Additional Contributions: The Swiss Federal Statistical Office for providing mortality and census data.


COMMENTS AND OPINIONS

Grief in Health Care Professionals: When Screening for Major Depression Is Needed

We appreciate the important articles by Granek et al1 and Shayne and Quill2 regarding grief in health care professionals (HCPs). Although HCPs can, and often do, experience grief over patient loss, this important issue has not received the attention it deserves. Physicians form meaningful connections with their patients and have human responses to their deaths, including grief reactions.3 The intensity of sadness, sense of loss, and possibly self-doubt varies, but even when intense and somewhat protracted, “normal” grief should not be confused with major depression.

However, the death of an emotionally meaningful patient may trigger more than a “normal” grief reaction. For some HCPs, especially those with unique vulnerabilities such as personal histories of mood disorders, bereavement may bring on the worsening of a preexisting depression or even a new-onset major depressive episode (MDE).3,4 When that occurs, not only is the grief more severe and persistent, but all the other malignant consequences of MDE, including the risk of suicidal behaviors, may ensue.5 Thus, any HCP whose grief over a dying or deceased patient is accompanied by depressed mood, present most of the time for several days, and/or has a markedly diminished interest and pleasure in all, or almost all, activities should be systematically screened for the presence of a MDE.

To meet MDE criteria, the symptoms should be present for at least 2 weeks and associated with significant distress or impairment. Generally speaking, some relatively specific features suggest the presence of a MDE in addition to grief: mood and ideation are mainly negative (in grief alone, positive thoughts about the deceased are often present, and the individual may retain his or her sense of humor); the agony is relatively persistent (in grief alone, painful feelings tend to come in bursts or waves); feelings of worthlessness and self-loathing are present (in grief alone, self-esteem is usually preserved); and suicidal ideas, psychomotor retardation, and severe impairment of functioning may be more likely.3,4

Thus, we suggest that specific programs should be provided to HCPs, especially to those experiencing repeated losses of patients, such as oncologists and palliative care or emergency department HCPs. These programs should include education about MDE, its consequences and treatments, screening for MDE, and support for bereaved clinicians and staff. Finally, referral for treatment, all too often not provided to HCPs, can be lifesaving.5

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In reply

In response to our study,1 Corruble et al note that grief should not be confused with major depressive episode (MDE) and that health care professionals whose grief lasts longer than 2 weeks should be screened for MDE. I thank the authors for their letter; however, I am concerned about these conclusions for the following reasons:

1. Two weeks is not enough time to allow for oncologists’ grief. The literature on grief supports the fact that mourning lasts longer than 2 weeks. In an informal survey of nearly 8000 bereaved people, one-fourth reported feeling normal “one to two years” after the loss and 30% reported feeling “normal” or symptom-free again within 6 months after a loss.2 The ma-
Jority of mourners grieve for longer than 2 weeks, and this is likely true for physicians as well. 2. Symptoms of grief and symptoms of depression may overlap, but this does not necessarily indicate a pathologic condition or merit an MDE diagnosis even if MDE criteria are met. One study that looked at a national survey of 8098 people found that 90% of those diagnosed and treated for major depressive disorder attributed their depression to a bereavement-related loss or another loss. 3. Grieving is context specific and is a natural reaction to loss that does not require intervention in most cases. 3. Oncologists’ grief may be different from the grief of the general population; thus, different criteria to assess distress are needed. The authors suggest that there are features that are unique to grief vs MDE. For example, “feelings of worthlessness and self-loathing are present (in grief alone, self-esteem is usually preserved).” For oncologists, grief included feelings of responsibility toward their patients. Guilt, worthlessness, and negative affect were key features of their phenomenological experiences of grief. 1 While these particular distinctions between grief and depression may be relevant to a general population, they may not be applicable to oncologists.

Grief over patient loss is a normal, pervasive, and expected part of the work of oncologists that can last longer than 2 weeks and can overlap with symptoms of depression. 1 Medical institutions should provide space, training, resources, and time to cope with this difficult but expected part of oncologist’s work at every stage of their career. Grief is not a pathologic condition. It is natural and normal response to loss in every context where there was an attachment to the deceased.

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Is Hypertension Overtreatment a Silent Epidemic?

I commend Kerr et al1 for their examination of overtreatment of hypertension. This issue has been given minimal attention despite potentially harmful consequences. There are a large number of publications on hypertension treatment, yet, using an Internet search, I found only 11 publications that mention the issue of hypertension overtreatment. The only publication that specifically looked at overtreatment was by Scheltens et al, 2 where 41.9% of the treated patients had blood pressures (BPs) below levels recommended by Dutch guidelines.

In my 30 years of clinical experience, I have seen serious consequences of low BP in hospitalized patients, including intensive care patients and outpatients and patients receiving hemodialysis. These consequences include acute renal failure, often recurrent, due to the continued use of antihypertensive medications despite normal or low BP levels. Acute renal failure episodes may contribute to the epidemic of chronic renal failure. 3 Other overtreatment consequences for hemodialysis patients are faster loss of residual renal function due to intradialytic hypotension and vascular access clotting.

Beyond these renal-specific issues, overtreatment of BP may contribute to myocardial ischemia and infarcts, as well as cerebral ischemia and dementia. In elderly patients, hypertension overtreatment may be associated with orthostatic hypotension, a significant contributor to organ ischemia and a possible contributor to falls, along with their associated morbidity and mortality. 4 In my practice of general internal medicine, I noted a disturbing but probably common pattern. Patients experienced a systolic BP of 100 mm Hg or less, often accompanied by symptoms, owing to the continuation of BP medication regimens despite a low systolic BP. Patients are not warned about the possibility of low BP-related symptoms and problems. In fact, at my local Department of Veterans Affairs (VA) hospital, BP medicine containers come with labels stating not to discontinue use of these medications without a physician’s input. Blood pressure fluctuations and white-coat hypertension are well recognized, but connecting this knowledge with appropriate BP medication adjustment, for example, withholding BP medications for a systolic BP below a certain threshold needs to become a standard clinical practice.

The VA database used by Kerr et al1 provides an opportunity to examine low BP-related morbidity, since it links BP and clinical diagnostic data. This kind of study may help determine if there is a silent epidemic due to hypertension overtreatment.

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