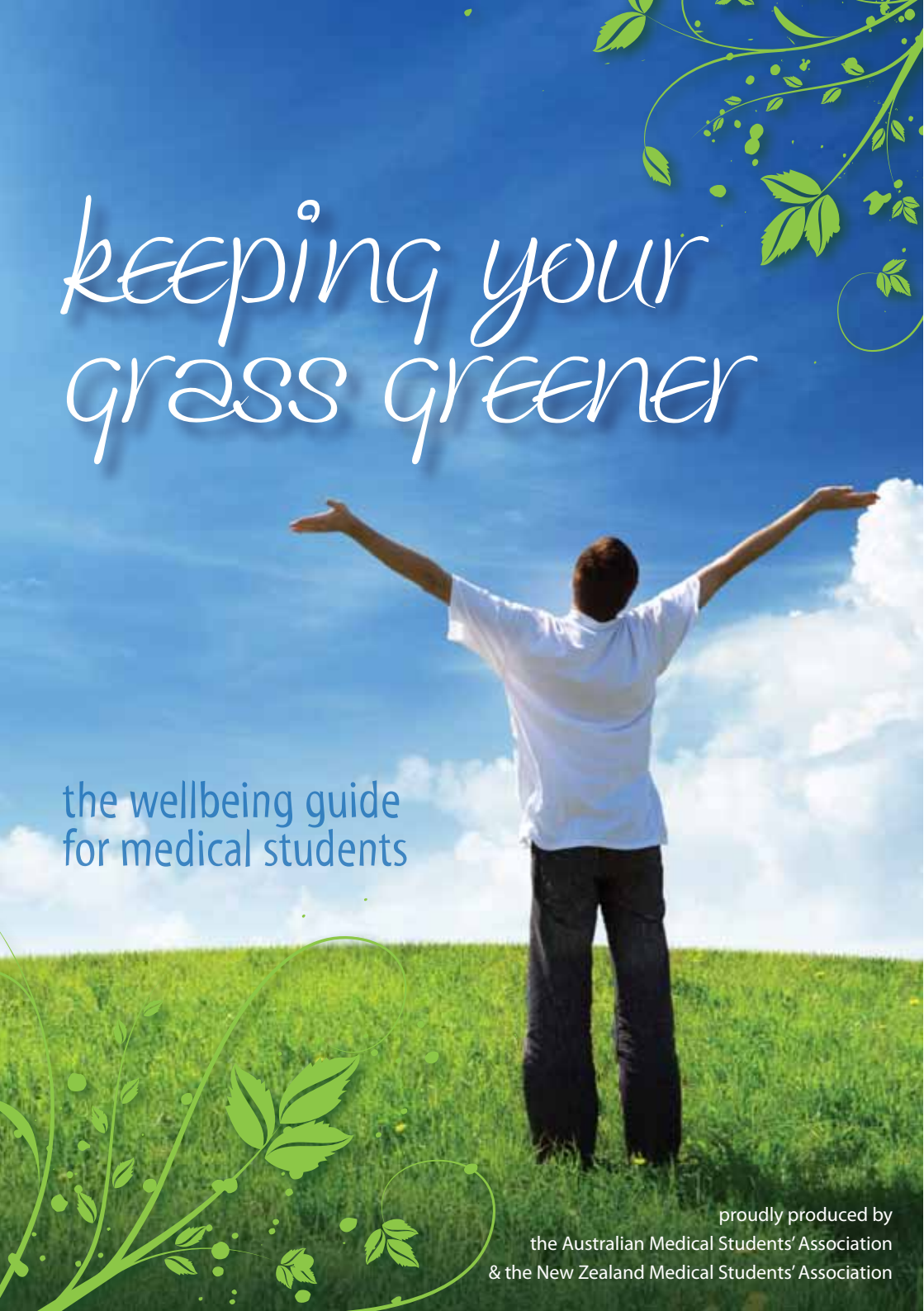
keeping your grass greener



the wellbeing guide for medical students

proudly produced by
the Australian Medical Students' Association
& the New Zealand Medical Students' Association

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amsa
AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

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MPS

MEDICAL ASSURANCE SOCIETY
We make it easy

contents

feel good

Dr Sally Cockburn

When I speak to medical students at O-Week every year, my message is simple: get a GP, get a hobby and get a life.

If you want to be a good doctor you actually need to put effort into looking after yourself. You are not invincible, physically or mentally. The course can seem daunting and chip away at your self-worth, so you have to work at keeping your view of yourself in perspective.

The Wellbeing Guide is essential reading for every medical student. In my view it's as important as those jabs you had before you started the course to build immunity to various infections you may encounter as a doctor. Like those immunisations, this book will help build resilience to another sinister and surreptitious problem - attacks on your mental health. They say plumbers have lousy bathrooms. In the same way, health professionals are generally not flash at looking after themselves. We spend our professional lives caring for others and often we are just too worn out to bother caring for ourselves. You might be able to get away with this for a while but sadly by the time you really need to do something about your health it's often too hard to ask for help.

If you have a family GP, don't lose contact. If you don't, then find one. This should be a high priority in the first few weeks after enrolling and will be insurance for surviving the course and the profession. Your GP is someone you can simply be a patient with, confide in and get support from. You have to let yourself be a patient and listen to advice. You need to practise this because it gets harder the longer you are a doctor.

Because of the intense focus needed to get into medical school, many people stupidly sacrifice things that they enjoyed doing. Getting rid of hobbies is not a sign of discipline; it's actually counterproductive to your goal. In my experience those people who keep up hobbies do better at medicine and life.

Medicine is a great career. It's always interesting and can take you anywhere. Most of all we have the privilege of travelling with people on their personal journeys with health, life and even death. Sometimes joyous. Sometimes devastating. Then again, beware, however enthralling it might be, don't get sucked into the vortex where medicine becomes your life.

There must always be life outside medicine. I sit here nearly 30 years after graduation - medicine is now more or less my hobby and my career is spreading the word on health on radio and TV. I still love practicing medicine. I believe this is because I have a life outside it.

AMSA and NZMSA Wellbeing Team

Dear Medical Students,

We are glad you have picked this booklet up to have a read. It contains some pretty important stuff and tackles issues that have long been neglected.

Medical student wellbeing has often been swept aside as something of little relevance. Any stress, distress or concerns of mental health have been thought of as a normal part of what can be a gruelling education. We, as a profession, did not know how to deal with it and did not want to deal with it - "Warning: Taboo subject lies dormant behind this door. Admitting to stress carries stigma and must be avoided. Do not enter under any circumstance".

Slowly, however, we have started to peek through the lock. Some of us have even opened that door to look inside. The Australian and New Zealand Medical Students' Associations now hope (with a bit of your help) to open that door properly and get things right on track. True, medical students will experience stress at different times, but it need not be at the highest levels of stress, distress and depression that we're at risk of.

Your health is important!

Have a think about it. To get the most out of medical school, and ultimately deliver the best care to your patients, you need to be physically and mentally fit. It is a situation where everyone will be glad you looked after yourself first:

If oxygen is needed in an emergency, a mask will be released from above you. Place the mask over your mouth and nose and tighten the strap. Pull down on the hose to start the oxygen flowing. Make sure you put on your mask first before assisting others.

We produced this booklet off the back of wellbeing research that AMSA and NZMSA conducted, and have included some of the results. We want this document to help break down the stigma that surrounds wellbeing, and provide some practical tips for surviving and thriving at medical school. We have also compiled a help directory that lists places you can go when you need some advice.

Finally, remember wellbeing includes avoiding stress, distress, and issues of mental health, but is also about having a balanced lifestyle, resting well and relaxing, and ultimately enjoying what you do.

Medical school will have its challenges but it should be fun at the same time.

are we that different?

Well, the simple answer is **yes.**

The good news is that we can do something about it (and to an extent already are).

Research studies have shown that medical students have similar psychological wellbeing to the general student population before their course.[1-3] During the course, however, we begin to exhibit lower levels.[4-10]

The statistics are concerning and not an acceptable norm. One study has suggested that almost a quarter of medical students show signs of depression, and of them a quarter will experience an episode of suicidal ideation.[11] Other studies have had more conservative estimates, but they still show we have rates of depression and stress well above the general population.[10]

One of the most worrying statistics from the AMSA/NZMSA research was that 55% of medical students believe there is a stigma associated with experiencing stress and distress.[12] This stigma creates a potential barrier to accessing support services, as we will not want to admit to having a problem (the first and often most difficult step to seeking support). As part of their Doctors' Mental Health Program in Australia, *beyondblue* has conducted a literature review that further emphasises perceived stigma and embarrassment as barriers to seeking help.[13]

So, what does this mean? It means that you have to look after yourself, and as a group we need to look out for each other. We also have to address wellbeing more actively, and realise that stress is normal as a medical student but that we can handle it better.

Our experiences at medical school will mould how we handle stressors as a doctor, so it really is important that we get on top of them all now.

Definitions

Stress
anyone's response to the various factors influencing their life

Distress
a maladaptive response to these factors

Wellbeing
the optimisation of physical, mental and social health

Medical school is a lot of fun. We have some pretty unique experiences and whether good or bad, they make us who we are. These experiences, however, are not necessarily fun at the time.

Cadaver dissection can be eye-opening for many. It can be hard to conceptualise the background to that learning opportunity. The first severely ill patient who you meet may also rattle your cage. Life is precious and it is normal to have these responses.

It's not all death and dying though. There are simple stressors like the continual assessment and sheer volume of knowledge we are expected to carry. Sometimes we are put on the spot by clinicians. That can be a bad feeling too, when you freeze and can only think of whether or not your classmate will still date you!

Dr Dyrbye is a Primary Care Physician at the Mayo Clinic in Minnesota, USA. She has done a lot of work looking at what contributes to the stress of being a medical student. Here are some stressors she identified in a literature review:[14]

Academic

- Substantially increased workload[15,16]
- Concern for academic performance[17]
- High-stake examinations[15,18]

Life

- Personal life events
- Finances and debt
- Lack of time for recreation and hobbies

Support and role models

- Separation from peer-support groups in clinical school and frequent rotations into new environments
- Interpersonal interactions with teachers[19]
- Supervisors who are stressed, depressed or burned out, which leads to modelling of cynicism and unethical behaviour

Student abuse

- Verbal abuse that affects confidence

Exposure to human suffering

That's a scary list! But don't run. Knowing about them means you can be more consciously aware of how they may affect you. You can then ask for some help earlier than you might have done otherwise!

could this be me?

beyondblue

Looking after your mental health and wellbeing

When you're focused on a career in helping others with their health, it can be hard to admit when you need help yourself.

It's important to recognise the signs that you or a fellow student might be experiencing stress or mental health problems. If left untreated, stress and acute distress can lead to depression and anxiety disorders, severely impacting on your mental and physical health - and on your studies.

The good news is that there are many types of effective, easily accessible supports and treatments available. Help is out there, so nobody should be afraid to ask for it.

Depression

Depression is more than just a low mood - it's a serious illness. 1 in 6 Australians will experience depression in their lifetime, but with the right treatment most people recover.

How do you know if a person is depressed and not just sad?

A person may be depressed, if for more than two weeks they have felt sad, down or miserable most of the time, or lost interest or pleasure in most of their usual activities, and experienced some other symptoms which include:

- stopping going out
- poor attendance and lack of involvement in their studies
- withdrawing from friends and family
- relying on alcohol and sedatives
- an inability to concentrate
- feeling overwhelmed, irritable, frustrated or indecisive
- a loss of confidence
- physical symptoms including constant tiredness, headaches, muscle pains and sleep problems
- significant weight loss or gain

Recommended depression & anxiety websites

www.beyondblue.org.au
Information on depression, anxiety and related disorders, available treatments and where to get help.

www.youthbeyondblue.com
beyondblue's website for young people.

www.mmha.org.au
Mental health information for people from culturally diverse backgrounds.

www.headspace.org.au
Information, support and services for young people aged 12 to 25.

www.reachout.com
Information, help, support, advice and connections for young people.

www.bluepages.anu.edu.au
Information about depression compiled by the Australian National University's Centre of Mental Health Research.

www.crufad.com
Clinical Research Unit for Anxiety and Depression.

Anxiety

An anxiety disorder involves more than just feeling stressed. People with anxiety disorders find it hard to function every day - it's a serious illness, experienced by one in four people at some stage of their lives.

How do you know if a person is experiencing anxiety?

A person may be experiencing anxiety if they:

- Feel very worried and anxious most of the time
- Find it difficult to calm down
- Feel overwhelmed or frightened by sudden feelings of intense panic/anxiety
- Experience recurring thoughts which cause them anxiety, but seem silly to them
- Avoid situations or things which cause them anxiety e.g. social events, crowded places, or giving a speech
- Experience ongoing difficulties (e.g. nightmares or flashbacks) after a severely traumatic event

What help is available?

People can often find it difficult to take the first step in seeking help. You can help someone who is experiencing depression or an anxiety disorder by assisting them to get information, encouraging them to get involved in social activities, and suggesting that they see a doctor or health professional.

Treatments

Different types of depression and anxiety disorders require different types of treatments. Depending on the severity of the person's symptoms, these can include physical exercises through to psychological treatment and the use of antidepressants. Everybody is different, and the most important thing is to find a treatment that works.

Psychological treatments deal with problems that particularly affect people with depression or an anxiety disorder, such as changing negative patterns of thinking or sorting out relationship difficulties. The most common and effective psychological treatments are:

Cognitive Behaviour Therapy (CBT)

A structured program which helps to correct negative thought patterns. CBT recognises that the way people think affects the way they feel.

Interpersonal Therapy (IPT)

A structured program with a specific focus on improving relationships. Antidepressant medication is also prescribed sometimes, alongside psychological treatments, when a person experiences a moderate to severe episode of depression and/or anxiety. It's important to discuss your treatment options with a doctor. With the right treatment, most people recover from depression. Remember - you are not your own doctor. If you or someone you know needs help, talk to your GP or another health professional about getting appropriate treatment.

let's avoid this...

Yes, this is all avoidable.

Remember, fit your own oxygen mask before helping those around you.

the importance of having your own GP

Dr Roger Sexton

A GP offers many advantages when deciding to seek formal health care. The value of the partnership between yourself and your nonjudgmental and broadly skilled doctor in guiding you through the health system is immeasurable.

Most people undertake informal self-care before they seek the formal intervention and advice of a GP. That may include the recognition of symptoms, discussion of the symptoms' severity with a friend or relative, minor self-medication such as analgesics, awaiting improvement and, finally, the recognition that the severity or persistence warrants professional advice.

This process can be significantly modified when the patient is a doctor or medical student. The symptom recognition can be poor and corrupted by 'partial' knowledge and degrees of embarrassment and hypochondriasis. Advice may be bypassed in order to avoid exposure of the illness to a potentially critical peer group or supervisor. Self-administration of minor medication can be followed by stronger prescription medication and the use of drug samples that are easily accessible to medical personnel.

There are certain expectations which go with the decision to seek the professional advice of a GP. They can be summarised as the 4 Ts. The treating doctor will be expected to offer sufficient time, possess the required talent, engender trust and display virtuousness and TLC. Disappointment can follow and taint the clinical experience where one or more of these expectations are not met.

The choice of a GP may therefore take a little time until the one who displays these qualities is found. The result should be someone who is your trusted confidante who can advocate for you in the health system, can create a complete medical record and recall you for health checks, is available for phone advice, can connect you with an independent network of health professionals and above all can give you skilled independent medical advice.

It is worth spending the time to find one.

a script for healthy living and wellbeing

beyondblue

Any kind of study can be stressful, but the demands of being a medical student may be especially tough, and it's natural to feel a little overwhelmed at times.

For some people, these feelings of stress, when experienced intensely and for long periods, can result in a range of physical and mental health problems such as headaches, not sleeping, depression or anxiety.

The key is to find a balance between studying hard and living healthily. It's important to look after your mental health and wellbeing. Simply put, if you are mentally healthy and know how to manage stress, you will study better. And if you aren't, your studies may suffer.

Luckily there are some simple steps you can take to safeguard and strengthen your mental health and wellbeing.

Stay physically healthy

Often, simple strategies for staying physically healthy will result in good mental health as well. These include:

- **Keeping active** - Research shows that keeping active can help lift mood; help people get a good night's sleep; increase energy levels; help block negative thoughts and/or distract people from daily worries; help people feel less lonely if they exercise or socialise with others; and increase general wellbeing.
- **Getting a good night's sleep** - Poor-quality sleep can lead to tiredness during the day; poor concentration; irritability; aches and pains; an immune system that doesn't work well (leading to more frequent illness); and overall poorer mental health.
- **Reducing alcohol and other drugs** - Drinking, smoking and using illegal drugs may have a brief mood-lifting or relaxation effect, but can later cause feelings of depression, anxiety, panic attacks and paranoia.
- **Eating a healthy diet** - Food can play a vital role in maintaining mental health as well as physical health. In general, eating a nourishing diet gives people an overall sense of wellbeing.
- **Socialising** - Keeping connected with people helps increase levels of wellbeing, confidence and opportunities to participate in physical activities.

Managing Stress

Stress is common in daily life, and is experienced by everyone at some point. Students are especially susceptible to stress. The pressures of studying are substantial, and most students will feel stressed at some point during their studies. Quite often stress is a natural, healthy response, which can help keep you motivated and focused. However, if left unmanaged it can lead to poor mental health and put you at risk of developing a range of health problems, such as depression or an anxiety disorder.

Stress may be associated with studying, work, family or personal relationships. Whatever the cause, there are things you can do to manage it.

Postponing major life changes, resolving personal conflicts, making time for pleasurable activities, controlling workload, exercising regularly and seeking help early from a friend, teacher, doctor or counsellor may help to reduce stress.

Controlled breathing and/or alternating muscular tension and relaxation can also help you manage stress. For more information on these exercises visit www.beyondblue.org.au, click on Get Information, and download Factsheet 6 - Reducing Stress.

It's important to note that stress isn't depression - but prolonged stress can be a risk factor for anxiety and depression.

Where to get help

The above hints will help you manage stress and lead a healthier life. However, it is important to seek professional help if necessary, especially if you feel that you may be experiencing depression. If you or someone you know needs help, talk to your GP or another health professional about getting appropriate assistance.

To view 'When the Cowpat Hits the Windmill' written by the National Rural Health Students' Network, visit the *beyondblue* website and click Get Information, then Downloadable Information Materials, or visit www.nrhsn.org.au.

For more information on stress and depression, available treatments, where to get help, and how to lead a healthier life visit **www.beyondblue.org.au** or **www.youthbeyondblue.com**, call 1300 22 4636 or email infoline@beyondblue.org.au

To study the phenomena of disease without books is to sail an uncharted sea, whilst to study books without patients is not to go to sea at all - *William Osler*

effective study and managing exam stress

Dr Kieran Le Plastrier
MDA National

Despite years of exposure to exams and assessments, many medical students and graduates continue to report significantly increased levels of anxiety, distress and psychological ill health in response to them.

From the first few weeks of medical school, through to vocational specialist training and academic advancement, a career in medicine involves regular periods of potentially high stress examination and assessment. But unlike the hundreds of hours devoted to teaching the skills and knowledge required to perform clinical examinations and interpret findings, most students will receive barely a lecture or two, and perhaps some printed material, to assist them with acquiring a mastery of independent learning. And passing exams is no indication that study habits are optimal.

The influences and interactions of personality, environmental supports and constraints, cultural issues, as well as features of the assessment structure and study habits of a student all contribute to the complex process of learning. A relationship exists between effective learning and study habits, and later career performance, reinforcing the importance of a more sophisticated understanding of this multidimensional process.[20]

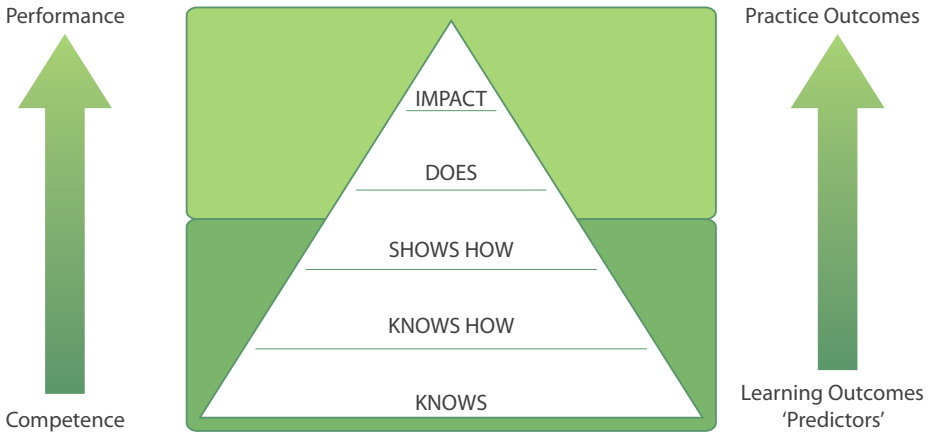

Figure 1: Combined "Bloom's Taxonomy" with Competence-Performance continuum[21]

Over 50% of lawsuits involving junior doctors and adverse outcomes including death in the US in a 22 year period included factors relating to technical competence and knowledge.[22] They are both direct products of the learning environment. But the practice of medicine is greater than knowing a 'whole lot of stuff'; a non-linear relationship exists between the paradigms of competency (showing skills and knowledge in test conditions), and performance (actually doing it in real life).

Effective learning appears to be the outcome of the interaction between a good approach to learning (strategic or deep); provision of appropriate learning environments and teaching methods; awareness of one's learning styles and strategies to exploit their strengths and manage their limitations; and a significant contribution from a well designed curriculum and assessment program. Evidence suggests that trying to adopt new strategies for learning is demotivating and associated with negative feelings,[23] making it even more important to foster the most adaptive behaviours as early as possible in training.

Validated resources and tools are available for students to assist them to better appreciate their individual learning styles and understand the behaviours and strategies for optimal approaches to learning (see useful resources list on page 51). Given a student's very limited control over important environmental factors (curriculum, exam design), it is even more critical that they pursue best-practice goals in their own study. Fortunately, one's approach to study and learning are not fixed, and more effective methods can be learned.

Worldwide, the concept of 'lifelong learner' is now highly valued and embedded in the framework of what constitutes a 'Medical Expert',[24] and is thus considered a critical responsibility of the young professional to develop and foster during their training years.

Approach	Characteristics
Surface	Memorise facts and follow sequences without attempting to understand limits and boundaries, or to integrate learning with other knowledge. Motivated by passing/fear of failing an exam. Replicate what is taught without creating new meaning.
Deep	A focus on understanding rather than memorising. Attempts to relate new material to previous learning. Motivated from within by an intellectual curiosity. Attempts to transform what is taught so that their understanding of the subject is changed and a more abstract representation of theory and practice emerges.
Strategic	Well organised and efficient, adapting the approach to maximize probabilities of getting the best marks. Often a deep learner applying surface approaches where necessary to maximise results.

Figure 2: Taxonomy of Learning Approaches[21,25]

mental resilience

Dr Antonio Fernando

Mental resilience is very similar to being physically fit. Being resilient allows us to withstand the stressors, frustrations and annoyances that beset medical doctors. But more than that, when one is resilient, life takes on more meaning. Some researchers call this state of being "flourishing"! This is much more fun than just existing or surviving.

There has been a recent explosion in research on this area. You might want to research it yourself and Google "positive psychology". The good news is that many of us can change our attitudes and develop skilful means in order to flourish. The following are certain attitudes we can all develop:

1. Mindfulness.

It is a 2500 year old Eastern approach to daily living. A mindfulness practitioner pays attention to the moment, in a non-judgmental manner. One is not bogged down by all the "what if's" and instead savours the current experience. The overall effect is an attenuation of the sympathetic overdrive allowing the person to "chill" naturally. It can be an addictive state of mind!

2. Gratitude.

Learning how to be grateful for many things that we normally do not notice can change our perspective. A daily gratitude log where one lists things s/he can be thankful for at the end of the day has been shown to increase happiness and resilience after two months. This attitude is one of my favourites and one of the easiest to do.

3. Compassion.

All of us can actually increase our levels of compassion to other people, even the most annoying ones. By seeing that all of us, including those who pester us, are all the same, can make a difference in how we perceive others. Being conscious that all of us are actually very similar can make us feel connected and more forgiving. All of us actually want to be happy. All of us want to live in peace. Focus on how similar we are and not on the differences.

If you are interested in some of these techniques, please visit www.calm.auckland.ac.nz.

preventing burnout: don't say yes

Maria Gardiner and Hugh Kearns
(ithinkwell.com.au)

A key cause of burnout and poor work morale is just being too busy - being overcommitted. Medical students in particular can be at risk of being overcommitted because not only do you have very demanding work, but you also have study. Before you know it you've signed up for a committee, been talked into taking on an extra work shift, committed yourself to chairing the fundraising group and squeezed in yet another last minute work request. Often it feels easier to agree and deal with the consequences later. It's hard to say no when someone is standing there in front of you asking (often pleading) for something. Often (well, sometimes) what they're asking for is worthy, fairly reasonable and absolutely plausible. However, as we like to say - even good things can kill you! For most of us it's very hard to say no.

Emotional reasoning

What happens in these situations is that we feel under pressure to agree. Under this pressure a part of our brain (the rational logical bit) goes absent without leave. The part that's left (the emotional bit) can tend to respond without thinking through the consequences. We often say that you shouldn't make decisions unless you have a consenting adult present.

Don't say yes

A useful skill to learn is to buy yourself some time - time for your rational brain to re-engage - a cooling off period if you like. And to do this you need to get out of the habit of automatically saying yes.

Some responses you can use instead of yes are

- I'll get back to you about…
- I'll need to check my diary before I can
- I'll need to check with my wife/husband/friend/border collie about what we're doing
- I think I already have something on then, but I'll check

While you are checking (and cooling off) you can be

- Really checking
- Thinking through if this is such a good idea
- Working out what else you can give up (hint: it's not family/friends! Or you!)
- Coming up with a diplomatic way of saying no. For example, 'I appreciate you asking me to… but right now is not a good time. Perhaps next week/month/year/never'
- Thinking of another option for them. For example, 'I can't do it, but I know Rodriguez is really good at doing that'.

But if you find the idea of not saying yes difficult, you can always book something into your diary so that you have a cast iron alibi. Just make sure that the thing you book in isn't worse than the thing you are trying to get out of. One medical student we know joined a knitting circle so that she would not be available on Tuesday nights when the local council wanted her to chair a working party. Fortunately, she enjoyed knitting!

It's the thought that counts.

Finally, here are some common thoughts people have that allow them to stay overcommitted (and stressed). Next to each thought is a more accurate view.

But...	What's accurate
They'll be upset.	How do I know? Does it matter?
I should do it.	Why? I have a choice, even though it doesn't feel like it.
They won't like me.	They might not be happy with my decision, but they are unlikely to dislike me personally.
They won't ask me in future.	And the problem with this is …?
The patients/staff/community will suffer if I say no.	Even if I say no just once? Am I responsible for everyone and everything? I have a limit (apparently I am human!)

courage, resilience and becoming a doctor

Professor Beverly Raphael
Professor of Population Mental Health and Disasters, University of Western Sydney
Professor of Psychological Medicine, Australian National University

The field of medicine brings special experiences which may be very rewarding, extremely stressful, or both. On top of life and study, such experiences may well be "traumatic" in the psychological sense and lead to stress reactions such as heightened arousal, irritability, intrusive images, or numb feelings. They usually settle in a few days, although if they are severe, even horrific, the reactions may persist, and even develop into a "trauma" syndrome or other problem.

When a stressful or "traumatic" experience occurs, the shock, fear and helplessness experienced shift one's normal equilibrium. While most people deal with this well, it is important to recognise and validate the nature of the person's experience, and to acknowledge their courage and strength in dealing with it.

There are many ways of adapting to stressful experiences. There is evidence that the support of others is helpful, and sharing experiences with a study or peer group, colleague or mentor can help. Families are a vital source of ongoing support, however a student may hesitate to discuss such experiences in this setting for fear of disturbing others, or because of confidentiality concerns.

"Debriefing" is a widely used term in referring to a personal support process where one may "unload" feelings and concerns about such experiences. Recent research indicates however this "Critical Incident Stress Debriefing" model does not prevent the negative mental health impacts, and may even lead to some people being more vulnerable.

The current model is now one of Psychological First Aid which provides some general support in the emergency and opportunities to talk through such experiences if one wishes, but only when ready to do so, usually at a later time. The majority of people are resilient and do not go on to develop trauma syndromes, however treatment such as trauma focused CBT is available to assist if impairments persist, functioning is disrupted, or other symptoms such as depression are evident. There may be formal or informal review processes days or weeks after a major incident that are part of organisation requirements. They may be a form of "debriefing" and generally helpful in putting such experiences in context.

The question becomes, however, how to deal with stressful experiences, in the course of medicine and subsequently as a doctor. There are several components to this:

1. Recognise and build your personal resilience.

This is a pattern of personal and social strengths that will get you through tough times. It involves an element of courage, as well as being able to recognise and deal with your emotions in adaptive ways. This ability to think things through and problem solve will allow you to learn about challenges and identify your best ways of managing them. This knowledge is a valuable resource you will use for years to come.

2. Connectedness with others helps.

Peer support groups and mentor programs are good examples. They can be helpful in dealing with, and learning from stressful situations you may face.

3. Look after your physical and mental health.

Nutrition, exercise, and sleep are key aspects of both, as is building and sustaining your relationships. Caution about substance use is also important as drugs and alcohol may seem easy solutions, but damaging consequences are frequent if they are used to deal with problems, and trauma/stress difficulties.

4. Manage your life stress load.

For instance, ensure you have periods of relaxation and positive experiences. If you look at your experiences as challenges rather than stresses, whenever appropriate and possible, it can help make experiences less problematic.

Becoming a doctor requires courage, empathy, managing relationships, hope, and belief in people and the future. It involves being part of a team, working together, connecting, respecting and supporting one another.

It also involves getting expert help when help is needed. Opting to value and look after one's own life and wellbeing is an important commitment, which can reflect personal strengths, compassion for self and others, and a focus for positive goals in the future.

quick tips

Dr Fiona Moir
Senior Lecturer in Mental Health and Communication Skills,
Department of General Practice and Primary Healthcare,
University of Auckland

Life Outside Medicine

At medical school (and beyond), the high workload often means that students turn all of their focus to their studies, and in doing so neglect other areas in their lives. Whilst it is important to set aside enough time to get the work done, in a realistic way, it is a good idea to step back and think about the best way to achieve this.

It is not the hours spent studying which are assessed - it is how well you have grasped the knowledge and skills required to be a doctor. Often we sacrifice the things in life we used to enjoy - sport, interests, time with friends and family - in order to free up more time for work. However, in our work time we can procrastinate or use inefficient study techniques.

It is possible to do well in the exams and to keep some of your life outside medicine. Try to be aware of how you are spending your time and make sure you develop and maintain a social support network. From the research that has been done in this area, it is quite clear that paying attention to the non-work areas of your life can have a protective effect against burnout.

You may also work more efficiently if you are having regular exercise. It is important to try to step back from time to time and to look at the bigger picture, rather than to remain focussed on any day-to-day worries and tasks. Reminding yourself of the purpose or the meaning in your life can also boost your mental wellbeing.

Asking for Help

It is a sad fact that medical students do have higher levels of anxiety and depression than other people the same age in the general population. Depression and anxiety are common problems, which will affect many of us at some point in our lives.

The NZ Mental Health Survey states that 46% of the New Zealand population will experience a mental disorder at some point in their lives. However, as well as having a higher chance of becoming unwell, medical students also have a tendency to avoid asking for help when they become unwell. This is thought to be due to a fear about lack of confidential support, and concerns that admitting to ill-health may have an impact on a future career. Although these are common thoughts, there are confidential services that can assist you – so seek help early!

Asking for help and looking for solutions is a way of empowering yourself - it is not a sign of weakness. There are many strategies and skills that you can learn, which will help you to recover, and which can lessen the likelihood of becoming unwell in the future.

maintaining your wellbeing

Therese Forbes: Psychologist
Bush Support Services, CRANAplus

Finding a balance between maintaining your own wellbeing and meeting the demands of studies can be a juggling act. Undoubtedly there will be times when you may need to work harder for a short time to meet deadlines and the stress response provides extra energy to do so. This is a healthy process. However, if your stress response is constantly on overload you will lose the ability to set realistic goals, prioritise and establish essential boundaries.

Avoiding this is about putting boundaries and structures in place that allow you to sustain yourself over time.

Maintaining your wellbeing usually includes elements of the following:

Set realistic goals
There is no surer path to burnout than either unclear goals or those that are too high.

Manage your time
Invest time and energy selectively and strategically in ways that further your goals.

Exercise
Burn off that stress producing 'physical energy' pent up in the body. Use exercise to put a buffer between your studies and personal life.

Rest & relaxation
The mind and body are one. If you can calm your body your mind will follow and vice versa, therefore relieving symptoms. Laughter, pleasurable activities or 10 deep breaths are some suggestions.

Meditation or mindfulness
Bringing yourself into the present moment – tuning in to the sounds and the environment around you is a really helpful way to bring yourself to a state of calmness.

Maintain non-work aspects of your life
Work out what the really important aspects to your life are and make time for them.

Establish and maintain friendships
Having a good social network around you is probably the best investment you can make towards your long term wellbeing.

Access professional support if things get a bit too hard

planning and prioritising

Dr Tiffany Fulde

What do you want to be when you grow up? We've all been asked this question - and, once you're in medical school, it usually means what specialty do you want to do down the track. Most will answer with a nonchalant 'I haven't decided yet', some will expand it to 'I don't know exactly, but I've crossed a few things off the list', and a few will outline their specialty and possibly even their training hospital of choice.

Medicine is a very longitudinal career. We frequently talk about training pathways, lifetime learning and continuous medical education, but have you ever stopped to link what you are doing now to what you want to be doing in twenty years?

It can be very daunting at medical school to try to learn 'everything'. It is a new and different learning environment, and the scale of what needs to be done can be overwhelming. Medical school also offers many extracurricular opportunities, there are family and social commitments, and it is important to maintain balance and interests outside the classroom. So how do you fit it all in? The answer is to make sure you use your time effectively, not just efficiently. Being effective means that you are putting the appropriate amount of effort into the tasks that matter the most, prioritising them over the less important tasks.

What is your immediate goal? To pass medical school? To be a good intern? To be awarded Honours? Perhaps it relates to extracurricular activities or social life? Whatever it is, you should decide what you want to get out of medical school, both in the short-term and in the longer-term. Try to keep this goal in mind, and it will help you place the tasks, assessments and activities in perspective.

It is easy to get caught up in deadlines, and spend most time on more urgent or pressing tasks first, even though they may be less important than other tasks that are due later. Equally, more enjoyable activities frequently take precedence over important work. Taking time to plan and rank things by their importance is good motivation, and helps avoid last-minute stress by letting you work smarter. Prioritisation of important tasks, and planning time and effort accordingly will help you to spend your efforts on things you enjoy more. There are a number of styles and strategies, and you should find what works best for you. Setting these skills up now will help you later in your career.

So, next time someone asks you what you want to be, consider telling them who you want to be instead. Do you want to be the youngest consultant neurosurgeon at the biggest teaching hospital in the country, the next Nobel Prize winner for medicine or something less tangible - a good doctor, with a balanced lifestyle.

Remember what you want to be doing – not only will you enjoy what you're doing more, but it will make it easier to see what is important to get you there.

say NO to bullying!

Prof Bruce Barraclough
Dean of Education,
Royal Australasian College of Surgeons

Bullying and harassment occur too commonly in the health workforce, including to (and also by) medical students.[26,27] In fact, over 50% of Australian and New Zealand junior doctors have been bullied during clinical placements.[28,29]

Bullying is unacceptable at all stages of becoming and being a doctor. It may involve threatening, oppressing or teasing someone and can be both physical and/or emotional. It can come from colleagues, more advanced doctors, other members of the health workforce and patients.

If you find yourself being bullied, here are some tips:

- Say STOP! And state that you find such behaviour unacceptable.
- Document threats or actions taken by the bully.
- Discuss your concerns with your tutor, mentor or supervisor.
- If you still have concerns, discuss them with your course coordinator or clinical dean.
- Also consider making a complaint under your university's harassment and bullying policy.

Sometimes you might find yourself being the bully (and it might be completely unintentional from your perspective). If this is the case, it is appropriate to say "Sorry" and apologise for what has occurred. You can clarify "But, I didn't mean to..." if it wasn't deliberate. Making excuses, however, like "I had to let off steam" or "That is just the way I am" show that a problem needs to be addressed.

Bullying and harassment have no role whilst you are a medical student or at a later stage as a doctor.

Ideas in this article were adapted from the Royal Australasian College of Surgeons' Bullying & Harassment Booklet available at www.surgeons.org.

Some simple tips:

- Set some clear, achievable goals to help you keep things in perspective
- Write a 'to-do' list, and rank things in order of importance, not just urgency
- Find the times of day when you are most effective
- Be honest when you're procrastinating, and why
- Reward yourself for achieving your goals
- Review your goals regularly to make sure they adapt as you do
- Remember, you're not alone - ask for advice and help when you need it

compassion fatigue

Dr Peter Huggard

Compassion fatigue (CF) is a response that those working in caring and helping roles may experience as a result of continued exposure to the traumatic experiences of those they care for. That is, they are 'secondarily traumatised' by their experiences. Other terms commonly used to describe this experience are secondary traumatic stress (STS) and vicarious traumatisation (VT). Current thinking is that compassion fatigue has two components: burnout and STS. Although STS is much less common than burnout, it usually has a higher impact upon the person experiencing it, and frequently includes a component of feeling fearful, particularly fear for one's own safety or the safety of those around them.[30] We have relatively limited information about these constructs and it is only recently that clinicians and researchers have sought to understand them.[31-34] A link between CF, STS or VT, and Post Traumatic Stress Disorder (PTSD), has been suggested in that one of the DSM criteria for PTSD includes witnessing, or hearing about, the traumatic effects experienced by a family member or a significant person in one's life - a colleague, patient or friend.[32]

Compassion fatigue has been described as an "occupational hazard" and an "inevitable effect of trauma work".[35] Whilst for some the effects may be inevitable, much can be done to manage the effects of these experiences. Working as a doctor exposes one to both the joys, and the tragedies, of the human experience - you will hear profoundly sad stories; see horrific injury; and be present when patients die including, tragically, when they are young. We cannot be unaffected by these experiences. However, one of the various 'duties' of being a doctor is the duty of care of oneself - that of self care. Bearing witness to this sadness is just that - bearing witness. The sadness is not ours but belongs to patients and their families. We still can experience strong empathic connection, but their sadness is not ours to take away.

Clinicians who experience profound CF may have several of the symptoms associated with PTSD - intrusive imagery, hypervigilence, and avoidance behaviours. More generally, and linking with the experience of feeling burned out, are symptoms of emotional exhaustion, insomnia, somatisation, avoidance of certain patients, problems with personal relationships, impaired ability to make decisions, distancing from patients, family and friends, depression, reduced ability to feel empathic, and difficulties in separating professional and private life.

The key approach to managing the effects of CF is to first recognise and acknowledge that such experiences are possible and that there are preventative strategies that can be adopted. A particularly powerful strategy is to further develop one's resilience, particularly mental resilience.[36] Key attributes of resilience include one's attitudes and perspectives; a balance and prioritisation in life's activities; one's practice management style; and having supportive relationships.[37] Within these four themes are several sub-themes including self-awareness, setting professional limits, spirituality, peer support, and support from partner, family, and friends.

Another important 'protective mechanism' in preventing CF is emotional competence, particularly self-awareness and understanding the limits of one's ability. By being aware of one's emotional experiences and knowing when to seek support, CF can be more effectively managed.[38] Such support may come from people who are close such as family and friends, trusted peers or senior colleagues, or from a GP, counsellor or psychologist. More formal support processes may include belonging to peer groups or Balint groups.[39]

Whenever you are emotionally affected by your work experiences as a doctor, think about them as a natural consequence of what you do, and that they can be a gift that patients give to you. There is much that you can do to understand these experiences and to build your own resilience to assist in managing them. Caring for others is an amazing and privileged experience, and one that can lead to immense satisfaction. Seek all opportunities to maximise the pleasure you can receive from your work.

Basic Facts About Compassion Fatigue
Compassion fatigue is a natural consequence of witnessing the distress and suffering of those we care for in our work
At times, symptoms can include those of PTSD – as well as emotional exhaustion, difficulties in relationships, insomnia, feeling isolated, numbing, breaking down of boundaries between your professional and private lives and fear for one's safety
A key to managing compassion fatigue is recognising when feeling overwhelmed and distressed by the suffering of those you care for and finding someone you trust to talk to about these feelings
Developing your resilience will assist you to minimise and manage the effects of compassion fatigue
Resilience-building strategies include: • paying attention to your attitudes and perspectives on your work • maintaining a balance between your professional and private lives • prioritising your work and reflecting on your practice management style - the ways you manage your workload, the balance in your life, delegation of work, ways you work within your team • having supportive relationships • developing trust in your ability • looking for the humour in life
Find ways to maximise the joy and pleasure you receive from work

taking the stress out of managing your money

Medical Assurance Society

We make it easy

Looking at where your money goes and setting up a budget can be daunting. But spending a bit of time on it now can prevent financial worries later – leaving you free to concentrate on the more interesting things in life.

No matter where you lie on the income and expenditure continuum, taking the time to manage your money has considerable upsides. There's the satisfaction of making real use of your cash and working towards medium or long-term goals, such as saving for a new car, going on an overseas trip or reducing your student loan.

For some people, getting their finances on track might be as simple as thinking before they spend. For others it might require a full-scale turnaround. A useful and comprehensive starting point is the New Zealand Retirement Commission's website, www.sorted.org.nz, which suggests:

- Setting short, medium and long-term goals.
- Making a realistic budget.
- Managing your cash flow. A budget helps you plan where your money should be going - cash flow shows you where the money goes in reality.
- Controlling your debt. Not all debt is bad, but it's easy for it to go the wrong way.
- Saving. It doesn't matter what your income, everyone can save, even if it's just enough to see you through a tight spot.

Budgeting doesn't have to mean cutting out fun. Look into the options for low cost fun, such as having friends over instead of going out, going hiking, visiting local beaches or the many free museums and art galleries. Other ways to cut costs include bargain hunting, shopping at markets, planting a vegetable garden and reducing electricity consumption.

Need help?

For New Zealand medical students, Medical Assurance Society can help with checking your financial health. For advice, call us on 0800 800 MAS (627), visit www.medicals.co.nz or email society@medicals.co.nz.

This article is of a general nature and is not a substitute for professional and individually tailored advice. The views expressed are not necessarily those of MAS.

mentoring

Dr Zoe Wainer
Cardiothoracic Surgical Trainee

One of the biggest sources of medical knowledge comes from wisdom of our elders. It is no surprise then that many clinicians have someone (or multiple people) they consider a mentor.

Mentors can provide general guidance and advice that can relate to many aspects of one's life including career development, emotional support, research and any other issue you consider important. A mentoring relationship can originate from a structured mentoring program or informally via workplace experiences or colleagues identified by the mentee. Often such mentors relate to you best, because there is common ground that led you to meet one another in the first place.

In establishing a mentoring relationship, you should consider what you aim to gain from it. If you are after career advice, for example, you can contact a clinician to ask questions about their specialty. You can then ask them if you can sit in on their clinic or attend theatre with them. Within a short period of time, you may find yourself with someone who can provide advice about your career.

And you don't have to limit yourself to clinicians. If you admire someone for professional or personal characteristics, and want to learn from that person, then don't hesitate to approach them and ask for a mentor relationship. The worst thing that can happen is they may say no. As a medical student, you may initially feel shy or out of place asking a senior clinician for their assistance. Most clinicians are extremely keen to engage with the next generation of doctors, especially when those students have an interest in their field.

Ultimately there is plenty to do, learn and also choose in medicine. It can be made a lot easier with the advice of those who have walked the path before you. We all stand on the shoulders of giants, and having the opportunity to be guided by these giants can be enormously rewarding and enriching.

they're feeling it

see someone experiencing mental distress?

Dr Eleanor Flynn
Academic Mentor, University of Melbourne

Once you become a medical student your non-medical family and friends often ask you about health problems but your medical student friends rarely ask for help, partly because medical students think they should be able to cope without help.

Evidence shows medical students are more likely to suffer from stress and mental health problems, particularly at transition, for example, into the course and from campus teaching to clinical experiences. Students from other countries are also vulnerable when they first arrive at medical school. You can help friends or classmates with psychological problems if you know the signs that suggest there is a problem, and if you know what services are available in your medical school, medical board, university and general community, and how to access these services.

The common signs that a student needs help are:

- Poor attendance and lack of involvement in university studies
- Lack of interest or involvement in other activities
- Increased irritability
- Increased alcohol intake
- Major weight change
- Believing that everyone is against them

How to help

- Make sure you are in a private place
- Ask gently if the friend is OK, perhaps saying you are a bit worried about them
- Suggest they might get help from their GP or the medical school or campus health services and give them the web link, phone number or address
- Do not gossip about another student's health problems; provide practical support

If you are really worried and the person seems unwilling to accept that there is a problem then you should discuss the issue with a trusted member of the medical school or campus health service. This is extremely important if the person is suggesting that they might commit suicide or is behaving in a very unusual manner.

use mental health first aid to help!

Mental Health First Aid - www.mhfa.com.au

Mental Health First Aid is the help offered to a person developing a mental health problem or experiencing a mental health crisis until appropriate professional help is received or the crisis resolves. Do not ignore the symptoms you have noticed or assume that they will go away. It is also important that you do not lie or make excuses for the person's behaviour as this may delay them getting appropriate assistance.

It is important to care for yourself. After providing mental health first aid to a person who is in distress, you may feel worn out, frustrated, or even angry. You may also need to deal with the feelings and reactions you set aside during the encounter. It can be helpful to find someone to talk to about what has happened. If you do this, though, you need to remember to respect the person's right to privacy; if you talk to someone, don't share the name of the person you helped, or any personal details which might make them identifiable to the person you choose to share with.

mental health first aid action plan

1. Approach the person, assess and assist with any crisis

Approach the person if you think there may be a problem, look out for any crises and assist the person to deal with them.

2. Listen non-judgmentally

Set aside judgments about the person or their situation. Most people who are experiencing distressing emotions and thoughts want to be listened to empathetically before being offered options and resources that may help them.

3. Give support and information

Once a person with a mental health problem has felt listened to, it can be easier to offer support and information. This may be:

- emotional support
- practical help
- asking if they would like some information about mental health problems

4. Encourage the person to get appropriate professional help

A person with mental health problems will have a better recovery if they receive appropriate professional help. Treatment options available include medication, counselling and assistance with educational goals, income and accommodation. (Refer to page 8 of this book).

5. Encourage other supports

Encourage the person to use self-help strategies or seek the support of family and friends. Other people who have experienced mental health problems can also provide valuable help in the person's recovery.

This information is taken from the Action Plan in the
Mental Health First Aid Training and Research (MHFA) program.
More information about MHFA can be obtained from: www.mhfa.com.au

stories now told

There are so many stories of people becoming completely overwhelmed by our profession. Later on you will probably have your own. Medical students and doctors provided us with anecdotes they wanted to share, to help create awareness about the stressors we face day-in day-out. Here are their stories.

Halfway through my shift and I was overwhelmed to the point of tears.

It was my third year out of medical school and was working as the trauma registrar on a busy Friday night at a major tertiary emergency department. My responsibility was to see all trauma patients that came through the door. As the night wore on, the ambulances kept arriving to unload their severely injured patients. I had seen some terrible injuries but that wasn't what I was struggling with - rather it was trying to give each patient the care they deserved but finding I was too overwhelmed with the sheer workload to do so.

Two incidences on that night are ingrained in my memory because they brought home the difference that colleagues can make to dealing with stressful situations.

The first was when I admitted to the senior emergency registrar that I was not coping. It was with some embarrassment that I asked him for help. "Not my problem" was his response and instead he advised that I should wake up the trauma consultant on call to ask for support. It had been bad enough that I had to go up to the registrar who was already there in the department to ask for help - and at that point I felt my perceived inability to cope would be compounded if I actually woke up the consultant on call.

Shortly afterwards, I raced over to review one of my many patients and found the surgical registrar with him suturing up his many lacerations. I was overwhelmed with gratitude as it was not actually his responsibility to do that task. When I asked him why he had helped me without me even asking, he said "We're a team - we've got to look after one another."

The surgical registrar's words have remained with me ever since and are a reminder to me of how important it is for doctors to support one another. I have often wondered how I would have coped on that night if he had not come to my aid.

Junior doctors work in demanding and stressful situations. We are constantly juggling the demands placed on us from patients, our supervisors and our training program. We sometimes have a lack of senior support when confronting challenging clinical situations and often

When I was first diagnosed with a mental illness, I felt a bit lost. I didn't know what was going to happen. I didn't really know a great deal about depression management and psychosis management; it was a real feeling of uncertainty.

These days, I've worked out my early warning signs. I see a psychologist and visit my GP regularly. I've got some really good friends and when I'm having a rough time, they're there for me.

My advice to someone struggling would be: have a GP that you can trust. Jot

struggle to get the necessary administrative support we need to do our job properly. Enduring long hours and a stressful work environment is unfortunately still a rite of passage for many junior doctors as they start their careers.

What I have noticed changing is the willingness of medical students and doctors to discuss stress and its opposite, wellbeing, and to acknowledge its importance to our profession. I'm sure that I would not have written publicly about my own personal experience with stress 20 years ago.

Further evidence of this greater willingness to discuss these issues is the biennial Doctors Health Conference, which was last held in September of 2009. The conference reinforced to me the importance of peer support as a mechanism to manage stress in medical students and junior doctors, whether it be by sharing the workload, or indirectly through informal debriefing and sharing of common experiences.

The AMA in March of 2009 passed a number of resolutions recognising the importance of doctors' health and wellbeing. It also conducted the AMA Junior Doctor Health and Wellbeing Survey the year before,[31] which helped put the issue of medical student and doctors' health on the radar of many mainstream medico-political organisations.

The AMA will continue to use our influence and resources to further heighten the awareness of doctors' health issues. We will aim to do this in collaboration with key groups like AMSA, and as part of this we are very pleased to be able to support this Wellbeing Guide.

I am sure that many medical students and even junior doctors will find this guide useful at some stage. It is likely we will all have a similar experience to my trauma registrar episode regardless of where we are training. When it happens remember to not be afraid to ask for help - and in the meantime offer your assistance to colleagues if you see them struggling.

Dr Andrew Perry
Immediate Past Chair, AMA Council of Doctors in Training
Emergency Medicine Registrar

things down before you go so you can let them know what's been happening. Don't be afraid to go in and say "I think I might have depression and anxiety"; they're there to explore that with you.

If you don't feel confident about going to the doctor, use resources available in your community. It's crucial to remember that you're not your own doctor. When I'm unwell, I'm the patient. Don't try to treat yourself.

Dr Naomi Harris,
FRACGP, FARGP/Grad Dip
Rural *beyondblue* ambassador

I have been qualified now for over 30 years, most of that time in full-time General Practice. Ten years ago I was particularly busy: my father had recently died, the practice had done a major refit of its premises and computer systems while continuing to work from them, and, to cap it off, there were difficult staff problems. I was feeling under pressure and starting to struggle to keep it all together. I had always had the attitude that there was 'no such thing as a problem, only a solution'. One day at work I 'ground to a halt', with patients to see, phone calls to answer, and lots of requests for this and that. I suddenly did not know which task to do next, could not prioritise, and sat at my computer with a rising sense of panic and helplessness. It was a very unpleasant feeling, something I was definitely not used to. I realised I needed help, fairly promptly!

I knew a psychologist colleague, who was able to see me and gave me some [common sense!] strategies to deal with things. With a few sessions I recovered, and avoided tipping into a depressive episode. Valuable lessons learned!

I am naturally an optimist and over the years had learnt, or so I thought, to handle the daily rough and tumble of medical work. It was a shock and humbling experience to realise I too could come to grief if I was not careful.

'Stress' in my view has become a fashionable diagnosis: people have 'stress', and we think of it as something bad and to be avoided. Yet 'stress' is a normal part of most people's lives and is often a useful motivator ('if it wasn't for the 'last minute' nothing would ever get done' as someone once said). And there is nothing wrong with hard work and multitasking either. The critical thing is how you manage these things and knowing how to manage it for yourself. And not feeling guilty about doing just that.

GP

I felt like throwing it all in. I had just started clinical school and found the process completely overwhelming. There was so much to learn and the hospital was a foreign environment for me. I was trying to keep up with my life outside of med school but found myself trapped in my room at the flat feeling I needed to study but not really achieve anything. I didn't get out and socialise and stopped doing heaps of things I liked.

The straw that broke this camel's back was when my consultant humiliated me in front of a patient for getting an answer wrong. Sure I probably should have known the answer but it was not ok. They made me feel small and I wanted to leave. I didn't turn up for the next week of school.

Then I finally grew up courage to talk to someone at med school about it. They got me back on track and have been a mentor since. I am now doing everything I used to, loving med school, and about to sit final exams and am not even stressed! Turns out a lot of people experienced similar things to me in those first few months. I wish I had known that then so we could all deal with it together and so that I didn't feel like a failure having to seek help.

5th Year Medical Student,
New Zealand

My wake up call as a doctor came, fortunately, as an intern, when I became septic with appendicitis. It was a wake up call because it was the first time I realised that I couldn't do everything, at least not without consequences.

It had been a very busy run of night shifts in the Emergency Department and I had then tried to get plenty of things done during my days off. After a morning of study and grocery shopping (I'd been existing on take away meals and petrol station chocolate for a while), I started to feel off but thought going for a run might help.

It should have been obvious by the time I got home that things weren't right. Even running for a short distance had left me exhausted with intense cramping abdominal pain. To top it off, I vomited on the front steps.

We are taught during our training to look at evidence and by this point there was a mountain of it that said go and see a GP or head up to the hospital. But still I didn't go for more than 12 hours. I was consciously talking myself out of the need to seek treatment. I thought I knew what was wrong and that it would go away.

My eventual hospital stay after surgery was a week, almost certainly due to my very late presentation.

It took weeks to feel normal again. For me this anecdote is an ever-present reminder that my health is so valuable for doing the job I love and when I compromise it, even in relatively minor ways, I can't perform at my best.

Dr Michael Bonning
Chair, AMA Council of Doctors in Training

My experience was a rather general and common one as a junior doctor of being overworked and under-supported by the system. For me, it led me to look outside the general hospital system and into GP-land. That in itself gave me a break, allowed me to learn new things, and to come to the realisation that I didn't need to leave what I was doing in the first place.

Doctor

No one thought of me as having a mental illness, I was a young man running around. At medical school I was getting excellent marks; people assume that if you're smart, you can't be having problems. I was just one of the crowd.

When I had my first manic episode, I had all the classic symptoms: I was highly anxious and sleeping only an hour or two per night. It was like being a cat on a hot tin roof; I was chasing my tail.

Eventually I found a great psychiatrist and we've built a strong relationship. I've learned things that help me cope, like Cognitive Behavioural Therapy, exercise, meditation, resilience and sleep management strategies.

I'd advise medical students to get a good GP early on in their careers. Go and see them every 3 or 6 months even if you feel alright, just to have a quick chat. Don't wait til you get sick to decide who is going to look after you. Talk to them, even about uncomfortable stuff. They can help.

Dr John,
GP and consumer advocate
beyondblue ambassador

stories now told

Medicine can be very confronting. No matter how much you think you have prepared yourself, something one day will rock your foundations. It might be your first patient who dies, working on a mangled trauma patient, or telling the parents of a three year old that their child has cancer.

Whatever the trigger is, it is normal to experience some sort of emotional response. Failure to acknowledge your distress is unhealthy and can lead to other issues down the track, including burn-out, compassion fatigue and even wanting to leave the profession. Unfortunately, many of us have been taught that it is "unprofessional" to show emotion or admit that something has upset us.

One of the best things my mentor (also an Emergency Physician) taught me, was that it is ok to feel and show emotion. This was after she found me in tears after a particularly distressing resus. I was horrified to have been caught out, and apologised for being so unprofessional. She reassured me that a patient and their family would much rather know that their doctor was upset that their loved-one had died than to think they hadn't cared at all. I have reflected on this many times, and I now allow my sorrow to show when I have to break terrible news to families.

We all have different ways of dealing with stress, but the important thing is not to keep this sort of stuff bottled up. Figure out early on what works for you, because you will need to be able to use your coping strategies often. Avoid "quick fixes" such as alcohol or smoking, and focus on other options such as sport, yoga or meditation. And remember, we all go through this, so no matter how alone and isolated you feel, there is always someone who has gone through something similar.

Dr Alex Markwell,
Emergency Physician

So, I was biting off a bit more than I could chew. With exams looming (clouds on a not-so-distant horizon), I was putting in twelve hour days on my rotation (with little benefit I might add), working part-time, sitting on a few committees and trying to plan the coming holidays, in addition to assembling my first work in research. And when I wasn't doing all this, I was out 'socialising' (read: drinking excessively). Thus, the few spare moments I had, were either spent feeling hungover, or wasted and exasperating. What dawned on me, too late, was that I hadn't made any time for myself. I had so little time that even family became supernumerary. The defining moment was when I found myself becoming really annoyed when my dad asked how my day was after not having spoken to me for three weeks. He's wasting my time, I thought. And that thought said something deep to me.

It's as simple as taking a ten minute breather, sitting down with friends or family over a meal, or going for a good run. Finding time for yourself is one of the most important parts of not only being a doctor, but also being human.

Medical Student

enhancing the health of medical students

Dr Craig Hassed
Senior Lecturer and Deputy Head of Department,
Monash University Department of General Practice

Despite the many hundreds of studies identifying the major health issues confronting medical students and doctors - such as high stress, poor mental health, unhealthy lifestyle and substance abuse - self-care remains an almost universally ignored part of medical education. At Monash University we have tried to go some way to redressing this problem with a Health Enhancement Program. It is based upon the 'Essence of Health',[40] Essence being an acronym which stands for Education, Stress management (mindfulness-based), Spirituality (meaning and purpose), Exercise, Nutrition, Connectedness (social support) and Environment. Evaluation indicates that student wellbeing can be significantly enhanced even during high stress periods like exams. Many frustrated enthusiasts for promoting wellbeing among medical students ask, "How did you get the curriculum time? How did you manage to make a case for having it included?" I would rather challenge anyone to make a sound rationale for omitting such content. The aims and rationale are briefly outlined below.

1. Student and doctor wellbeing is important in its own right.
2. Health affects performance - performing at a high level sustained for a long career is not possible without attention to wellbeing.
3. Doctors who are burned out and depressed make many more clinical errors - self-care is therefore an investment in patient wellbeing and has medico-legal implications.
4. Doctors are role models for patients - 'if we can't be an example then we can always be a warning.'
5. Through an experiential teaching model, students can learn important clinical skills such as in stress and lifestyle management, and integrate the clinical science much more fully.
6. Appreciation of the importance of the wellness approach to healthcare is vital as increasingly dysfunctional healthcare systems based upon the illness model struggle to survive.

Medical students can be powerful advocates for change. The question that faces the current generation is whether to be part of a constructive change to the future of medical education and practice, or whether to allow history to keep repeating itself through a medical culture of denial and self-neglect. For many reasons I would argue that the first alternative is the better.

from medical student to doctor

Dr Peter Foley
Chairman, New Zealand Medical Association

NEW ZEALAND MEDICAL ASSOCIATION

After years of study, the transition from medical student to doctor is a significant milestone. You will be eager to put your training into practice and embark on your medical career and the promising future that awaits you. During this time many young doctors must adapt to working long hours and assessing a diverse array of health problems while also maintaining a balance between training and looking after their patients. It can be an overwhelming and stressful time.

To provide optimal care to your patients you need to make your own wellbeing a priority - which means being aware that you must make a personal commitment to manage your mental health. It is crucial to pursue a balanced lifestyle so that you avoid burnout, stress and other mental health issues. Finding the balance that enables your wellbeing, while also juggling the intensity of your workload can at times be challenging. In this booklet you will find practical advice on how to achieve this.

As stated elsewhere in this booklet, many medical students believe there is a stigma associated with experiencing stress and distress. A recent study showed that this stigma is so negative that almost a third of depressed medical students cited it as a barrier to accessing treatment. Stress or mental illness was often associated with feelings of weakness, shame and embarrassment. A key strategy for redressing stigmatising attitudes is education, which can challenge stereotypes.

The other strategy is being aware that confidential help is available and accessing professional support. As a doctor, your wellbeing is crucial because it has a direct influence on your ability to care for your patients.

Medicine is a very rewarding profession but there are many triggers for stress. Seeking the support of others or approaching a colleague or mentor for help can make a difference.

The New Zealand Medical Association strongly supports AMSA and NZMSA's work to raise awareness of mental health issues for students, especially through university discussion and changes to medical curricula. The NZMA has recently developed a members' resource for doctors' health. It includes advice about the importance of doctors having their own GP, accessing the array of health services that are available, and being prepared to share their problems with trusted others. The NZMA will also continue to advocate for measures that optimise doctors' wellbeing.

We wholeheartedly support this booklet which provides practical advice for surviving and thriving at medical school and beyond. I urge you to arm yourself with the knowledge you need to ensure your own wellbeing is protected, which in turn will enable you to provide the best possible care for your patients.

NZMSA and AMSA are doing what?

Oliver Hansby and Robert Marshall
New Zealand and Australian Medical Students' Associations Presidents

The AMSA - NZMSA collaboration on medical student wellbeing started with the Medical Student Wellbeing Survey by Dr James Hillis and Dr William Perry. Since then our two organisations have collaborated very closely on our wellbeing policy and various other initiatives. We are delighted to now be able to present this booklet to you.

In New Zealand, the NZMSA Action Plan on Wellbeing has given us a good set of goals to improve wellbeing amongst our colleagues. Our first two goals are to raise awareness of wellbeing and reduce the stigma associated with mental illness. Since increasing our focus on wellbeing, there has been more discussion amongst students and faculty about these issues. NZMSA has instituted a wellbeing fortnight in July to bring wellbeing to the forefront. We hope to improve the resources available to students and significant progress is being made in this area. There is still heaps of room for improvement but the initial response to talking about wellbeing has been positive.

Across the ditch in Australia, AMSA has a number of initiatives to help improve the wellbeing of students. The Get-A-GP Campaign has helped encourage students to have their own regular GP. This initiative offers a list of GPs willing to bulk-bill medical students in their local area. AMSA also has the Healthy Body Healthy Mind Campaign with MDA National which has been running for a number of years now and equips students with resources to manage stress. At our National Convention, we run wellbeing workshops as well as promote student wellbeing through AMSAtv. AMSA partners with a number of organisations on student and doctor health including the AMA and *beyondblue*. At a local level, AMSA advocates for universities to provide sufficient pastoral care and support services for students.

AMSA and NZMSA have now started work on a second wellbeing survey looking specifically at what the resilience factors and triggers are for medical students undergoing stress.

Further information on all of these initiatives, and more, can be found at www.amsa.org.au and www.nzmsa.org.nz.

All the best for your studies!

amsa
AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

nzmsa

help is at hand

a problem shared

Gareth Gillespie
Editor, Medical Protection Society

Doctors and health professionals are not immune to the stresses and strains of life - work-related complaints, the general stress of the job, personal problems and issues around home life add substantial pressure to an already demanding profession.

In 2005, MPS and the Medical Assurance Society (MAS) set up a free and confidential counselling service for any doctor in New Zealand and, in 2009, it was expanded to include not only doctors but any healthcare professional who is a member of MPS.

Occasionally, the service has uncovered serious mental health problems in doctors. It has found that the impact of a patient complaint can consist of anger, shame, and reduced enjoyment of work, while blighting a doctor's trust of and goodwill towards patients. A complaint also brings with it the threat of adverse publicity, restrictions on practice and negative effects on a doctor's family.

For a number of doctors, a complaint may be the trigger that leads them to leave their place of work or leave medicine altogether.

In addition, the effect on patients cannot be disregarded. Stress can reduce work performance and impair patient care, and providing counselling for stressed doctors and health professionals can potentially improve the delivery of health services in New Zealand.

how to use the counselling service

- Call MPS on 0800 225 5677.
- Press 1 for medicolegal adviser.
- Your call will be answered by the duty medicolegal consultant.
- Calls to this number can be made in the strictest confidence.
- The medicolegal consultant who answers the phone will ask to whom they are speaking. However, there's no need to divulge the details of your situation; just that you would like to access the counselling service. Your name will not be recorded by MPS.
- Preferably, you will know of a particular psychiatrist or clinical psychologist you would like to see. If you do not have a specific person in mind, you will be provided with names of therapists in your area.
- If you require more than four to six sessions, your therapist will be asked to contact MPS to arrange for more sessions.
- The counselling service is free of charge.

australia nationwide

beyondblue
T: 1300 22 4636 or
infoline@beyondblue.org.au
http://www.beyondblue.org.au or
http://www.youthbeyondblue.com
Information on depression, anxiety and how to help yourself or a friend.

Lifeline
Key focus suicide prevention in Australia
T: 13 11 14 (available 24/7)

Suicide Helpline
T: 1300 651 251
http://www.suicidehelpline.org.au

Headspace
Australia's National Youth Mental Health Foundation
http://www.headspace.org.au/

Sexual Assault Line
T: 1800 010 120

MoodGYM
This is a free online cognitive behaviour therapy program for preventing depression provided by the Centre for Mental Health Research.
http://www.moodgym.anu.edu.au

Blue Pages
BluePages has good resources relating to recognising the warning signs of depression, seeking treatment, preventing reoccurrence and finding the relevant resources.
http://bluepages.anu.edu.au/home/

Black Dog Institute
The Black Dog Institute is an educational, research, clinical and community-oriented facility offering specialist expertise in mood disorders.
http://www.blackdoginstitute.org.au/depression/explained/index.cfm

Direct Line
Drugs & Alcohol Counseling
T: 1800 136 385

G-Line
Problem Gambling
T: 1800 622 112

SANE Australia
The SANE Helpline provides information about symptoms, treatments, medications, where to go for support and help for carers of people with schizophrenia.
T: 1800 18 SANE (7263)
or email helpline@sane.org
http://www.sane.org/

Mensline Australia
A dedicated service for men with relationship and family concerns
T: 1300 789 978

Women's Line
T: 1800 811 811

Family Relationships Centre
T: 1300 364 277

Relationships Australia
T: 1800 817 569 (Free call)
Office Administration: 1300 364 277
Your call will automatically be directed to the nearest Relationships Australia office.

Headspace ACT
T: (02) 6201 5343

Doctors' Health Advisory Service
For more information call 02 6270 5410
To contact service call 0407 265 414

ANU
Student Year Coordinators
There is a Student Year Coordinator for each Year cohort: two are based on University campus for Years 1 and 2; and two are based at the School of Clinical Medicine at Canberra Hospital for Years 3 and 4. They act as student support and first point of contact for students in distress.

australian capital territory

University Counseling Centre
http://counselling.anu.edu.au/
This site also contains numbers for Mental Health Crisis Assessment and Treatment Service (in case of emergencies)

University Health Services
http://health.anu.edu.au/

University Disability Services Centre
http://disability.anu.edu.au/

University Fitness Centre
http://www.anu.edu.au/sport/

new south wales

Doctors' Health Advisory Service
The Doctors' Health Advisory Service (NSW) is an independent, confidential, collegiate service which offers professional medical help to doctors, dentists, veterinary surgeons and students.
For more information call 02 9902 813
To contact service call 02 9437 6552

Medical Benevolent Association of NSW
The MBA was founded in 1896 to assist medical practitioners, their spouses and children during times of need. It is a completely independent organisation, funded solely through donations from the medical profession. Assistance is available to every registered medical practitioner in NSW and the ACT who is in need.
T: (02) 9987 0504

UNSW
Dr Suzie Allman
Student Affairs Coordinator, Faculty of Medicine. (Support for academic, study, personal or health concerns)
http://www.med.unsw.edu.au/medweb.nsf/page/student+affairs+coordinator

Key Contacts
Each campus and hospital has a contact for students. On campus contact:
Dr Liz Tancred (e.tancred@unsw.edu.au)
Dr Ute Vollmer-Conna (ute@unsw.edu.au)

UNSW Counselling Service
http://www.counselling.unsw.edu.au/index.html

UNSW Uni Life Directory
https://my.unsw.edu.au/student/sitelists-sydstudents.html

Peer Mentoring Program
http://www.counselling.unsw.edu.au/for-students/peer-mentoring/

Academic Skills Support
http://www.lc.unsw.edu.au/

northern territory

Headspace Top End
T: 1800 659 388

Headspace Central Australia
T: (08) 8958 4544

Doctors' Health Advisory Service
T: (08) 8927 7004

University of New England
Student Assist
(Support Services)
http://www.une.edu.au/student-assist/

Academic Skills Office
http://www.une.edu.au/tlc/aso/

University of Notre Dame, Sydney
Counselling Service
To make an appointment
T: (02) 8204 4429
E: sydneystudentlife@nd.edu.au
or drop by the Sydney Student Life Offices.
http://www.nd.edu.au/sydney/current%20students/Counselling.shtml

University of Sydney
Sydney Medical School
Student Support, Health and Wellbeing
http://www.medfac.usyd.edu.au/current-students/student-support/index.php

University of Newcastle
Student Support Services
http://www.newcastle.edu.au/service/student-support/

University of Western Sydney
Student Services
http://www.uws.edu.au/currentstudents/current_students/getting_help

Medical Student Society Peer Mentoring
http://www.uwsms.org/index.php?option=com_content&view=category&layout=blog&id=59&Itemid=123

New Students' Guide
http://www.uwsms.org/index.php?option=com_content&view=category&layout=blog&id=73&Itemid=154

University of Wollongong
Academic Services Division
T: (02) 4221 3445
E: StudentServices@uow.edu.au

Student Support Advisor
T: (02) 4221 5332
E: StudentServices@uow.edu.au

University Counselling Services
T: (02) 4221 3445
E: StudentServices@uow.edu.au

Campus Medical Centre
T: (02) 4229 9298

GSM Sub Dean
T: (02) 4221 4317

queensland

Doctors' Health Advisory Service
For more information: (07) 3872 2222
To contact the service: (07) 3833 4352

Doctors' Health Working Party
The working party is not a clinical service organisation, but strongly supports the work of the local Doctors' Health Advisory Service.
T: (07) 3872 2222

Headspace Townsville, Southern Downs, Gold Coast and Fraser Coast
http://www.headspace.org.au/home/headspace-sites/

Griffith University
Student Services and Support
http://www.griffith.edu.au/futurestudents/services-support

GUMURRII Support Unit for Indigenous Australians
http://www.griffith.edu.au/gumurriistudent-support-unit

James Cook University
Counseling Service
http://www.jcu.edu.au/student/counselling/index.htm
Townsville T: (07) 4781 4711
Student Services Building
Cairns T: (07) 4042 1150
Building A1.013

Student Support Services
http://cms.jcu.edu.au/student/support/index.htm

Cairns Adult Mental Health
T: (07) 4050 3100 or (07) 4050 6333

Townsville Adult Mental Health
T: (07) 4796 3000

Townsville General Practice Network Doctors for Doctors
http://www.tgpn.com.au/Docs4docs.shtml

University of Queensland
UQ Student Services
http://www.uq.edu.au/student-services/
Student, person, worker... it's a juggling act. Sometimes you need some help to sort things out.
T: (07) 3365 1704
E: ss@uq.edu.au

UQ Counselling Online Service
http://www.uq.edu.au/studentservices/UQ+online+counselling

UQ Counselling
http://www.uq.edu.au/studentservices/Counselling
T: (07) 3365 1702
E: ss@uq.edu.au

UQ Lifeline
Emergency 24 hour support available 24 hours a day on 13 11 14

UQ Health Service
http://www.uq.edu.au/healthservice/
T: (07) 3365 6210

UQ International Student Support
http://www.uq.edu.au/studentservices/International+student+support

New Student MBBS Information
http://www2.som.uq.edu.au/som/FutureStudents/Pages/default.aspx

UQ MBBS Student Support
Year 1 somyr1.enquiries@uq.edu.au
Year 2 somyr2.enquiries@uq.edu.au
Years 3 & 4 som3&4enquiries@uq.edu.au

University of Queensland Medical Society
MBBS Student Society
http://www.uqms.org

Bond University
Student Support Services
http://www.bond.edu.au/studentresources/student-support/index.htm

south australia

Doctors' Health Advisory Service

The service aims to provide confidential support, information and appropriate advice for distressed medical practitioners.
For more information: (08) 8303 5050
To contact the service: (08) 8273 4111

Medical Benevolent Association of South Australia

The association provides assistance to South Australian medical practitioners and their families in need of assistance due to financial hardship.
T: (08) 8267 4355

Rural Doctors Workforce Agency: Dr Doc Program

Dr DOC aims to support the health and wellbeing of South Australia's rural general practitioners and their families. The project broadly addresses two areas - crisis intervention and crisis prevention. Crisis intervention provides emergency support and networks to assist rural GPs and their families. Crisis prevention promotes the concept of Duty of Care and good health for GPs and their families through a broad range of activities.
T: (08) 8234 8277

Flinders University

University Support Services Guide
http://www.flinders.edu.au/currentstudents/services/get-connected/your-guide-to-student-services.cfm

Flinders One
Student Support and Advocacy
http://www.flindersone.edu.au/Content.aspx?p=59

Counselling Service
Level 3, Student Centre
T: (08) 8201 2118
Sue O'Brien (Counsellor) makes Graduate Entry Medical Program (GEMP) students a special priority. Year 3 and 4 Students Contact GEMP Coordinators, Year Level Coordinators, or Departmental Head of Psychiatry.

University of Adelaide

University Student Support Services
http://www.adelaide.edu.au/student/support

Adelaide Medical Student Society (AMSS)
Health and Wellbeing activities
http://amss.org.au/health-a-wellbeing

tasmania

University of Tasmania

UTAS Support and Equity Unit
http://www.support-equity.utas.edu.au/counselling/services-for-students

AMA Tasmania Peer Support Service

T: 1300 853 338 Every day, 8am-11pm
(Anonymous and confidential - this service is provided by AMA Victoria on behalf of AMA Tasmania).

victoria

Victorian Doctors Health Program
T: (03) 9495 6011
http://www.vdhp.org.au

AMA Victoria Peer Support Service
T: 1300 853 338
Every day from 8am-11pm
(Anonymous and confidential)

Better Health Channel
http://www.betterhealth.vic.gov.au/bhcv2/bhcsubmit.nsf/topicsaz?open&a=1&v=a

Mental Illness Fellowship
Helpline for people with a mental illness, their families and friends, professionals, students and the general public.
T: (03) 8486 4222
Factsheets: http://www.mifellowship.org/understanding_facts.htm

Turning Point
Drug and Alcohol Service
T: 1800 888 236 (24 hours, 7 days)
www.turningpoint.org.au

National Association for Loss and Grief (NALAG)
Statewide not-for-profit association that works towards facilitating and improving the community's awareness of loss and grief issues.
For telephone counselling services, call Griefline on (03) 9596 7799 (12 noon-3am)
For statewide telephone and referral service, call (03) 9650 3000 or 1800 100 023
(9am-5pm Monday-Friday)

Medical Benevolent Association
This association provides assistance to medical practitioners and their families in need of assistance due to circumstances of hardship etc.
T: (03) 9857 5482

Deakin University
For student support contact: Sharyn Milnes or Karen D'Souza
Academic issues: Alister Ward
Current contact: http://www.deakin.edu.au/hmnbs/medicine/staff.php

Full List of Student Services
Faculty of Health, Medicine, Nursing and Behavioural Sciences Student Manual
Available at: http://www.deakin.edu.au/hmnbs or on DSO

General Practitioners' Association Geelong
Can provide details of local GPs who will see medical students.
T: (03) 5229 1922

Division of Student Life (DSL)
http://www.deakin.edu.au/studentlife/contact-us.php

Monash University
HUB
The HUB is responsible for all support services available to Monash students in general. The HUB links to services including counselling, childcare services, financial aid, health and medical (University Health Service), housing assistance, international support, spirituality and OH&S.
www.monash.edu.au/healthwellbeing/index.html
Clayton T: (03) 9905 3156
E: hub.clayton@adm.monash.edu.au
Gippsland T: (03) 9902 6425
E: hub.gippsland@adm.monash.edu.au

MBBS Student Services Support Unit
Assists students with formal university requirements and acts as a point of referral for student assistance (personal/academic) within the faculty
Clayton T: (03) 9905 2048
E: mbbsstudentservices@med.monash.edu.au
www.med.monash.edu.au/medical/central/current-students.html
Gippsland T: (03) 9902 6445
E: gippslandmed@med.monash.edu.au
www.med.monash.edu.au/medical/

University Health Service
http://www.adm.monash.edu.au/community-services/health/
Clinical site administrators and academics. Various emails - refer to MBBS Student Services Support Unit webpage

Student Academic Support (Clayton only)
http://www.med.monash.edu.au/current/sasu.html

Learning Advisor Groups (Gippsland only)
Students can elect to have a learning advisor who provides academic support
E: William.Hart@med.monash.edu.au

Student Support Committees
Committees are made up of staff and students from all year levels of MBBS programs. Meetings are held regularly to discuss any issues arising around students' wellbeing.
Clayton E: Gill.Read@med.monash.edu.au
Gippsland E:
Judith.Embleton@med.monash.edu.au

MUMUS (Monash University Medical Undergraduate Society)
www.mumus.org

University of Melbourne
Medical school course coordinators provide the first port-of-call for support services. In clinical years the Sub-Deans provide support and advice to students in each school. For contact details:
http://www.medicine.unimelb.edu.au/current/support.html

Academic Mentor
Dr Eleanor Flynn: for appointments with Dr Flynn please text her on 0450 307 734 or email her on academic-mentor@unimelb.edu.au or call Celia Ayers on (03) 8344 9794

Student Health Service
A bulk-billing medical clinic for any student of the university.
Ground Floor, 138 Cardigan Street, Carlton 3053
T: (03) 8344 6904

Counselling Services
A free service for all students.
Level 2, 138 Cardigan Street, Carlton, 3053
T: (03) 8344 6927/6928
T: 1800 671 559 (free call for rural students)

International Student Support Services
http://www.services.unimelb.edu.au/international/Melbourne/health.html

western australia

Colleague of First Contact
24 hour service
T: (08) 9321 3098

University of Western Australia
UWA has a formal Sub-Dean structure which reports to the Associate Dean (Student Affairs). There are four Sub-Deans in the medical school who provide advice to students and monitor academic progress. Students are encouraged to liase with their Sub-Dean if they have any concerns or need assistance during their course. These are: Sub-Dean Years 1 to 3; Clinical Sub-Dean Year 4; Clinical Sub-Dean Year 5; and Clinical Sub-Dean Year 6

Student Support Manager (Student Affairs)
Dr Jan Dunphy
jan.dunphy@uwa.edu.au
T: (08) 6488 6000

Associate Dean (Student Affairs)
Associate Professor Roland Kaiser
roland.kaiser@uwa.edu.au
T: (08) 6488 6000

University Counselling Service
http://www.studentservices.uwa.edu.au/ss/counselling

UWA Student Services
http://www.studentservices.uwa.edu.au

UWA Student Administration
http://www.studentadmin.uwa.edu.au

UWA Student Guild
http://www.guild.uwa.edu.au

UWA Sports Centre
http://www.sport.uwa.edu.au

WAMSS
http://www.wamss.org.au

University of Notre Dame Fremantle

Medical Students' Association of Notre Dame
http://www.msand.org.au/

University Counselling Service
To make an appointment T: (08) 9433-0580 or attend the reception desk at the Student Life Office.
http://www.nd.edu.au/fremantle/current%20students/student%20services/counsellingService.shtml

new zealand

New Zealand Medical Association
http://www.nzma.org.nz/

Lifeline
T: +64 9 522 2999
Mon-Fri 10am-2pm, Mon-Thurs 7-10pm
http://www.lifeline.org.nz

Mensline
T: +64 9 522 2500
Daily 6:30-10:30pm
http://www.mensline.org.nz

Youthline
T: 0800 376 633
Daily 11am-11pm
http://www.youthline.co.nz

OUTLine
T: +64 9 303 3584
Weekdays 10am-10pm, weekends 5-10pm
http://www.gayline.org.nz

Alcohol and Drug Helpline
T: 0800 787 797
Daily 10am-10pm
http://druginfo.org.nz/helpline/home

Medical Protection Society & Medical Assurance Society
See page 42.

University of Auckland
In all situations involving illness, accidents or family circumstances where your work may be affected, you should check with staff responsible for a particular course. You are also encouraged to talk with Prof Tim Cundy who is the Assistant Dean (Student Affairs). The Assistant Dean (Student Affairs) is available to students for confidential counselling and support of personal issues impacting on academic progress. The Student Services Manager (FMHS Student Centre) may also be able to assist with other aspects of student support.

Professional Relationships
From time to time, situations may arise where staff behaviour may adversely affect you. This could be due to sexist or other discriminatory comments. While the FMHS makes every effort to ensure this will not be the case, it has responded to the student request to have a procedure established which enables you to discuss any concerns about such incidents in confidence. In the first instance, you should contact the Assistant Dean (Student Affairs).

University Health Services
Make an appointment by calling during office hours or visiting reception at the health centre:
Level 3, Kate Edger Information Commons, 2 Alfred Street, City Campus
T: +64 9 373 7599 ext 87681
Maori Counsellor: Rodney Greaves
Asian Counsellor: Candy Vong
Emergency Counselling Services:
A Duty Counsellor is available daily between 10am-12pm and 2-4pm for emergency situations. Please contact the University Health Reception to make an appointment with the Duty Counsellor.

Contact Counselling Services
City Campus: The main counselling service is located in University Health Services on the City Campus, see above.
Grafton Campus: University Health Services, 89 Grafton Rd, Grafton
T: +64 9 373 7599 ext 86962 on Tuesdays and Thursdays (restricted hours)

University Support Services Directory
http://www.auckland.ac.nz/uoa/home/for/future-postgraduates/fplife-at-auckland/fp-student-supportservices/fp-personal-support

Support for Specific Groups:

Maori students, international students, Pacific students, students with disabilities, parenting support.
http://www.auckland.ac.nz/uoa/home/for/future-postgraduates/fplife-at-auckland/fp-student-supportservices/supportforspecificgroups

Health and Counselling Services
Available through the Tamaki, Grafton and City Campuses:
http://www.fmhs.auckland.ac.nz/faculty/studentcentre/health.aspx

Auckland Women's Refuge Crisis Service
T: +64 9 360 7635
http://www.womensrefuge.org.nz

Auckland Sexual Abuse HELP
Sexual abuse/assault services
T: +64 9 623 1700, 24 hours a day
www.asah.org.nz

University of Otago
Medical School Contacts:
Dunedin: Jillian Tourelle (Manager, Student Affairs/Medical Education Group)
T: 03 470 3886
E: dsm.student-affairs@otago.ac.nz
Christchurch: Carol Milnes (Secretary/Administrator, Undergraduate Education)
T: 03 364 1547
E: carol.milnes@otago.ac.nz
Wellington: Alice Jay (Student Affairs Adminstrator)
T: 04 385 5465
E: alice.jay@otago.ac.nz

University Student Health & Student Counselling Services
http://www.otago.ac.nz/studenthealth

Otago University Medical Students' Association
http://oumsa.otago.ac.nz/

Maori Student Support Services
http://www.otago.ac.nz/services/maori.html

International Student Support
http://www.otago.ac.nz/international/studentsupport.html

Otago University Support Services Directory
http://www.otago.ac.nz/services/

Unipol Recreation Limited (Dunedin only)
http://www.unipol.co.nz/
Dunedin School of Medicine Buddy/Mentoring Programme for Advanced Learning in Medicine (ALM - Years 4 - 6).

Useful Resources from "Effective Study and Managing Exam Stress" - pages 14-15

Felder-Silverman Model of Learning Styles. Assess your own learning style and discover how to make it work better for you.
http://www.engr.ncsu.edu/learningstyles/ilsweb.html

Semones J. Effective study skills: a step-by-step system for achieving student success. Fort Worth TX, USA: Holt Rinehart Winston; 1991. A comprehensive guide to study skills. More than a "how to", it answers some of the big questions about "why to".

Hamdy H et al. BEME systematic review: predictive values of measurements obtained in medical schools and future performance in medical practice. Med Teach. 2006;28(2):103-16.

Publications

When The Cowpat Hits The Windmill

Fantastic resource created by the National Rural Health Student Network in conjunction with *beyondblue*. A guide for staying mentally fit.
http://www.nrhsn.org.au/site/index.cfm?display=40504

Red Cross Australia

Resources to assist recovery after an emergency crisis.
http://www.redcross.org.au/ourservices_acrossaustralia_es_recover.htm

Avoiding Burnout in Remote Areas.
Surviving Day to Day Hassles: A Guide for Remote Health Practitioners

Publication of the Council of Remote Area Nurses of Australia Inc.
http://bss.crana.org.au/cms//file_library/Other/Other_7.pdf

Multimedia Tools

CALM (Computer Assisted Learning for the Mind)

Audiofiles available for download giving specific techniques to manage three sources of long lasting happiness - mental resilience, healthy relationships and finding meaning in life.
www.calm.auckland.ac.nz

The MoodGYM

Learn cognitive behavioural therapy skills for preventing and coping with depression.
http://moodgym.anu.edu.au/welcome

e-couch

Online program for preventing and coping with depression, generalised anxiety disorder, and social anxiety disorder.
http://ecouch.anu.edu.au/welcome

Keeping the Doctor Alive Booklet

This guidebook provides medical practitioners with information and resources on strategies for self care as an essential element of their professional life. It aims to encourage medical practitioners to recognise and discuss the challenges facing them, promote self care as an integral and accepted part of the professional life of medical practitioners, and assists medical practitioners to develop useful strategies for self care.
Available to order at: http://www.racgp.org.au/publications/tools

pleases and thankyous

a word from medical deans

Professor James A Angus
President, Medical Deans Australia and New Zealand
Dean, Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne

Each year I have the opportunity to welcome new medical students to the University of Melbourne. I use this time to remind them of their responsibilities to their course, family, community and recreation. In writing this concluding statement on behalf of all medical schools, I encourage you to do the same: remember your responsibility to recreation and, more broadly, to yourself.

Your journey through medical school will provide plenty of fun and excitement. It will also present many challenges that exceed those you have experienced in the past.

When the going gets tough, please do not be afraid to ask for help. The biggest barrier to a medical student seeking help is often his or her lack of willingness to do so. Getting back on track is frequently easy once this barrier is broken.

All medical schools offer counselling and support services that remain independent of academic progress. There are also support services available outside of universities as detailed in this booklet.

Ultimately it is up to you as an individual to be aware of your own wellbeing. You can only help others from a position of strength. Please look after yourself and take care during your medical school days.

AMSA and NZMSA first published

"Keeping Your Grass Greener"

in 2011.

Thank you to the team behind the booklet:

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RESEARCH LETTER

ONLINE FIRST

Why Physicians Work When Sick

Despite ongoing attention to rising rates of hospital-acquired infections and efforts to stem this growth,[1] limited focus has been given to whether physicians and other health care personnel contribute to workplace transmission of illness by choosing to work when ill.[2-4] *Presenteeism*—the act of working while ill—has important implications for health care personnel, whose repeated interactions with patients make productivity declines from illness more dangerous and disease transmission more likely. While the pressure to work while ill is common across all health care workers, the demand among resident physicians may be particularly great due to pressure from peers and lack of an adequate system of coverage.[5,6] Most residents report coming to work when sick at least once annually, with rates varying little according to sex, specialty, or hospital. These results suggest that presenteeism is ubiquitous and not confined to specific specialties or hospital cultures.[5,6] Despite evidence that most residents work when ill, little is known about the reasons they choose to do so.

Methods. We conducted a paper-based, anonymous, in-person survey of 150 resident physicians present during the 2010 meeting of the American College of Physicians, Illinois chapter. The sample included residents from 20 internal medicine programs in Illinois. We asked residents whether they worked with flulike symptoms in the prior training year and, if so, their reasons for doing so. Ethical approval of the study was granted by the institutional review board at the University of Chicago Hospitals.

Results. Presenteeism among residents was common: 77 residents reported working with flulike symptoms at least once in the last year (51%), and 24 reported working sick at least 3 times (16%). Although not statistically significant at the $P<.05$ level, several important trends were found. Second-year residents were more likely to report working when sick than first-year residents (58% vs 51%) ($P=.51$). Male residents were less likely to work while sick than female residents (48% vs 56%) ($P=.22$). When residents were asked whether they believed that they ever directly transmitted an illness to a patient, 14 responded yes (9%), while 32 believed that there were instances in which other sick residents transmitted their illness to a patient (21%).

Among residents who chose to work when sick, the most frequently reported reasons were an obligation to colleagues and an obligation to patient care (57% and 56% of all residents, respectively) (**Table**). Few residents stated that they worked when sick because they were afraid other colleagues would think they were "weak" (12%); 8% of all residents reported working when ill because they felt pressured to repay colleagues who would otherwise have to cover their missed clinical responsibilities. Second-year residents were more likely than first-year residents to state that responsibility to patient care prohibited them from taking time off for sickness (60% vs 46%) ($P=.21$), while female residents were more likely than male residents to place patient care as a reason for presenteeism (65% vs 49%) ($P=.14$). Compared with male residents, female residents were more likely to report working when ill because they were afraid of being perceived as weak (18% vs 7%) ($P=.16$).

Comment. Although drawn from a nonrepresentative sample of residents, our findings are consistent with national estimates of the prevalence of presenteeism among residents.[5,6] Our results provide the first-ever information to our knowledge on the reasons that residents in the United States choose to work when sick. Residents appear driven mainly by a sense of obligation to patients and colleagues, exemplified by higher rates of presenteeism among more senior residents, who traditionally shoulder more responsibility for unifying care for a

Table. Reasons Given by Resident Physicians for Working When Ill[a]

Reason for Working When Ill	Resident Physicians, No. (%)				
	All (n=77)	First-Year (n=37)	Second-Year (n=40)	Male (n=43)	Female (n=34)
Did not want to force colleagues to cover	44 (57)	23 (62)	23 (57)	24 (56)	20 (59)
Felt pressured to repay colleagues for coverage	6 (8)	0	1 (3)	4 (9)	2 (6)
Afraid colleagues would think they were "weak"	9 (12)	7 (19)	4 (10)	3 (7)	6 (18)
Felt responsibility to care for patients	43 (56)	17 (46)	24 (60)	21 (49)	22 (65)

[a] Data are from a convenience sample of resident physicians attending the 2010 annual meeting of the American College of Physicians, Illinois chapter. A total of 77 of 150 residents reported coming into work sick at least once in the previous year. Differences between program years and sex were not statistically significant at the $P<.05$ level.

team's patients and therefore may feel more pressured to provide care when sick.

The practice of presenteeism by resident physicians raises important questions about the development of professionalism in young physicians. Deciding among conflicting values and resolving ethical and moral decisions is basic to this process. On the one hand, sick residents may be motivated to work when sick because of their duty to care for their patients, dedication to work, loyalty to colleagues, and possible fear of institutional reprisal. On the other hand, residents may be conflicted by the ethical injunction against harming patients; their own scientific knowledge and awareness of the risks of exposing patients, colleagues, and staff to potential illness; and their professional obligation to perform at their best when caring for patients. High rates of presenteeism highlight that the current balance of these values is in favor of coming to work sick.

Resident presenteeism should be better identified and addressed by medical educators and residency leaders. In addition to adequate systems of coverage and occupational health guidelines regarding working when ill, faculty should ensure that residents are taught that refraining from work while ill is the best and most professional way to ensure responsible and safe care for patients.

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MAYO CLINIC

Opioid-Abusing Health Care Professionals: Options for Treatment and Returning to Work After Treatment

See also page 260

We congratulate *Mayo Clinic Proceedings* and the authors Hamza and Bryson[1] on their decision to publish an important and controversial article about the use of buprenorphine maintenance treatment in opioid-dependent health care professionals (HCPs). (Buprenorphine is a semisynthetic opioid agonist-antagonist drug with adverse effects shared with other opioids. It is sometimes used to treat opioid addiction, much as methadone is used.) The Hamza and Bryson article sheds light on some of the problems associated with this practice and with the state monitoring systems (eg, physician health programs [PHPs]) that are in place to secure recovery from addiction and protect the public. Our colleagues in addiction medicine have engaged in bipartisan clinical decision making related to the use of buprenorphine. There are zealots on both sides: some advocate for everyone with opioid dependence to have maintenance buprenorphine treatment, whereas others believe that no one should use it. Without scientific inquiry and data, we lack predictors to help determine the appropriate use of this treatment for our patients. Opioid-dependent HCPs are a distinct, singular group, but the literature reviewed by Hamza and Bryson and their documentation of state policies for the use of this treatment help us to understand buprenorphine's shortcomings in this population as well as limitations of the state monitoring systems, such as PHPs. This article exposes a buprenorphine practice that is relatively unsupported by literature and does not account for risks associated with cognitive deficits. The article also reveals how the lack of national standards for decision making on the timing of HCPs' return to work promotes variable decisions and potential risks.

The success of methodone use in the maintenance treatment of heroin dependence is well documented.[2] The primary positive outcomes for this treatment include facilitating psychosocial stabilization, increasing treatment retention, reducing infections due to blood-borne pathogens, and reducing criminal behavior. Buprenorphine maintenance has also been studied extensively for the treatment of heroin dependence and has been shown to have outcomes comparable to those of methadone maintenance.[3] Buprenorphine maintenance treatment of prescription opioid dependence is increasing in frequency and appears to be effective.[4] However, no data exist for buprenorphine maintenance treatment of addiction to fentanyl or sufentanil, the most common drugs of abuse among anesthesia personnel.[5] In addition, the role of buprenorphine maintenance treatment for such safety-sensitive specialties and professions has not been studied.

Hamza and Bryson thoroughly document the literature on cognitive deficits associated with taking buprenorphine. Although not considered a major hindrance to buprenorphine's use for the general population, cognitive deficits are of great concern to practicing HCPs, whether the deficits result from ongoing buprenorphine use or the opioid on which the HCP was originally dependent. State medical boards and state PHPs need to consider these data when evaluating whether an opioid-dependent HCP can return to work while taking buprenorphine.

Other problems with buprenorphine maintenance treatment exist. Nonopioid drug use (eg, benzodiazepines, cannabis) is common during maintenance treatment with buprenorphine and requires ongoing monitoring. The dropout rate is substantial for those on buprenorphine maintenance, often leading to opioid relapse.[6] Also, the abuse of buprenorphine appears to be increasing. It is commonly diverted to relieve opioid withdrawal symptoms and to reduce the use of other opioids.[7] Patients report using it when they are out of money or opioids. Buprenorphine can be used in doses higher than the daily maintenance dose to provide intermittent euphoria and intoxication. All of these factors need to be accounted for among HCPs, especially if the HCP is being considered for return to work in a safety-sensitive position.

Regarding opioid-abusing HCPs, considerable efforts have been made by numerous state PHPs to ensure abstinence, promote recovery from addiction, protect the public, and afford highly trained professionals the opportunity to return to their chosen fields. However, the survey on state policies regarding HCP work reentry while on buprenorphine treatment, provided by Hamza and Bryson, reveals significant concerns with such programs. The low response rate to their request for information and the lack of any standards among responders suggest a disorganized national system at best. Only under ideal monitoring should those with parenteral opioid dependence return to the health care workplace in settings that expose them to opioids. Without

these ideal standards in place, abstinence rates will not be maximized, protection of the public cannot be ensured, and efficacy of such programs will continue to be questioned.[8]

State PHPs can be hesitant to ask HCPs to change their specialty or their practice, but such a change may be necessary for those with parenteral opioid dependence, even after appropriate medical treatment, because of the risk of relapse to using the dangerous and possibly lethal medications they encounter at work. The use of maintenance buprenorphine, with its potential to undermine cognitive functioning in a safety-sensitive clinical setting, may require HCP placement in a lower-risk occupational environment. For some, this may be a reasonable, even lifesaving, alternative. Time away from medical practice to prove abstinence and establish recovery behaviors is often recommended for parenteral opioid–dependent HCPs, but it is not standardized within the approach taken by individual states' PHPs. The American Association of Nurse Anesthetists (AANA) should be applauded for its clear, specific recommendations for nurse anesthetists with parenteral opioid dependence. The AANA recommends a minimum of 1 year away from the clinical anesthesia arena after a diagnosis of intravenous drug addiction or major opioid use.[9] Unfortunately, such recommendations do not exist for other medical specialties or personnel. Furthermore, we would welcome evidence-based guidelines from the Federation of State Physician Health Programs similar to those from the AANA.

Hamza and Bryson recommend against buprenorphine maintenance for HCPs with opioid dependence. Instead, they support *abstinence-based* recovery consistent with the current standard utilized by PHPs. With such standards, several PHPs have demonstrated the lowest relapse rate ever reported in the literature.[10] Such high success rates among HCPs are related to multiple factors, including the individual's motivation to maintain licensure and professional practice, the extensive treatment provided to this group, and the long-term monitoring established by state PHPs.[11] In fact, one can clearly make the argument that reported success rates are so high that introducing opioid maintenance to this paradigm would not be appropriate. Individual and large collaborative studies of state PHPs have demonstrated that under ideal circumstances, 80% of physicians being monitored for the 5 years after abstinence-based, 12-step treatment do not have a single relapse.[12] Will an institutional review board ever approve a study comparing buprenorphine maintenance with this form of treatment? Can buprenorphine maintenance be justified in the face of such data?

Hamza and Bryson state that potentially addictive substances when appropriately prescribed can interfere with mandatory drug testing and that their use may be "psychotoxic." We disagree on both counts. Because positive urine toxicological results in HCPs are routinely confirmed by gas chromatography or mass spectrometry techniques, prescribed drugs do not interfere with mandatory drug testing. We object to the use of the term *psychotoxic* because it is not defined. We are not aware of any published data that support the premise that buprenorphine maintenance therapy causes increased risk of relapse in HCPs.

It has been our experience in working in the physician health field for several years that hospitals and clinics are extremely concerned that HCPs who take potentially impairing medications, even when appropriately prescribed, constitute increased risk and liability for these institutions. Also, it is unclear whether a malpractice insurance company would support and insure a physician returning to work on buprenorphine maintenance. Initial, as yet unpublished, studies from PHPs suggest that physicians who are being monitored by PHPs (without buprenorphine treatment) have fewer malpractice claims during the monitored period (typically 5 years) than in the 5 years preceding treatment and monitoring (D. Gunderson, MD, oral communication, December 2011). Further favorable reports are anticipated to mitigate this concern on the part of hospitals and clinics for those physicians in monitoring, but they are unlikely to alter concerns over the potential cognitive impairment associated with buprenorphine maintenance in the health care workplace.

Finally, there may be an alternative to the use of opioid maintenance to reduce risk of relapse. A large treatment center (P. Earley, MD, and M. Oreskovich, MD, oral communication, December 2011) and a large PHP (P. Earley, MD, and M. Oreskovich, MD, oral communication, December 2011) have demonstrated a significant reduction in relapse when opioid-dependent HCPs receive monthly injections of depot naltrexone, an opioid antagonist drug that lacks the potentially intoxicating effects of buprenorphine. Routine use of this medication may negate the need or indication for buprenorphine maintenance among HCPs.

We agree wholeheartedly with Hamza and Bryson that caution is needed in decisions associated with the use of buprenorphine maintenance among HCPs returning to the health care workplace. The foundation information required to make good decisions regarding this medication in this population working in safety-sensitive positions is lacking. The use of a medication that has the potential to undermine cognitive function in HCPs work-

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ing in an emergency or critical patient care setting cannot be supported at this time, given the lack of evidence of efficacy in this population and the absence of adequate national standards for its use. We do support national guidelines regarding the use of buprenorphine among HCPs in the workplace, with limits regarding the type of work appropriate for this patient population.

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MAYO CLINIC

Buprenorphine Maintenance Therapy in Opioid-Addicted Health Care Professionals Returning to Clinical Practice: A Hidden Controversy

Heather Hamza, CRNA, MS, and Ethan O. Bryson, MD

Abstract

It remains controversial whether it is safe for recovering health care professionals to return to clinical practice after treatment for drug addiction. One specific component of reentry that remains particularly contentious is the use of pharmacotherapeutics, specifically buprenorphine, as opioid substitution therapy for health care professionals who wish to return to clinical work. Because health care professionals are typically engaged in safety-sensitive work with considerable consequences when errors occur, abstinence-based recovery should be recommended until studies demonstrate that it is safe to allow this population to practice while undergoing opioid substitution therapy.

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For editorial comment, see page 213

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The incidence of drug diversion among health care professionals (HCPs) as indicated by referral to treatment centers has been reported to be between 1% and 2%,[1] but estimates based on anonymous self-report suggest the actual number may be as high as 10%,[2,3] mirroring that of the general population.[4] It remains controversial whether it is safe for these recovering individuals to return to clinical practice after treatment for drug addiction. Current recommendations for reentry are based on collective expert opinion with little empirical data.

For HCPs in recovery from opioid abuse, the use of pharmacotherapeutics, such as methadone and buprenorphine, is particularly controversial, as indicated by the difficulty encountered while attempting to obtain information regarding individual state policy. Some states allow reentry of HCPs undergoing buprenorphine maintenance therapy; others are adamant that reentry remain strictly forbidden. Some do not have any official policy, whereas others take a "hands-off" approach and allow the individual's addiction counselor to make the decision. Several states have demonstrated reluctance to share their policies.

In this article, we review the pharmacology of buprenorphine, summarize reports of problems associated with its use in the general population, and report a survey of individual states' views on whether opioid-abusing HCPs can return to work vis-à-vis use of buprenorphine as a part of a treatment program.

BUPRENORPHINE

Intended Uses

Buprenorphine is a semisynthetic, partial μ-opioid agonist and κ-receptor antagonist that is currently used for analgesia and to treat opioid dependence.[5] The use of buprenorphine as treatment for opioid dependence was first approved in France in 1995, and it currently is approved for such use in 44 countries worldwide.[6] Compared with full μ-agonists, it is believed that buprenorphine has a safer pharmacodynamic profile because of its slow dissociation from μ-receptors and less respiratory depression.[5,7] This slow dissociation allows for less frequent dosing but can make detoxification from the drug difficult.

A limited number of approaches are available for managing and treating drug abuse, namely, a harm reduction and damage control model or an abstinence-based model. Not all addicted individuals necessarily adhere to an abstinence-based model, so the treatment provider needs to consider the risks vs benefits of a harm reduction model (eg, the risks to the addicted HCP or their patients of spreading blood-borne pathogens such as human immunodeficiency virus or hepatitis via infected syringes) and decide which treatment modality will be the most efficacious for the individual.

Effects and Adverse Effects

Despite its partial μ-agonist qualities, buprenorphine still induces the same physiologic responses as full μ-agonists, including cognitive and psychomotor impairment, memory deficits, miosis, respiratory depression, decreased gastrointestinal motility and urinary retention, and nausea. As well, it has been reported by users to have "euphoric" and "drug-liking" qualities and is associated with drug dependence and subsequent withdrawal.[4,8,9] Table 1 compares the pharmacologic properties of different buprenorphine- and naloxone-containing preparations.[10]

TABLE 1. Summary of Pharmacotherapeutics

Generic drug	Trade drug	Drug class	Common dosing frequency and administration route	Diversion and abuse potential	DEA schedule	Potential for neurocognitive and psychomotor impairment	Recommended by AANA for reentry
Naloxone	Narcan	Opiate antagonist	Not applicable (used for overdose)	No	None	No	No (too short-acting)
Naltrexone	Revia	Opiate antagonist	Once a day by mouth	No	None	No	Yes
Naltrexone	Vivitrol	Opiate antagonist	Once a month intramuscularly	No	None	No	Yes
Naltrexone	Addex	Opiate antagonist	Once every 3-4 months, subcutaneous pellet	No	None	No	Yes
Buprenorphine	Subutex	Partial opiate agonist	Every other day or 3 times a week; sublingual, tablet or film	Yes	Schedule III	Yes	No
Buprenorphine with naloxone	Suboxone	Partial opiate agonist and opiate antagonist	Every other day or 3 times a week; sublingual, tablet or film	Yes	Schedule III	Yes	No
Methadone	Dolophine	Opiate agonist	Every day by mouth	Yes	Schedule II	Yes	No

AANA = American Association of Nurse Anesthetists; DEA = Drug Enforcement Administration.
From Hamza and Monroe,[10] with permission.

Abuse Potential

As a partial μ-agonist, buprenorphine is not completely free of abuse potential, although it may have less potential than a full μ-agonist, such as methadone. Several studies have addressed the abuse potential of buprenorphine specifically. After reports of patients crushing buprenorphine pills and administering them parenterally, the oral tablets were manufactured in a 4:1 ratio of buprenorphine with naloxone (a full μ-antagonist; Suboxone). Naloxone (Narcan), the antidote for acute opiate overdose, is a full antagonist capable of reversing all μ-receptor activity. The naloxone is not absorbed systemically when buprenorphine with naloxone is taken orally as intended, but intravenous administration can precipitate withdrawal in dependent individuals and will prevent the euphoria associated with pure buprenorphine.[3,4,9]

Smith et al[11] analyzed poison control center hot-line calls from 2003 to 2005, using specific call inclusion criteria that would be highly suggestive of buprenorphine abuse. Interestingly, they found that the combination drug of buprenorphine and naloxone had a higher abuse ratio than plain buprenorphine, although the authors did not speculate why this might be the case. An obvious limitation of this study is that there is no way to track how many patients abused these medications without calling poison control. Maxwell and McCance-Katz[12] conducted a similar study. In addition to poison control data, they added emergency department visits, treatment admissions, deaths, prescriptions written, surveys, and toxicology laboratory data to track buprenorphine use and abuse. Their data clearly show fewer poison control center calls and deaths related to buprenorphine vs methadone. Their data also depict a sharp increase in buprenorphine distribution with an enhanced difficulty tracking this drug because it is also prescribed for pain.

Winstock et al[13] investigated the methods and motivations for buprenorphine diversion (taking the drug in a different manner than the one prescribed). Described methods of drug diversion include hiding the oral preparation in a piece of gum or surreptitiously removing it from the mouth when buprenorphine is administered in a monitored setting. Most patients initially denied diversion when confronted, but admitted reasons for diversion included the following: too high a dose, desire to stockpile the drug to manage withdrawal, desire not to take buprenorphine, fear of greater addiction, fear of buprenorphine withdrawal, and fear of precipitated withdrawal. Other reasons included intent to divert the medication to a friend or other person or plans to inject the medication at a later time. In a different study, Winstock et al[14] implemented a cross-sectional survey of 669 community pharmacists to analyze buprenorphine diversion. The authors explain that detection is difficult because the tablets are small and thus easy to hide in the oral cavity. As well, the tablets take several minutes to dissolve sublin-

gually, and it is tedious and time-consuming for physicians to verify full dissolution.

Neurocognitive Effects

Many clinical trials have assessed psychomotor performance, decision-making ability, and neurocognitive functioning while under the influence of buprenorphine.[15] Pickworth et al[16] investigated the subjective and physiologic effects of intravenous buprenorphine in healthy volunteers. Although the number of participants in their study was small (6), the researchers found, when compared with placebo, that participants had responses prototypical of full μ-opioid agonists, including increased positive responses regarding "feel drug" questions and scores on "liking" scales, "good effects," euphoria, and apathetic sedation.

Zacny et al[17] compared subjective, psychomotor, and physiologic effects of intravenous buprenorphine, morphine, and placebo (saline) in 16 healthy volunteers. Participants were not currently drug dependent and did not have a history of substance abuse or dependence, but all reported a history of experimentation. The authors implemented 5 subjective measures and 6 tests of psychomotor and cognitive performance. Subjective measures included "drug liking," a locally developed visual analog scale, and the Addiction Research Center Inventory. Psychomotor-cognitive tests included eye-hand coordination, auditory reaction time, a logical reasoning test, and a memory test. The results were unexpected: buprenorphine produced impairment in 5 of 6 measures of psychomotor performance in a dose-dependent fashion, whereas morphine caused minimal impairment. Furthermore, it was buprenorphine, not morphine, that caused more respiratory depression.

Schindler et al[18] assessed driving aptitude in 30 patients receiving maintenance therapy, half taking methadone and the other half taking buprenorphine. They used the ART 2020 Standard (Act & React Test system) to evaluate 7 different domains of traffic-relevant performance, including concentration capacity, reactive behavior, orientation, and stress resistance. The authors report no overall difference between the methadone and buprenorphine groups; however, significant differences were found between them and the controls. In particular, the buprenorphine group exhibited a significant number of incorrect reactions in the attention test under the monotonous circumstances portion of the examination.

Mintzer et al[19] analyzed the dose-effect relationship on performance in opioid-dependent volunteers, using repeated administration of buprenorphine and naloxone instead of a single-dose regimen. The researchers used a computerized version of the Digit Symbol Substitution Test, 2 computerized Trail-Making Tests, and a time estimation task. The use of a control group is not described; rather, repeated measures were administered to the same participants. They did not detect impairment until the highest dose of buprenorphine-naloxone (32 mg/8 mg), for which recognition memory was negatively affected (ie, worsening performance).

Soyka et al[8] studied driving-relevant psychomotor performance in 62 patients with a history of opioid dependence who were randomly assigned to buprenorphine or methadone treatment. They implemented a battery of psychomotor, cognitive, and visual perception tests that specifically addressed attention, working memory, and cognitive flexibility. Participants were tested at baseline, then after 8 to 10 weeks of treatment, when the patients had reached a stable maintenance dose of the medication. The authors concluded that although both groups had impairment, the buprenorphine group demonstrated less impairment.

Pirastu et al[20] also compared outpatients undergoing methadone and buprenorphine maintenance therapy with a history of opioid dependence but used a different battery of cognitive tests. Their instruments included the gambling task (to assess decision-making ability), the Wechsler Adult Intelligence Scale, the Wisconsin Card Sorting Task (to measure abstract conceptual skills, cognitive flexibility, and error feedback), and the Benton Visual Retention Test. The researchers found that the patients undergoing buprenorphine maintenance therapy performed much better in the gambling task but that the remaining test results were not significantly different.

Rapeli et al[7] compared cognitive performance in buprenorphine-naloxone–treated vs methadone-treated patients during early opioid substitution therapy, comparing the 2 groups to healthy controls. The researchers implemented a battery of cognitive tests that assessed attention, working memory, and verbal memory. They found deficits in both patient groups with respect to all 3 groups of tests, but it is not clear if this was due to the substitution therapy or a residual effect of prior opioid abuse.

Jensen et al[21] used 23 healthy volunteers to evaluate the pharmacokinetic-pharmacodynamic relationships of cognitive and psychomotor effects of intravenous buprenorphine. Three tests were used for neuropsychological measurements: the Trail-Making Test (to measure neurologic impairment and to test visual information processing), the Finger-Tapping Test (a simple measure of psychomotor speed and motor control), and the continuous reaction time (to measure vigilance and attention by testing ability to respond to external

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stimuli). The authors found that buprenorphine significantly impaired cognition and psychomotor performance in all domains tested.

Messinis et al[5] studied patients undergoing buprenorphine maintenance therapy vs abstinent heroin abusers undergoing naltrexone therapy. This study was unique in that 1 group was taking a full μ-antagonist. A total of 50 patients were recruited from drug treatment programs and were given a battery of neuropsychological tests to assess a broad range of cognitive functions, including verbal learning and memory, verbal fluency and language, visual learning and memory, psychomotor speed and attention, selective-sustained attention, and executive functioning. The researchers found that the buprenorphine group performed worse than the controls (naltrexone) on several cognitive tasks, in particular, the encoding and delayed recall of verbal information, conceptual flexibility and executive functions, and visual perception and delayed recall of visual information.

PROFESSIONAL HEALTH PROGRAMS

Recognizing the significant investment of limited societal resources in the education and training of HCPs, programs designed to rehabilitate addicted HCPs and return them to clinical practice have been created by most state medical or nursing societies. Maintaining a balance between preservation of these resources and maintenance of patient and public safety, these professional health programs (PHPs) offer an alternative to outright suspension or revocation of the license to practice, provided the professional complies with the rehabilitation contract and remains in recovery. Voluntary enrollment in these programs temporarily prevents action by the state licensing board and allows for eventual return to clinical practice. However, a number of HCPs are participating in PHPs without the knowledge of the licensure board. These individuals are either self-referred or referred to PHPs by hospitals, practices, treatment centers, or others. Although these individuals are subject to the same terms imposed on participants referred as part of an alternative to discipline program, the state board of medicine or nursing does not necessarily have knowledge of their status unless reported by the PHP.

We inquired of the 51 physician programs in the United States what their stance is concerning returning an HCP to the workplace while the HCP is undergoing buprenorphine maintenance therapy. Fully 25 remained unavailable for comment despite our multiple attempts to contact them, 2 programs replied that they were unwilling to discuss this issue, and 1 program director "felt uncomfortable" revealing the state's practice. The nursing programs were a little more cooperative, although 16 of 51 state programs still remained unavailable for comment on this issue. Table 2 summarizes the individual physician and nursing policies by state.

DISCUSSION

Most studies evaluating the effects of buprenorphine maintenance therapy found some degree of impairment when participants were subjected to a variety of tests designed to assess particular nuances of higher cerebral functioning. Many studies compared performance with buprenorphine vs methadone, clearly showing that although buprenorphine causes less impairment, it still causes impairment. Unfortunately, evidence is lacking in the specific population of HCPs treated with this medication. Studies need to be conducted that evaluate participants' ability to perform tasks specific to those required of HCPs while undergoing buprenorphine therapy. These studies should involve standardized patients or operating room simulation, using realistic scenarios that require rapid analysis and action, complex decision making, eye-hand coordination, and fine motor skills.

Considerations of damage control and harm reduction are appropriately influential when prescribing pharmacotherapeutic adjuncts in a comprehensive program of recovery. For example, if the only way for a heroin addict to maintain abstinence is to become dependent on methadone or buprenorphine, the risk-benefit ratio may be justified. From an epidemiologic standpoint, dependence on these other medications can reduce the risk of human immunodeficiency virus infection, hepatitis, and other complications related to intravenous drug use. These harm-reducing measures multiply in heroin-abusing populations that are known to share needles, but they hardly apply to the population of addicted HCPs because these people typically have access to sterile needles and syringes, thus reducing that risk exponentially.

The effect of abstinence-based recovery has implications apart from the public health and safety considerations. The improved quality of life for the professional under this model of treatment further justifies the use of the abstinence model specifically in HCPs, and the literature suggests that the success rate of PHPs is much higher than in other populations.[22] This offers another argument against use of buprenorphine in HCPs and one that may be more persuasive to addicted professionals and others who are considering how to get them needed help.

Abstinence from all potentially addictive drugs remains the criterion standard for HCPs in recovery. Most PHPs that use an abstinence-based model for

TABLE 2. State Policies Regarding Reentry of HCPs Undergoing Buprenorphine Maintenance Therapy

State	PHPs and/or SBOM policy	Nursing and CRNAs alternative to discipline and/or SBON policy
Alabama	No; citing concerns of cognitive impairment	Yes; under special circumstances
Alaska	No policy	State has no alternative to discipline program for nurses at this time
Arizona	Unavailable for comment	Unavailable for comment
Arkansas	Unavailable for comment	No; state has no alternative to discipline program for nurses at this time; this is the policy of the SBON
California	Not allowed under any circumstances; state has no official PHP at this time; this was the policy of the California diversion program before dissolution and is the current policy of the state medical board	No if in monitoring program; yes if on probation (reported to the NPDB)
Colorado	Yes; for some physicians after neuropsychiatric testing to evaluate for significant cognitive impairment but not for anesthesiologists	No
Connecticut	Yes; on a case-by-case basis	Allows nurses of all levels to reenter while undergoing buprenorphine therapy, but there is no formal policy from DPH or BON
Delaware	No policy; but allowed if prescribed by the treating psychiatrist	No position at this time
District of Columbia	Unavailable for comment	Yes; under special circumstances
Florida	No policy; but allowed if prescribed by the treating psychiatrist	Not allowed under any circumstances
Georgia	Unavailable for comment; state has no official PHP at this time	No policy; but allowed if prescribed by the treating psychiatrist; state has no alternative to discipline program for nurses at this time; this is the policy of the SBON
Hawaii	No policy; but allowed if prescribed by the treating psychiatrist	Unavailable for comment
Idaho	No policy; not allowed under any circumstances	No policy
Illinois	Unavailable for comment	Unavailable for comment
Indiana	Decline to comment	No; nurses are tapered off buprenorphine before returning to clinical duties
Iowa	No policy; no experience with physicians taking buprenorphine	State has no alternative to discipline program for nurses at this time
Kansas	Not allowed under any circumstances	Not allowed
Kentucky	Not allowed under any circumstances	Unavailable for comment
Louisiana	Unavailable for comment	Not allowed under any circumstances
Maine	No; physicians are tapered off buprenorphine before returning to clinical duties	Yes; but then the nurse is placed on probation; state has no alternative to discipline program for nurses at this time; this is the policy of the SBON
Maryland	No policy; but allowed if prescribed by the treating psychiatrist	Yes
Massachusetts	Decline to comment	Not allowed under any circumstances
Michigan	Unavailable for comment	Unavailable for comment
Minnesota	No policy; but allowed if prescribed by the treating psychiatrist	No policy; but allowed if prescribed by the treating psychiatrist
Mississippi	Unavailable for comment	State has no alternative to discipline program for nurses at this time
Missouri	Unavailable for comment	Yes
Montana	Unavailable for comment	Yes
Nebraska	Unavailable for comment; state has no official PHP at this time	No policy; but allowed if prescribed by the treating psychiatrist

(continued)

Mayo Clin Proc. ■ March 2012;87(3):260-267 ■ doi:10.1016/j.mayocp.2011.09.007
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TABLE 2. Continued

State	PHPs and/or SBOM policy	Nursing and CRNAs alternative to discipline and/or SBON policy
Nevada	Unavailable for comment	No policy; but allowed if prescribed by the treating psychiatrist
New Hampshire	No; physicians are tapered off buprenorphine before returning to clinical duties	No; nurses are tapered off buprenorphine before returning to clinical duties
New Jersey	Yes; provided the physician participating in a comprehensive treatment program	Not allowed under any circumstances
New Mexico	Unavailable for comment	Unavailable for comment
New York	No policy; but allowed if prescribed by the treating psychiatrist	Yes
North Carolina	Not allowed under any circumstances	Yes
North Dakota	Unavailable for comment; state has no official PHP at this time	Unavailable for comment
Ohio	Unavailable for comment	Not allowed under any circumstances
Oklahoma	Unavailable for comment	Unavailable for comment
Oregon	Unavailable for comment	No official policy
Pennsylvania	No policy; but allowed if prescribed by the treating psychiatrist	Not allowed under any circumstances
Rhode Island	Unavailable for comment	Unavailable for comment
South Carolina	Unavailable for comment	Not allowed under any circumstances
South Dakota	Unavailable for comment	Opposed to it
Tennessee	Not allowed under any circumstances	No; nurses are tapered off buprenorphine before returning to clinical duties
Texas	No policy; but allowed if prescribed by the treating psychiatrist	Not allowed under any circumstances
Utah	Unavailable for comment	No policy; but allowed if prescribed by the treating psychiatrist
Vermont	Unavailable for comment	Yes; allowed if prescribed by the treating psychiatrist
Virginia	Unavailable for comment	Yes
Washington	Not allowed under any circumstances	Unavailable for comment
West Virginia	Not allowed under any circumstances	Yes; if prescribed by the treating psychiatrist
Wisconsin	Unavailable for comment; state has no official PHP at this time	Unavailable for comment
Wyoming	Unavailable for comment	BON does the monitoring; not the alternative to discipline program (no response from BON)

BON = Board of Nursing; DPH = Department of Public Health; HCP = health care professional; NPDB = National Practitioner Data Bank; PHP = physician health program; SBOM = State Board of Medicine; SBON = State Board of Nursing.

physicians in recovery report success rates far in excess of other programs.[23] There is a long history of success using this model, and the most recent data reported only 22% of physicians testing positive for drugs of abuse at any time during their 5-year monitoring contract and fully 71% remaining licensed and employed 5 years after their initial treatment.[24] In certain situations, potentially addictive drugs can and should be used when the benefit outweighs the risk, but in most of these cases, the situation is extreme and generally time limited. In the case of HCPs in early recovery who are not working clinically, patient safety is not compromised, but the longer-term use of these potentially addictive medications is problematic. These medications can interfere with mandated drug testing and increase the liability carried by the HCP and employer should there be a bad patient outcome. The inability to remain abstinent is often associated with multiple relapses. Although these medications can be widely used to help retain people in the detoxification phase of treatment, maintenance is another matter and indicates severe difficulty with maintaining recovery. More important, these drugs may actually be "psychotoxic" to those in recovery, and inability to remain abstinent without opioid maintenance therapy may be a potential predictor of increased risk for relapse (Mark Broadhead, MD, medical director of the Idaho Physician Health Program, oral communication, February 24, 2011).

The real possibility of relapse once recovering HCPs have returned to clinical practice has a number of implications for the health and safety of the HCPs and their patients. Because the risk of relapse and death is highest during the first year of sobriety and decreases over time, it seems reasonable that the HCP in recovery should spend some time away from clinical practice before returning to work. The appropriate length away from clinical practice after discharge from the initial inpatient treatment facility has not been determined. Most nursing programs require a period away from clinical practice, ranging from a few months to a year or more, but this practice is not standardized and varies from state to state. Physician programs are equally varied, and although recommendations suggesting a minimum of 1 year have been made,[25] there is still no consensus.[26] When a formerly opioid-dependent HCP who is maintained with a full μ-opioid antagonist (naltrexone) returns to clinical practice, it undeniably strengthens the safety net. Conversely, if a reentrant is taking a partial μ-agonist and relapses on a very potent full μ-agonist, such as fentanyl, it is reasonable to assume that this would precipitate an overdose.

CONCLUSION

Opioid-addicted HCPs are masters of drug diversion. Education does not grant anybody immunity from developing addiction, and in this population, intelligence can be used to cleverly circumvent narcotic accountability and drug substitution. When considering all of the aforementioned issues with buprenorphine diversion, it does not seem reasonable to prescribe this medication to an HCP with a history of opioid addiction. After carefully considering the evidence, we believe that opioid-substitution therapy with buprenorphine is not a reasonable choice for this particular patient population. HCPs are engaged in safety-sensitive work that requires vigilance and full cognitive function. We therefore recommend abstinence-based recovery until studies with this specific HCP population performed in a simulated health care environment document that highly safety-sensitive tasks can be performed without deterioration in performance.

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La salud del MIR

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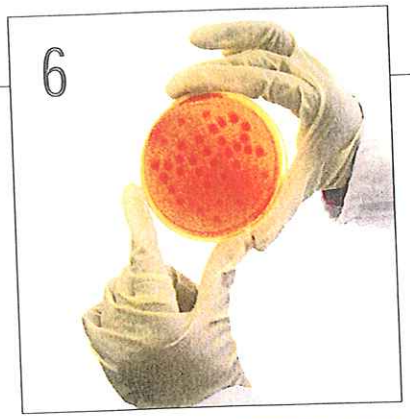

En este número

Cuidar de quien nos cuida

La autosuficiencia o la negación de la enfermedad son en ocasiones las causas de que los médicos no sean buenos pacientes

Los médicos no suelen ser buenos pacientes. Hay excepciones, claro está, pero esa afirmación es aplicable a la mayoría, como reconocen los propios galenos. Sin embargo, nadie escapa a la enfermedad. Estudios que han comparado la mortalidad del colectivo médico con la de la población general muestran que los facultativos tal vez viven algo más que sus pacientes, un dato que en buena parte se basa en la más temprana y mayor disminución del consumo de tabaco entre estos profesionales que entre el resto de ciudadanos. Sin embargo, la tendencia apunta hacia unas tasas de muerte y enfermedad que irán acercándose cada vez más.

Como cualquiera, los médicos son personas expuestas a la enfermedad. En determinados aspectos, algunas características de su profesión pueden abocarlos a problemas de tipo psíquico. El estrés, la exigencia y el contacto constante con la enfermedad pueden afectar a su equilibrio psicoemocional, de modo que se calcula que alrededor de un 10% de nuestros facultativos puede experimentar durante su vida un trastorno psíquico o conductas adictivas.

No es infrecuente que el afectado trate de negar u ocultar su situación, lo cual no hace más que provocar un retraso en afrontar el problema y, en consecuencia, un empeoramiento del pronóstico. Si no se busca solución, la enfermedad del médico superará el ámbito personal y puede convertirse en un problema comunitario por el perjuicio que la mala praxis, los errores o la negligencia pueden ocasionar en sus pacientes.

La autosuficiencia o la negación de la enfermedad son en ocasiones las causas de que los médicos no sean buenos pacientes. Según la Fundación Galatea, a cuyo presidente hemos entrevistado para este número, el de los médicos es, paradójicamente, uno de los colectivos peor atendidos dentro del sistema sanitario. En el reportaje que abre este número se habla del Programa de Atención Integral al Médico Enfermo (PAIME), una iniciativa ejemplar para cuidar de quien nos cuida que arrancó en 1998 en Barcelona y que se ha extendido por gran parte de nuestra geografía para prestar asistencia específica, especializada y confidencial a los médicos que necesitan ayuda.

Sin embargo, el reportaje se centra en mayor medida en la salud de los médicos residentes. El Programa de Salud del Médico MIR, que puso en marcha la Fundación Galatea en 2005, se difundirá por diferentes puntos de España para que lo conozcan mejor tanto los propios residentes como sus tutores y los responsables de sus centros docentes.

Este programa se basa en la necesidad de que los jóvenes que inician su formación como residentes sean conscientes de las dificultades que se pueden encontrar en su profesión y que pueden afectar a su salud psicoemocional, lo que podríamos llamar la cruda realidad de ser médico. A través de las actividades que se desarrollen con el apoyo de los colegios de médicos, los futuros especialistas recibirán una serie de recomendaciones a aplicar desde ya mismo, pues se reconoce que el periodo de formación, tal vez cuando se es más vulnerable, es clave para sensibilizarse acerca del futuro como profesional. Cuidar la propia salud asumiendo hábitos y estilos de vida adecuados, saber afrontar los momentos de ansiedad y estrés, conciliar la vida familiar y la profesional, actualizar constantemente los conocimientos o no llevarse los problemas a casa forman parte de ese conjunto de recomendaciones.

Es posible que muchos médicos que hayan sido realmente pacientes se conviertan en mejores médicos. Pero lo que no hay que olvidar es que la salud del médico es fundamental para la salud de sus pacientes. ■

La salud del MIR

Óscar Giménez

Con el fin de sensibilizar al colectivo de médicos MIR sobre la importancia de su propia salud y de los riesgos psicosociales a los que pueden enfrentarse, se está difundiendo por toda España el Programa de Salud del Médico MIR, gracias a un convenio firmado por la Fundación Patronato de Huérfanos y Protección Social de Médicos Príncipe de Asturias (FPHOMC), la Fundación Galatea y Laboratorios Almirall.

Según la Fundación Galatea, se estima que uno de cada diez médicos puede sufrir durante su vida profesional algún episodio relacionado con enfermedades psíquicas o conductas adictivas. El hecho de que los padezca un médico conlleva dos problemas principales. Por una parte, pueden afectar a su ejercicio profesional, dar lugar a mala praxis, a errores o negligencias evidentemente perjudiciales para sus pacientes. El otro problema es que los médicos no suelen ser buenos pacientes cuando están enfermos.

En 1998 el Colegio de Médicos de Barcelona puso en marcha el Programa de Atención Integral al Médico Enfermo (PAIME), que progresivamente se ha ido extendiendo a otras partes de la geografía nacional. Se creó para superar las barreras que impiden a los facultativos verse como pacientes y para facilitar el acceso a una atención sanitaria de calidad y especializada en caso de enfermedades relacionadas con trastornos psíquicos o conductas adictivas.

Fue una iniciativa pionera en Europa, aunque inspirada en experiencias que habían demostrado funcionar bien en Estados Unidos, Canadá o Australia.

Cinco años después nació la Fundación Galatea, fruto de la necesidad, entre otros motivos, de contar con un instrumento de gestión del PAIME. Según su presidente, Jaume Padrós, «nos dimos cuenta muy pronto de que habíamos puesto mucho el acento en el ámbito de la atención de los médicos con problemas de salud mental y de adicción que podían comprometer la praxis, pero que también era necesario profundizar en los aspectos que pudieran propiciar o desencadenar situaciones adversas y, por tanto, abocar al médico a esos problemas mentales o de adicción».

Extensión del PAIME

«Hay cosas intrínsecamente relacionadas con el propio ejercicio de la profesión, como inmersos en un modelo de organización en un sistema público o privado, determinadas especialidades o determinados periodos del ejercicio, que pueden conllevar más riesgo para el médico –afirma Jaume Padrós–. También existía la necesidad de que esa reflexión fuera compartida no solamente entre médicos sino entre otros profesionales sanitarios, como enfermeras –que lo pusieron en marcha más adelante a través del Programa Retorno en Barcelona–, veterinarios, farmacéuticos, odontoestomatólogos y otros profesionales de nuestro contexto. En algunos casos tienen características muy comunes respecto al cuidado de la propia salud y al hecho de basarse en el principio de "cuidar a los que cuidan de nosotros", que es el lema de la Fundación».

«No hemos creado un programa asistencial para médicos que pueda entenderse como un privilegio para los propios médicos –continúa–. Se trata de un recurso asistencial específico, porque sabemos que cuando se ponen enfermos tienen dificultades para acudir al médico y pedir ayuda, y que cuando se trata de enfermedades de carácter mental o de adicción se agudiza mucho más el problema. Hay evidencia de que existe cierta cultura de ocultación del problema entre el mismo afectado y su entorno, con lo cual la evolución, si no se interviene, acaba siendo muy negativa. Y esto puede poner en riesgo la calidad de la praxis de ese médico y, por tanto, la salud y la atención sanitaria que pueda recibir el ciudadano. Este es el principio por el cual el Colegio de Médicos de Barcelona, y por extensión el conjunto de la profesión médica española, decidió poner en marcha un programa de estas características».

Para Juan José Rodríguez Sendín, secretario general de la Organización Mé-

La etapa de formación es un periodo clave para los futuros médicos y especialistas. Deben poner los dos pies en tierra y comprender que la realidad de la profesión que han elegido puede llegar a ser en ocasiones emocionalmente dura

dica Colegial (OMC), el PAIME cumple un doble objetivo: «Por una parte, conseguir que el médico enfermo se sienta respaldado y, por otra, dar una garantía todavía mayor de protección a los pacientes, la garantía de que el médico que los atiende está en condiciones óptimas para ejercer».

Programa de Salud del Médico MIR

Rodríguez Sendín destaca que «la profesión médica es la primera en dinamismo, en valoración social, y también la más exigente desde el punto de vista afectivo y emocional. De forma imprevista, a diario, los médicos se ven sometidos a tensiones para las cuales se necesita cierta fortaleza y no vale cualquier personalidad. Estas situaciones, que no son infrecuentes, cuando se plantean sobre todo en los profesionales más jóvenes, crean situaciones límites, algunas de las cuales pueden ser prevenibles o evitables para que no sufran determinadas desviaciones y trastornos».

Desde su origen, la Fundación Galatea ha estudiado si el hecho de ser médico implica unos problemas de salud distintos a los de la población general. También ha estudiado la salud de los médicos residentes, una etapa clave de la formación en la que el MIR debe consolidar sus competencias y enfrentarse a la realidad de la profesión. Guardias, presión asistencial, pocas horas de sueño, situaciones emocionalmente impactantes, dilemas éticos y morales, interacción intensa con pacientes y familiares... Para Jaume Padrós, que también es vicepresidente primero del Colegio de Médicos de Barcelona, son situaciones que pueden calificarse como estresantes y que pueden afectar seriamente al MIR en una etapa de especial vulnerabilidad.

Para afrontar el lado más duro de la realidad profesional, la Fundación Galatea, la Fundación Patronato de Huérfanos y Protección Social de Médicos Príncipe de Asturias (FPHOMC) y Laboratorios Almirall han firmado un convenio para difundir el Programa de Salud del Médico MIR. La FPHOMC promoverá la interlocución y coordinación con los distintos Colegios de Médicos españoles para procurar la organización de las sesiones teóricas, así como para fomentar su difusión. La Fundación Galatea, creadora de dicho Programa en 2005, aportará los contenidos y el material divulgativo de las sesiones teóricas programadas. Almirall, por su parte, se encargará de la organización y de todo el soporte logístico y económico necesario para las sesiones.

Para Padrós, el acuerdo «viene a plasmar no sólo el trabajo realizado hasta ahora, sino la voluntad de darle una continuidad. Queremos sensibilizar a los profesionales sobre la necesidad de cuidar su propia salud y bienestar, adquirir esos hábitos y hacerlo a las tempranas edades de la formación, de residencia –declaró cuando se firmó el convenio–. Los valores de la profesión se basan en tener un equilibrio psicoemocional, desarrollar valores como la capacidad de compromiso, la generosidad, o en el hecho de ser competente en una profesión muy exigente».

La salud de los residentes

El estudio realizado sobre la salud de los MIR, realizado en Cataluña y editado en 2009, arrojó unas conclusiones interesantes. En primer lugar, subrayó la necesidad de aumentar la concienciación sobre la práctica de estilos de vida saludables entre los médicos residentes, ya que su papel ejemplar, junto con la difusión activa de consejos preventivos, puede tener un gran impacto en la población.

La investigación señala que la prevalencia del malestar psicológico durante la residencia, que se sitúa en torno al 30%, confirma que la medicina es una profesión con riesgos psicosociales que puede hacer especialmente vulnerable al médico joven.

Papel de los tutores

Los tutores y formadores desempeñan un papel fundamental en todo este contexto. Su labor no debe restringirse a proporcionar conocimientos y a supervisar la adquisición de los mismos por los residentes. Como profesionales que están cerca del médico en formación, son también los receptores de sus problemas e inquietudes y con frecuencia deben plantearse cómo actuar para que los conflictos de sus tutorandos se resuelvan.

Guía para tutores y profesionales de los centros sanitarios docentes

Las sesiones que se llevan a cabo por toda España sobre la salud de los residentes abordan también el rol de los tutores. Hace unos años, la Fundación Galatea editó una Guía para tutores y profesionales de los centros sanitarios docentes, cuyo objetivo es informar sobre los problemas de salud más habituales a los que se enfrentan los médicos residentes y saber cómo actuar ante distintas situaciones.

La guía abarca desde los factores que pueden favorecer el estrés del residente a la promoción del desarrollo profesional saludable y el reconocimiento de las situaciones que hacen necesaria una intervención especializada.

Se vio que los hábitos y estilos de vida de los MIR no son idóneos desde el punto de vista de ese papel ejemplar que deben asumir los médicos ante la población general. No obstante, el consumo de alcohol y de psicofármacos entre los residentes es claramente inferior a lo reportado en estudios llevados a cabo con médicos de mayor edad.

«Esta realidad justificaría, por un lado, la conveniencia de complementar los programas formativos de los especialistas con la adquisición de habilidades que ayuden en el manejo del estrés y el impacto emocional de la práctica médica y en la integración de espacios de apoyo emocional en las actividades habituales del residente», señalaba el estudio entre sus conclusiones.

Asimismo, ponía de manifiesto que los servicios docentes deberían garantizar una organización y un clima de trabajo que fuesen receptivos a las necesidades del residente, insistiendo en la función de los tutores como responsables de orientar y realizar el seguimiento del proceso de formación del residente.

Otra conclusión importante es que el bajo nivel de consulta que hacen los residentes con malestar psicológico plantea la conveniencia de establecer recursos de fácil accesibilidad para tratar sus problemas.

«Ser médico es una profesión vocacional –subraya Jaume Padrós–, a pesar de que esta palabra parecía estar desde hace años obsoleta e incluso proscrita del diálogo profesional. Es obvio que mantener el equilibrio psicoemocional es imposible si no existe una sólida vocación que sea enriquecida con la relación con los pacientes y con la propia profesión. Nada de esto se enseña en la formación de pregrado y los residentes se encuentran de golpe con una realidad sumamente compleja. Lejos de ser un gran problema, queremos que eso sea una gran oportunidad.»

Salud del MIR: Cuestiones en las que pensar

En el Programa de Salud del Médico MIR también se han editado recomendaciones dirigidas al médico que comienza su etapa de residencia, basadas en los resultados de los estudios llevados a cabo. Estas son las cuestiones en que pensar:

- Ya no eres solamente un estudiante. Ahora eres también un profesional de la medicina. Este nuevo papel significa responsabilidad y exigencia.
- Los pacientes y sus problemas no son una pregunta en un examen. Con ellos la relación será intensa y a veces emotiva. Pero sobre todo debe ser muy profesional.
- Nuestro sistema sanitario está considerado como uno de los mejores del mundo. Pero es muy complejo y, como en otros servicios públicos esenciales para el bienestar de las personas, existe presión asistencial, tareas burocráticas, condiciones especiales de trabajo, relaciones laborales diversas, competitividad entre colegas, etc. Aprender a moverte con facilidad entre todos estos factores forma parte de tu formación.
- Te incorporas a una profesión donde es muy importante el *long life learning*: la actualización constante en conocimientos y avances científicos y tecnológicos.
- La vida personal se puede complicar con tu nueva actividad y la conciliación entre la vida familiar y la profesional puede resentirse: te tocará hacer guardias, tus horarios no siempre serán estables, en algunos momentos te llevarás a casa los problemas del trabajo... Valora la gran importancia de tus vínculos familiares y sociales. Pueden ser un buen apoyo.
- Vivirás de cerca situaciones que te resultarán completamente nuevas y te asaltarán dilemas éticos y morales que nunca te habías planteado. Enfrentarlos, encaminarlos o solucionarlos desde un inicio es imprescindible para ser un buen profesional.
- Aprovecha el periodo del MIR para adquirir buenas habilidades y buenos recursos, tanto para la práctica profesional como para una vida profesional equilibrada. Aprende de los mejores profesionales.
- Procúrate formación y apoyo para saber afrontar momentos de ansiedad y estrés y para aprender a manifestar tus sentimientos de manera racional y ajustada a las situaciones.
- **Proponte mejorar las** habilidades sociales y comunicativas con los compañeros y tutores. Y con los pacientes y sus familiares, por supuesto.
- Si no te han ofrecido una acogida formal y en profundidad en tu centro de trabajo, pídela y solicita también que te presenten el equipo asistencial y el personal de apoyo.
- Si te encuentras ante situaciones difíciles (ya sean profesionales o personales) no renuncies a pedir ayuda y consejo a los demás.
- Habla con los residentes más mayores, su experiencia te será útil.
- Búscate un poco de tiempo libre para aquello que sea importante para ti, además de la medicina. No te descuides; procura mantenerte activo intelectual y físicamente, hacer deporte y seguir una alimentación equilibrada. Es fácil aconsejarlo y, aunque cuesta llevarlo a la práctica, los beneficios de hacerlo son evidentes.
- Y cuando hayas cruzado el ecuador del MIR, piensa en los residentes que necesitan tu apoyo. Años más tarde, cuando ya seas adjunto, tutor o jefe de servicio, recuerda también la intensidad de tus primeros días de médico.

Para los médicos residentes es muy importante acercarse a un ideario de profesionalismo muy ligado al equilibrio psicoemocional

Jaume Padrós
Presidente de la Fundación Galatea

–¿Qué es la Fundación Galatea y cuáles son sus objetivos?
–La Fundación Galatea es una institución que se creó auspiciada por el Consejo de Colegios de Médicos de Cataluña en 2003. Es una consecuencia del Programa de Atención Integral al Médico Enfermo (PAIME), que puso en marcha el Colegio de Médicos de Barcelona en 1998. La Fundación es fruto de la necesidad de contar con un instrumento de gestión de dicho programa, que tenía una parte básicamente asistencial, pero aparte de la gestión de la unidad ambulatoria y la unidad de ingreso, necesitábamos un instrumento más ágil que la propia institución colegial.

–El PAIME ha sido una iniciativa pionera en Europa. ¿Ha sido imitada en otras partes?
–Lo que se ha hecho en el conjunto de España ha sido desarrollar la idea que se creó en 1998 en Barcelona y que se ha ido extendiendo en todo el territorio. La idea que siempre defendemos es que existan unidades de atención ambulatoria y un solo referente para ingresos en todo el territorio nacional. Nos apoyamos e inspiramos en experiencias que en los años 70 y 80 comenzaron a desarrollar organizaciones profesionales en Estados Unidos, Canadá, Australia o Nueva Zelanda. Nuestra experiencia es la primera de Europa. No se trata de un recurso asistencial, que también lo es, sino un recurso para garantizar desde la profesión un ejercicio saludable y un ejercicio con seguridad, velando por la defensa de una buena praxis, ayudando al médico a salir de su problema y garantizando a la sociedad un nivel de calidad de la praxis de ese profesional de acuerdo con las funciones que los médicos tenemos encomendadas.

–Háblenos del Programa de Salud del Médico Residente.
–Además de los programas específicamente asistenciales como el PAIME, el programa Retorno para enfermería o los programas que ya hemos puesto en marcha para veterinarios y farmacéuticos, existe un desarrollo de programas para conocer el impacto sobre la salud que pueden tener determinadas facetas de la profesión: jubilación, género, edad, diferentes modelos de organización, etc. En Cataluña se hizo un estudio comparativo entre la salud de los médicos y la de la población general, gracias al cual tenemos criterios para conocer si hay diferencias. Uno de los puntos importantes es que el momento de la formación del médico es crucial y, por lo tanto, es un muy buen momento para adquirir hábitos saludables. También es cierto que es un momento en que se pueden adquirir actitudes no deseadas. En todo caso, es una época en la que hay una especial incidencia de estrés, exigencia y presión que puede poner al médico en situaciones límite. Como conocemos lo que sucede, queremos ver cómo desarrollar iniciativas para prevenir que esas situaciones sean menos impactantes, tanto a través de los residentes como de sus tutores y formadores.

–Recientemente se ha firmado un convenio para la difusión del Programa de Salud del Médico Residente. ¿Qué se va a hacer?
–Lo que se busca es que, desde los estudios realizados en la Fundación Galatea, el análisis no solo sirva a los médicos de Cataluña sino también a los de todo el territorio nacional. En primer lugar, debemos incidir en la formación de pregrado para que los médicos adquieran buenos hábitos y conozcan las realidades intrínsecas de la profesión. El médico tendrá que desarrollar mecanismos para saber compensar el sufrimiento de los demás, las expectativas de los pacientes o sus familias, la presión asistencial, la competitividad o la necesidad de actualizar constantemente sus conocimientos. Queremos que se extienda la idea de que para los médicos residentes es tan importante adquirir un cuerpo de conocimientos como acercarse a un ideario de profesionalismo muy ligado al equilibrio psicoemocional. Para eso es necesario adquirir unos hábitos y aproximarse a la realidad de la profesión de una forma no traumática. A través de documentos y material didáctico intentamos relacionar los grandes valores de la profesión con el mantenimiento de ese equilibrio. ■

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EDITORIAL

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Physician Substance Abuse and Recovery
What Does It Mean for Physicians—and Everyone Else?

David R. Gastfriend, MD

THE 10% TO 15% PREVALENCE OF SUBSTANCE USE DISorders among physicians is similar to that in the general population,[1,2] but the quality and intensity of treatment given to physicians may far exceed that available to other individuals with these disorders.[3-5] Recognition of the impaired physician began to emerge only in the 1970s[6] and has led to the development of physician health programs (PHPs). These are now mature models, available in many states, usually through medical societies, as an alternative to monitoring by state government boards of registration in medicine.[7] In many cases, physicians who voluntarily contract with a PHP may remain anonymous[7] to the state medical board and the National Practitioner Data Bank, a feature designed to promote early intervention in the disease process, ie, before patients are harmed. Many PHPs now offer services to other health professionals also. Treatment in these programs is probably the most compre-

See also p 1453.

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hensive available for the disease,[8] likely to include a full continuum of care, longitudinal (1- to 5-year) management, contracting for treatment and mutual help group (eg, Alcoholics Anonymous) participation, frequent assessment, random urine testing with observed micturition, hair testing for abused substances, and workplace surveillance.[9]

Referral of an impaired physician is nonpunitive, imperative, and can be life-saving—for both patients and the impaired physician. Both the Joint Commission on the Accreditation of Healthcare Organizations[10] and the American Medical Association[11] emphasize the ethical importance of reporting impaired and disruptive physicians. For any physician who is concerned about a colleague, regardless of the relationship, the key step is to call the regional PHP (http://www.fsphp.org) to anonymously request guidance.

Despite the differences in care for impaired physicians compared with other persons with substance use disorders, anything that adds to current knowledge of addiction in physicians potentially adds to the understanding of all human addiction. Hence there will be great interest in the article by Domino et al in this issue of *JAMA*[12] reporting 11 years of data from the Washington Physicians Health Program (WPHP), a posttreatment program monitoring physicians and other health professionals. The hypothesis was that anesthesiologists, reportedly overrepresented among impaired physicians[13,14] and at markedly greater risk for death from this disease,[15] would show the highest risk for relapse. Also, given that anesthesiologists have ready access to parenteral opioids, it would seem reasonable to hypothesize that opioids would be the agent with highest prevalence in relapse. Confirmed risk predictors can help improve outcomes in impaired physicians, although they might be rather specific for this subpopulation. Fortunately, broader questions about the disease were also asked in this study.

Addiction is a disorder of the brain's reward system. Functional imaging shows the vulnerable circuitry for addiction originating in the paleocortex.[16] Paradoxically, humankind's greatest adaptive advantage, the neocortex, responsible for the phenomenon of consciousness, is at best only minimally protective from addictive disease and may pose a hurdle for recovery. Unlike most medical disorders, in addiction a net effect of supraphysiologic reward, impaired inhibition, or both paradoxically leads the limbic drive system to reinforce exposure to the disease vector. This is in direct violation of the principle of survival of the species. In individuals with underlying vulnerabilities, limbic drive progressively recruits neocortical function to protect continued access to abused substances, the polar opposite of self-preservation. Thus, when physicians, whom society selects for high-level cortical functioning, become alcoholic or addicted, they often manifest exceptionally rationalized denial and sophisticated resistance.

In the study by Domino et al,[12] 1 in 4 monitored physicians (total n=292) relapsed at least once—risking license, livelihood, and identity. To those physicians who enjoy freedom from this vulnerability, relapsing under monitored, sanctioned conditions might seem to be a remarkably poor behavioral choice. The fact that well-trained (and not infrequently otherwise successful) physicians do so is at least circumstantial evidence that the drive to relapse originates far from the realm of conscious intent.

It is notable that the vast majority of physicians who have substance use disorders seem to do surprisingly well in recovery.[7,9,12-14,17] This is an unusual context, however. Monitored physicians receive an optimal treatment model that assumes primary medical responsibility for a disease that is inherently self-destructive. It combines empathic support with the high level of structure—restrictiveness, actually—of close monitoring and sanctions. Physicians' treatment appears to be matched according to need,[18] but for the general public, this is only a recent development, strongly championed by the American Society of Addiction Medicine,[19] and with evidence for validity in a range of populations,[20] although implementation is only now emerging.

The data in the study by Domino et al[12] suggest a particular pattern to physician relapse. It is a pattern that is neither attributable to chance nor to volition. What is left, if not accident or intent?

Family history, for one thing. As found in prior general population studies showing strong specific genetic risks for alcoholism[21] and among physicians surveyed for substance use,[22] nearly three fourths of these physicians had a family history of substance use disorder, and this more than doubled the likelihood of a relapse (hazard ratio [HR], 2.29; 95% confidence interval [CI], l.44-3.64). The original primary agent of abuse at the time of monitoring did not have an impact on relapse rates, challenging prior assumptions about the elevated risk of opioid use, although agreeing with more recent findings.[23] Instead, use of a major opioid increased relapse rates more than 5-fold but only in physicians with a coexisting psychiatric disorder (HR, 5.79; 95% CI, 2.89-11.42). More than a third of these physicians had a coexisting psychiatric disorder, but only 7% had any personality disorder. In physicians with all 3 factors (major opioid use, dual diagnosis, and family predisposition), the risk of relapse was elevated 13-fold (HR, 13.3; 95% CI, 5.22-33.6).

This finding regarding dual disorders suggests that psychiatric evaluation is an important aspect of assessing impaired physicians and that a final diagnosis should be made only following an extended period of monitored abstinence, as was done in this study. The doubling of the rate of dual diagnoses in the second half of the enrollment period is noteworthy. A similar increase was reported by Angres et al.[24] Attributed to better psychiatric staffing and psychometric assessment, this improved detection is potentially valuable in improving outcomes.

It remains to be seen how improved detection and better-matched recovery planning will address those with the doubled relapse risk of dual diagnosis and the multifold risk

of the triple-threat: dual diagnosis, opioid dependence, and family history. These data suggest that analyzing the trajectories of recovering physicians may improve the knowledge base for anticipating and matching the needs of physicians entering recovery. But retrospective cohort analyses from single states using clinically derived data, while better than no data at all, are inadequate in this millennium. Better data are needed, such as multistate data from prospective studies with research quality instrumentation. It is time for PHPs to become formal research programs, or better yet, to form a national research program.

Individualized monitoring plans and treatment contracts that take into account various risk loadings should improve outcomes for patients with substance use disorders. Success from substance use disorder treatment should be sought and expected not just for physicians but for every patient—but only if the conditions available for physician recovery can be provided to all.[17] These "ifs" are pivotal: if intervention occurs early, if structure is provided as well as support, if treatment resources are provided as if a life and career matter, and if close monitoring and treatment matching are provided with active treatment intervention and escalation to meet the clinical need. Surely this type of care is costly. Why should such high-quality care be provided? Because a brain disease that subverts self-preservation is a disease nonetheless, and helping patients recover from this disease can save lives, families, and productive careers.

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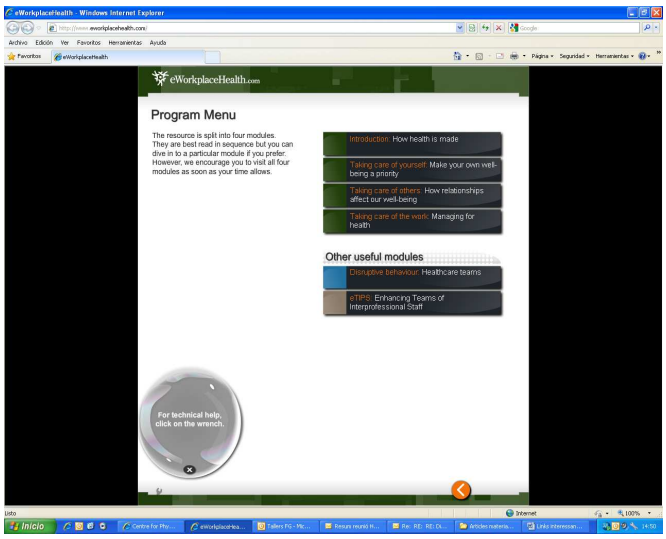

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