



COMMENTARY

Suicide in Physicians: We Need to Safeguard Our Mental Health in Times of Pandemic

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Suicide is the only cause of death that is greater in doctors, compared to those who are not, being the higher risk in women (RR 2.27; 95% CI 1.90-2.73) than in men (RR 1.41, 95% CI 1.21-1.65) [1]. These ideas on self-harm and suicide begin from the academy according to Rotenstein, et al. [2], where the prevalence of this type of thought is around 11.1% [2]. Burnout and depression have always been an issue of interest in the mental health of health care providers, as it is considered an under-diagnosed pandemic, killing around 400 doctors annually in the United States [3]. This fatal manifestation is more precipitated in surgical specialties, where the care and academic burden are very strong [3].

During the current COVID-19 pandemic, the emotional sphere of health workers has been overwhelmingly affected, as a result of the collapse of global health systems, lack of support from the state, discrimination and stigmatization by the general population, family isolation, loss of colleagues, among other causes; another condition is added that contributes to the progressive deterioration of the mental health of these, which is the Post-Traumatic Stress Syndrome [4]. Currently, there are no reliable statistics showing the variability in the secondary suicide rates to COVID-19 in both the general population and health workers, however, it is estimated that they tend to rise, thanks to the large number of reported cases at the global level [5]. Therefore, scien-

tific societies with an emphasis on mental health have spoken overwhelmingly, to mitigate the impact of this global catastrophe, describing some aspects that should be taken into account during healthcare practice [6]. If a doctor witness's insomnia, moderate-severe depression (marked by anorexia, constant crying, difficulty during decision-making, among others), somatization, and obsessive-compulsive disorder (manifested mainly by phobia and irritability), should be reported for strict follow-up by the psychological and psychiatric services, and if necessary establish pharmacological treatment [7]. The main risk factors that must be taken into account to identify the emotional involvement of health workers during the practice of care, which lead to suicidal ideation are insomnia, moderate-severe depression (marked by anorexia, constant crying, difficulty during decision-making, among others), somatization, and obsessive compulsive disorder (manifested mainly by phobia and irritability). In case of evidence of such symptoms, the case should be reported so that it is strictly followed up by the psychological and psychiatric services, and if necessary, to establish pharmacological treatment [8].

The prognosis on the mental health of doctors who have daily experienced this pandemic is uncertain, but unfortunately, it tends to be unfavorable. It is necessary that institutions that provide health services and for the



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Table 1: Degrees of emotional affectation due to distress during care practice.

Mild	Moderate	Severe
Represented by the control of symptoms thanks to family support and the social circle, no need for professional intervention/short-term emotional disruption that does not translate into a mental disorder.	Medium or long-term dysfunction, which needs professional support, but has the facility to quickly recover. It hinders the practice of care.	It requires strict follow-up by specialized services, prevents the practice of care and generates a mental disorder that constitutes a high risk of self-injury or suicide.

state, to establish health policies that facilitate the work of those who participate in the first emergency line, to diminish the degree of concerns of doctors. There is evidence that supports that in this type of adversity, you can work on resilience, which can become a powerful weapon to develop both physical and emotional resistance [9]. The ultimate goal of integrating mental health policies on physicians is to prevent psychological/psychiatric conditions from occurring during the acute phase of the tragedy, and thus to decrease the likelihood of medium- and long-term complications.

If the scenario that goes beyond that term is presented, we can predict what the emotional onslaught will be for medical students and residents in this type of situation, if they don't find support from a specialized service. It has been found that in situations where there is no social and welfare pressure at present, a significant proportion of students suffer from burnout syndrome and impostor syndrome [10], then it is visible that they will have many difficulties in facing a pandemic, an event that according to epidemiological predictions will be repetitive in the coming years [10].

We now have easily accessible tools, so that, even non-specialized doctors will be able to become alert to signs and symptoms of mental deterioration in both colleagues and the general population. It is important to recognize the degree of affectation, which can range from tolerable, mild, moderate to severe (Table 1) [11]. The interventions to be carried out in these cases are, support between colleagues, which should be given by the opportunity to talk and express concerns, referring them to support services, to be friendly, understandable and serene, to be attentive to their personal care, to work as a team during their care practice, and above all, if possible, to help mitigate the triggers of distress [11]. In addition, there must be rotations of assistance shifts, in the case that there are mixed groups where there is the presence of workers with risk factors that increase the probability of developing the severe type of COVID-19, as it is people older than 65 years, or suffering from hypertension, diabetes, heart disease, among others [11].

Whereas, as the evidence shows, mental health is currently a global safety objective, digital packages have been proposed for use as internal communication channels and learning support methods, which can be used by any individual, however, there are some specifically aimed at health professionals [12]. These, moreover,

allow the permanent updating about the evidence of the best quality on the current pandemic, so it is an indispensable tool in clinical practice, which can be given different uses [12].

The COVID-19 pandemic is a challenge for all health units, therefore, the research and practical work must be carried out by all participants, to facilitate the surveillance process. Mental health, as one of the most affected areas, cannot be left aside, so the use of strategies that support these must be part of institutional protocols since if health systems have collapsed having an emergency line of specialized doctors, the degradation of this barrier would be the greatest misfortune that could happen in the management of this very complex pathology.

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Authors Contribution

All authors have contributed for this manuscript.

References

- Schernhammer ES, Colditz GA (2004) Suicide rates among physicians: a quantitative and gender assessment (meta-analysis). *Am J Psychiatry* 161: 2295-2302.
- Rotenstein LS, Ramos MA, Torre M, Segal JB, Peluso MJ, et al. (2016) Prevalence of depression, depressive symptoms, and suicidal ideation among medical students: A systematic review and metaanalysis. *JAMA* 316: 2214-2236.
- DeCaporale-Ryan L, Sakran JV, Grant SB, Alseidi A, Rosenberg T, et al. (2017) The undiagnosed pandemic: Burnout and depression within the surgical community. *Curr Probl Surg* 54: 453-502.
- Reger MA, Piccirillo ML, Buchman-Schmitt JM (2020) COVID-19, Mental Health, and Suicide Risk Among Health Care Workers: Looking Beyond the Crisis. *J Clin Psychiatry* 81: 20com13381.
- Sher L (2020) The impact of the COVID-19 pandemic on suicide rates. *QJM: An International Journal of Medicine* 113: 707-712.
- European Psychiatric Association (2020) COVID-19 Resource Centre.
- Zhang WR, Wang K, Yin L, Zhao WF, Xue Q, et al. (2020) Mental Health and Psychosocial Problems of Medical Health Workers during the COVID-19 Epidemic in China. *Psychother Psychosom* 89: 242-250.

8. Pfefferbaum B, North CS (2020) Mental Health and the Covid-19 Pandemic. *N Engl J Med* 383: 510-512.
9. Villwock JA, Sobin LB, Koester LA, Harris TM (2016) Impostor syndrome and burnout among American medical students: A pilot study. *Int J Med Educ* 7: 364-369.
10. Khanna RC, Cicinelli MV, Gilbert SS, Honavar SG, Murthy GSV (2020) COVID-19 pandemic: Lessons learned and future directions. *Indian J Ophthalmol* 68: 703-710.
11. Walton M, Murray E, Christian MD (2020) Mental health care for medical staff and affiliated healthcare workers during the COVID-19 pandemic. *Eur Heart J Acute Cardiovasc Care* 9: 241-247.
12. Blake H, Bermingham F, Johnson G, Tabner A (2020) Mitigating the Psychological Impact of COVID-19 on Healthcare Workers: A Digital Learning Package. *Int J Environ Res Public Health* 17: 2997.