Physician Self Care: On Mental Health

By Dr Timothy Teoh, psychiatrist

It began with an innocent enough query in a WhatsApp chat:

"Hey, does anyone know what happened to AAA?"
"He is working at YYY clinic. Why?"
"Not sure if it is true. Friend mentioned he committed suicide in a hotel yesterday."

While there are many unknowns with regard to the cause of such an unfortunate event, it did prompt personal messages amongst individuals in the chat and a request to write this article.

When one is asked to write an article, invariably it starts off with a literature review. Pubmed and Google scholar searches were conducted. Some of the numbers that popped up in the search included how approximately 300 to 400 doctors died due to suicide a year (about one a day), how 12% of male doctors and 19.5% of female doctors suffer from depression (Interestingly, based on the Singapore Mental Health Study conducted in 2010 by IMH, as many as 1 in 17 (6%) people have suffered from Major Depressive Disorder at some time in their life) and how completed suicide rates for doctors are 1.4 to 2.3 times the rate achieved in the general population. However, to the family and friends of one who has committed suicide, data and statistics would hardly be in their minds.

What usually follows would be Kubler Ross' stages of grief: denial, anger, bargaining, depression and acceptance. "Surely it can't be true?" "Maybe I should have spent more time with him?" "Were there any signs I might have missed?" are common questions that family members and friends could have. Unfortunately, hindsight is always 20-20 and it would inadvertently lead to more questions than answers.

One question that pops up more often than not is whether such an unfortunate event could have been prevented. Thus, if we were to view mental illnesses as diseases, and utilise common preventive strategies in the battle against these diseases, we can proactively seek methods to try and prevent such incidents from occurring again.

Primary Prevention

Primary prevention focuses on preventing the onset of an illness or disease by removing causative risk factors. Methods utilised include protection against the disease agent, such as vaccination or behavioral changes, i.e. increased activity or stopping smoking. With regard to an outcome of suicide – unfortunately – there are a multitude of causes, each with its own risk factors. Suffice to say, the promotion of good mental health is a good starting point to the primary prevention of mental illness, a major cause of suicide.

At this juncture, I feel it is good to be reminded of the concept that health does not equate to the absence of disease. This is especially so in the realm of mental health, where it is more important to promote mental wellness than mental health. When one has to work from 8 in the morning all the way to 5 in the evening (and sometimes also the night shift), six to seven days a week – socially isolated in his or her own clinic – it is easy to shift into a routine. A routine of waking up to go to work, followed by attending to patients for the day (and night) before going home to sleep. Alas, a routine that repeats itself day after day, week after week, month after month and finally, year after year. The trap of routinisation is the absence of disease without the presence of wellness.

While one might not necessarily fall into depression when doing this for an extended period of time, it does not make one happy. Simple behavioral changes like meeting up with friends or initiating (and maintaining) a simple exercise regime or even taking up a hobby will break the monotony of work and could contribute to achieving mental wellness. Unfortunately, there are other behavioral changes that are sometimes rationalised to improve mental wellness but otherwise, do more harm than good. These include alcohol, drugs and other vices.

I recognise that it is easy to talk about something and much more difficult to implement and keep to it. Like any other forms of primary prevention, we have to first recognise the benefits of 'prevention rather than cure' in order to fully subscribe to committing to such lifestyle changes. Having a buddy to encourage will also be beneficial in attaining this goal.

Secondary Prevention

Secondary prevention focuses on early detection and intervention, thus stopping or retarding the progress of the disease. Many mental illnesses are neurodegenerative in nature and secondary prevention contributes to improving the quality of life further downstream. This is also where having a buddy is again beneficial in attaining this goal. The Chinese have a saying "pang guan zhe qing (旁观者清)", which loosely translates to "a bystander views more clearly". Subtle changes in one's mental state, be it being a little less tolerant of others, increased irritability or decreased levels of energy are more likely spotted by a pang guan zhe (旁观者) rather than to be self-noticed. Moreover, depression has been described by using the analogy of a frog in water being brought to a boil. So sinisterly subtle is the change that by the time it is noticed, the water has reached its boiling point.

Self-monitoring is the other option for early detection. While subtle subjective changes might not be detected, a mindful and truthful attempt on any of the many self-rating scales (easily available on the internet), makes one cognizant that something could be festering. A common self-rating scale for depression would be the Zung Self-rating Depression scale. Whilst not diagnostic, it does fulfil a two-fold purpose: (1) to make the physician cognizant that he is vulnerable to depression and (2) allows a trajectory to be charted over time if administered frequently enough with the correct mindset.

Tertiary Prevention

When one becomes symptomatic, we then move into the realm of tertiary prevention, whereby we attempt to reduce complications due to the mental illness or to reduce disability. The simplistic solution here is to seek professional help. 'Simplistic' because it is never easy for a physician to seek help from another colleague – remember the saying "Physician, heal thyself"? What is worse than to admit that he could be suffering from a mental illness and has to seek help from a psychiatrist? This is more apparent when the healer – so often the one placed in a position to help his patients – now finds himself needing help himself. Not uncommonly, the physician might try to "treat thyself" – either with medication or with substances like alcohol or drugs, owing to affordability or accessibility. Unfortunately, alcohol and substance misuse are precisely the complications that tertiary prevention attempts to reduce.

Mental illness is the proverbial elephant in the room. The main cause is often due to stigma. To non-medical folks, mental illness is usually associated with a weak personality and one can simply 'toughen up' and 'deal with it'. When it strikes a doctor – an individual whom others turn to for help – this elephant magnifies its size.

"I have survived through medical school, housemanship and specialist training, I can't be depressed. This is just a phase."

Similar to all other illnesses, no one is invulnerable to mental illness. The first step in preventing suicide is to recognise that doctors are just as vulnerable. As the circumstance of working solo in isolation as a GP can further contribute to this vulnerability, it is imperative to look out for any signs or symptoms or changes in mental state, either through self-reflection or close friends. And should that occur, the doctor ought to have the humility to acknowledge that help is required – not in the form of medication alone but also many other modalities to treat the full spectrum of mental illness."

Conducted in the 1980s by the American Medical Association (AMA) and American Psychological Association (APA), a study on physician suicide found that those who had committed suicide were seeing patients who were slightly more difficult or emotionally draining. This is something family practitioners would have to be aware of and likely to experience. This is unlike working in hospital setting, where there are other doctors and multi-disciplinary teams in one's department to discuss, consult and manage difficult/draining patients. If left to manage everything on his own, this would surely and steadily take a toll on the attending physician. In hospitals, there are already programmes to recognise medical personnels in distress and provide dedicated resources to address that, eg. the Staff-Support-Staff programme at TTSH. Perhaps something similar can be considered for our GPs?

On 17 April 2017, Prince Harry opened up on his struggles following the death of his mother, Princess Diana. In closing, he urged all listeners to seek help whenever needed and not to be ashamed when it comes to their mental health, because "you will be surprised firstly, (by) how much support you (can) get". Similarly, the avenues of support for all (including doctors!) with mental health challenges, are aplenty in Singapore. One simply has to be willing to ask.

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FAMILY PRACTICE SKILLS COURSE

Updates in Rheumatology

The College of Family Physicians Singapore would like to thank the Expert Panel for their contribution to the Family Practice Skills Course #69 on "Updates in Rheumatology", held on 06 May 2017.

Expert Panel:
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