Family Medicine: Bridge to Life

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Reflecting on the suicide of a close friend, this essay explores what comprises, and inspires a will to live, and how those in Family Medicine can address suicide risk even in the face of debilitating or terminal illness. Research indicates that the will to live is a measurable indicator of general well-being, distinct from depression, and an important predictor of a person's motivation to "hold on to life". As such, understanding what is at the heart of a desire to live should alter clinical practice. This essay offers ideas for ways in which to create bridges for patients that could help sustain life. (J Am Board Fam Med 2016;29:161–164.)

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One of my closest friends died this past year. She took her own life. She was beautiful, a gifted artisan, a good mother, a gentle and kind person who made the world better. She had no idea what an exquisite person she was removing from this physical world or how much pain she would cause those who loved her. She was defeated by a lack of self-worth, purpose, and hope.

To a certain extent, I understand why she did what she did. She had major challenges, including depression and a degenerative disease for which she received extensive medical care. Yet, since her death I have been haunted by unsettling questions of how this could happen and what more could have been done to help her. How is it possible that someone so beautiful could feel so void of hope and be so unreachable by so many—family, friends, and health care professionals alike? What clues were missed? What is my culpability as a friend, or that of the health care professionals from whom she received treatment?

I have been in the health field for many years, not as a physician but as a social worker, and for the past 17 years as a researcher in family medicine working closely with family medicine physicians. Examining factors that affect quality of life, health care, and patient outcomes is central to my work. I am now compelled to ask how family medicine and primary care providers and researchers can improve mental health care and become a bridge from death to life. This has led to reflections on the role and unlocked potential of family medicine to make a difference, to do what it does best and connect with patients in personal moments of profound importance to dramatically change outcomes.

Suicide is not as simple as a failure of crisis intervention. Preventing it goes beyond using current, limited clinical definitions of depression and administering brief depression scales that barely touch on what is going on in the very core of someone's being. How do we go deeper and tap what drives a person's "will to live"? How does one help to instill in another a will to live, especially in the face of debilitating or terminal illness? It seems to me that we have to start by knowing what is at the heart of a desire to live, what moves people to want to live, or not. I know full well the role of depression, mental illness, and other contributing factors, but I am still left asking, "What touches almost primal feelings about the value of one's own existence and an instinct to survive?"

There is no question that one of the greatest risk factors for suicide is the presence of a mental health disorder, depression in particular. But not everyone with a diagnosis of depression or mental illness loses the will to live. The same is true

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of other predisposing factors such as having suffered trauma, or having access to the means to commit suicide. We need to shine a light on what Freud referred to as the "life force." Then we need to find a better way to incorporate this knowledge into the practice of family medicine. It *is* possible. In most cases there are "red flags" that indicate someone is contemplating ending their own life. Intervening requires some degree of empathy and courage. It also requires that service providers know the well-documented risk factors[1] and warning signs[2] and have some understanding of underlying contributing variables that could guide treatment. My hope is that by exploring several key features of a will to live, then closing with ideas for ways in which family medicine can respond, we can create bridges for patients that help to sustain life.

What drives the will to live is not a new question, and it does not take much digging to amass stories, opinions, and hard evidence for answers that make sense. Most of it comes from the humanities. Theologians, philosophers, psychologists, and others over the centuries have provided compelling evidence of the necessity of important life characteristics to survival. There seems to be consensus that, at the very core, the will to live comprises a sense of self-worth, a sense of purpose or feeling needed, hope, futurity, social connectedness—and I will go as far as to add joy. A will to live is mediated by many variables such as health, culture, and economics, and it changes over time, but the critical components of purpose, hope, and joy repeatedly surface in the literature and research. Most of us want to feel that our life matters and that it is worth living. This holds true across time, place, and status, and is evident in ancient writings through the following few illustrative words of wisdom.

The inimitable Maya Angelou believed in the importance of joy in one's life. At her 2014 memorial service, her son spoke of her philosophy that joy, a life worth living, could make the difference between striving and thriving. Likewise, Atul Gawande,[3] in his powerful book on aging, death, and end-of-life care called *Being Mortal: Medicine and What Matters in the End*, explores the purpose of medicine to help people live a full life rich with joy and meaning, even in the face of a degenerative disease or death, according to their own definition of what gives life meaning.

Nowhere is this need for purpose and hope more exemplified than in the writings of Viktor Frankl,[4] MD, PhD, an Austrian neurologist, psychiatrist, Holocaust survivor, and author of *Man's Search for Meaning*, which details his experiences in a concentration camp. Frankl came to believe in the importance of finding meaning in all forms of existence, even brutal ones, as central to not only the will to live, but the ability to live. He observed that those who had nothing to live for were the first to die in the concentration camps.

In the past 20 years there has been a limited amount of social science research conducted on the will to live and the "valuation of life." But it has become more critical in this age of longevity and questions about how to handle end-of-life decisions. Researchers such as Dr. Sarah Carmel and others have concluded that the will to live is a measurable and important indicator of general well-being, distinct from depression. It is also among the best predictors of a person's motivation to "hold on to life" and has implications for decisions related to prolonging life.[5] At a recent lecture on ageism, the speaker referenced the eternal desire for longevity and, like me, questioned what affects this. What is at the heart of a will to live? I was reminded of the author of *The Blue Zones*, Dan Buettner,[6] who researched the world's best practices in health, longevity, and medicine in areas of the world where people live longer than anywhere else. His findings support the work of Carmel and others in that a sense of purpose and hope are essential. Buettner confirmed other key variables, including being part of a close, vibrant circle of friends and family, and having social connectedness, without which quality and longevity of life may be compromised. Likewise, in his best-selling book, *The Power of Purpose: Find Meaning, Live Longer, Better*, Richard Leider[7] states that purpose is fundamental to human life. It gives us the will not just to live, but to live long and well. Even Fred Rogers,[8] the wise and venerable host of the popular children's show *Mister Roger's Neighborhood*, wrote "one of the deepest longings a person can have is to feel needed and essential."

This brings me back to family medicine and why all this is relevant to clinical practice. Health care providers and researchers sometimes miss the mark. We wax on about person-centered care, doctor–patient relationships, and holistic health. We promote important predictors of good health, such as healthy diets, adequate sleep, and reduced stress. And yet, our models of care and treatment plans

rarely mention the will to live and the importance of a sense of purpose, hope, joy, and social connectedness. It is possible that as long as we fail to address community citizenship, purpose, and hope, we run the risk of failing our patients and losing them to substance abuse, suicide, and a far lower quality of life than what we claim to want for them. Family medicine can make a difference. It is, after all, the medical specialty that provides continuing, comprehensive, personal, holistic health care for the individual in the context of family and community. How do we take this knowledge of what drives a "will to live" and translate it into practice? How do we help people want to live, and live better?

Thankfully, some guidance does exist. The following ideas have been gleaned from the literature and experts and are offered as starting points: simple, concrete strategies that can be used by family medicine physicians and other health service providers. They do not require being everything to all people—a physician, social worker, psychologist, and Mother Theresa all rolled up into one. They do not require a great deal of expertise or time. They do, however, require a degree of trust, something that family physicians are able to build through taking care of patients over time, both during illness and in health. Practical ideas for addressing suicide risk start with knowing what the risk factors are: declining health, major depression, social isolation, feelings of hopelessness, previous attempts, and access to the means.[1] It is also important to know the warning signs, such as increased substance abuse, withdrawing, and having a concrete suicide plan.[2] Organizations such as the Substance Abuse and Mental Health Services Administration and the National Action Alliance for Suicide Prevention are rich resources for such basic information.

The next step is to ask the right questions. Check for major depression and mental disorders. Know the medications that contribute to depression. There are, of course, times when the decision to end one's life might be considered a reasonable autonomous act, not a sign of mental illness. However, as philosopher and gerontologist Harry R. Moody[9] has stated, "failing to diagnose and treat late-life depression could consign untold numbers of older people to self-imposed death by neglect under the label of self-determination." Asking whether a patient has considered self-harm as part of a standard depression assessment is a good start. If the answer is yes, it is advisable to ask whether they have a plan and access to the means, both of which indicate a need for urgent attention. Even in the absence of a plan, it is possible to move deeper into the question of will to live. There are quick, 1-item scales that have been proven effective, including the following: "If you could describe your will to live, on a scale of 0 to 5, would you say that it is: 5 = very strong, 4 = strong, 3 = intermediate, 2 = weak, 1 = very weak, 0 = no will to live?"[10] There are other complementary 1-item scales related to hope, well-being, desire to prolong life, and the other key factors associated with a will to live that could be considered.

As Buettner, Gawande, Frankl, and Mr. Rogers all suggested, it may be as simple as asking questions such as, "Do you feel connected to anyone or a group of people?" "What do you have in your life that feels meaningful or gives you a sense of purpose?" "What helps you get through times when you feel down? Are there people, ideas, things you can do that help you to hold on?" and "What gives you hope?" These conversations require attempting to make a connection with the person; taking a few short minutes to really listen, to turn away from the computer, look the person in the eye, and demonstrate genuine concern. This is person-centeredness at its best.

I am told that one reason physicians hesitate to ask these questions is because it may be unnerving when a person indicates their will to live is weak. Then what? Where is the decision tree, the standard protocol? At such times it is good to remember that what may be most important is not that you have all the answers, but that the patient feels heard and that someone cares. Simply saying, "I am concerned about you. How can I help?" could be the most profound thing a provider can do. It is not about saying, "Everything is going to be OK." It is about saying, "I am with you."

This is an empowering idea. It moves providers from feeling inadequate to the possibility that they can make a difference, even if the brief encounter is not executed as eloquently or perfectly as possible. We all know stories of one person's show of concern making *all* the difference, helping someone turn to life. The chance to make such a difference is a gift, one worth risk and setting aside concerns of failure.

If a patient has a plan and access to the means, an immediate referral to crisis intervention programs

is crucial. In all cases, assessing the will to live and elements of it, such as purpose and hope, should guide treatment. The most promising assistance may be that which bolsters the key components of the will to live. Exploring opportunities for volunteerism can provide a powerful combination of social connectedness and purpose, or feeling needed and valued. Encouraging the creative expression of oneself through journaling, poetry, and art can lead to an improved sense of self and joy. Suggesting ways in which to recognize and interrupt impulsive, desperate thoughts might get someone through 15 to 20 otherwise lethal seconds or minutes. Providing brochures, information, hotline numbers, and referrals can widen the safety net of involved expertise.

Together, more ideas can be generated. The trend toward interprofessional team care is a good one since no one of us alone can meet the needs of a person. It is not about dissecting a person into physical versus mental health, specific body parts or disorders, medications versus social, behavioral, environmental therapies. It is about working together and wrapping people in a circle of support, creating an entourage to walk with them. This is what family medicine is all about. Family medicine physicians are in a position to be vigilant, knowing that the will to live is dynamic; it can change with age, illness, and other psychosocial and health conditions. They establish relationships over time that make this possible. This essay is a request, a call to action, to explore the many ways in which family medicine can incorporate the concepts of a sense of purpose, meaning, hope, and joy into our practices, history taking, assessments, plans of care, and research.

My friend's death has underscored life's polarities. It is possible to hold completely opposing thoughts simultaneously. Everything is different now, even as all goes on as usual. Nothing matters; everything matters. A death can make one more grateful for life. Someone can be the strongest person you know, yet at the same time fatally fragile. Amid disbelief and deep sorrow there is a need to accept, to find peace and joy in living again, and to improve a system in which suicide seems like the only way to deal with life. Family medicine could take a lead role and become a critical bridge that leads from contemplating death back to a desire to live. Taking this call could lead to gentle or even revolutionary change that transforms practice and, subsequently, the lives of the people we serve.

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