

Talking Suicide, Advocacy, and Politics with the Honourable Dr. Fry

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Suicide is the tenth leading cause of death in our country, claiming the lives of 11 out of every 100,000 Canadians.¹ It is also the second leading cause of death amongst 15 to 24 year-olds.² For every completed suicide there are many more suicide attempts, leading to the hospitalization of 87 out of every 100,000 Canadians each year.³ These “high rates of mortality and morbidity surrounding suicidal behaviour constitute a major public health crisis,” according to the Honourable Dr. Hedy Fry, Member of Parliament for Vancouver Centre.

Fry entered politics in 1993, after spending 20 years practicing family medicine and serving as a committee member and then president with the British Columbia Medical Association (BCMA). These experiences prepared her for her political career. As a physician, Fry learned to appreciate “multifactorial causes and solutions” to her patients’ presenting complaints. With the BCMA, Fry was able to advocate for health policy changes that would alter social determinants of health for many marginalized populations by “attacking issues upstream ... and using evidence.” Although Fry had not previously considered a future in federal politics, when she was asked to run for the Liberal Party she jumped at the opportunity to extend her advocacy initiatives and create tangible social change.

Recently, Fry has challenged the federal Minister of Health to adopt a national, interdisciplinary, prevention-focused approach to suicide. Fry’s strategy proposes government-supported programs to “train family doctors, nurses, social workers, teachers, and other frontline workers to read between the lines and see that the child acting out or the introverted person is really struggling to cope.” Identifying these people early will allow timely referral to clinics run by family doctors, nurse practitioners, and mental health workers to help these individuals before suicidal behaviour patterns occur. Secondly, Fry proposes “secondary prevention measures,” meaning “adequate funding for [hospital] beds, outpatient care, and community supports,” to help those who have attempted suicide with recovery and to prevent future deteriorations in mental health.

At an individual level, stigma plays a large role in preventing early detection of mental illness. “Stents do not make people look at you any differently; but my goodness, depression does,” Fry states, reflecting on why many struggling with their mental illness are reluctant to speak up. Fry reports that mental illness is also

stigmatized at a social policy level, not receiving the same fiscal or program-based support as physical ailments do. Fry envisions a future national health policy that does not “separate mental from physical wellness or health.”

Physicians see the effects of mental illness and other social determinants of health every day in emergency rooms, wards, and clinics. But what can be done to help? Fry suggests that “advocacy is an inherent part of being a physician. I did this every day with my patients ... that couldn’t walk, couldn’t afford to eat nutritious food.” She also emphasizes, “We should all be more concerned with outcomes.” Not only will evidence-based practice prevent undue harm to patients, but “if more [doctors] were concerned [with outcomes], more would be moved to enter politics, and politics would benefit greatly as [doctors] have a broader way of looking at problems.” Physicians understand the range of factors causing symptoms and know how to successfully drive



In this photo: The Honourable Dr. Hedy Fry

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change, skills that are useful for the aspiring politician. However, physicians can also use these strengths on a daily basis to save lives, by recognizing, assessing, and advocating for patients who are at risk for suicidal behaviour.⁴

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Evidence for the Benefits of Carbohydrate Restriction in Metabolic Syndrome and Diabetes

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According to 2009 estimates by the Centers for Disease Control and Prevention, 34 % of Americans over the age of 20 are living with metabolic syndrome—a complex metabolic derangement characterized by insulin resistance, atherogenic dyslipidemia, hypertension, and elevated body mass index.¹ In addition, the prevalence of diabetes mellitus has more than doubled for all age groups since 1980.² The pervasiveness of these conditions suggests that a factor as universal as diet may be causative. Indeed, several studies have shown that the current recommended diet from the “Dietary Goals for Americans,” which is mimicked closely by Canada’s Food Guide, the Canadian equivalent of America’s Dietary Guidelines, may predispose individuals to diabetes and metabolic syndrome.⁴

As widely promulgated in 1977, when the first Dietary Goals for Americans was published, current guidelines encourage increased consumption of carbohydrates in conjunction with reductions in fat, saturated fat, cholesterol, and salt ingestion. The benefits of such a diet, however, have remained contentious since their inception. The American Medical Association (AMA) responded to the initial Dietary Goals for Americans with an opinion wrought with concern, “The evidence for assuming that benefits to be derived from the adoption of such universal dietary goals ... is not conclusive and there is potential for harmful effects from radical long-term dietary changes.”³ Arguably, these early concerns of the AMA may have forecasted the increased incidence of diabetes and metabolic syndrome that are observed in the U.S.A. and Canada.⁵

Many clinical trials have failed to show reductions in cardiovascular disease risk with adherence to low fat, increased

carbohydrate diets. The Women’s Health Initiative randomly assigned over 48,000 post-menopausal women to low fat and free living comparison groups. After six years of follow-up, there was no significant difference in non-fatal coronary heart disease risk and total cardiovascular disease risk between the groups.⁷ Moreover, the Nurses’ Health Study showed an increase in coronary heart disease risk in association with high glycemic load from refined carbohydrates, independent of other known risk factors.⁸ Another prospective cohort study included more than 15,000 middle-aged women and found similar increases in coronary heart disease in association with increased dietary glycemic load.⁹

Evidence suggests that carbohydrate restriction may lead to favorable changes in currently accepted biomarkers of cardiovascular disease when compared to low fat diets. Low carbohydrate diets restrict carbohydrates to 30–130 grams per day, without caloric restrictions of other macronutrients. Very low carbohydrate ketogenic diets typically restrict carbohydrate consumption to below 30 grams per day.⁶ A meta-analysis examining the effects of low carbohydrate versus low fat diets on cardiovascular disease risk included 13 studies that lasted at least six months and pooled 1222 participants of both sexes. Less attrition was noted in the low carbohydrate groups, as well as more beneficial alterations in HDL cholesterol (increased), triglycerides (decreased), and blood pressure.¹⁰ Similarly, Garner et al randomized 311 overweight premenopausal women into four diets for one year.¹¹ They found that the most improvement in metabolic profile occurred in the dietary group with the greatest carbohydrate restriction (less than 20 grams per day, without caloric restriction), with benefits also noted in the less carbohydrate restricted groups.

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