Who takes care of the mental wellbeing of the health professional?

Dr Noeline Nakasujja expounds on the neglected state of mental health for health professions

While health professionals spend an enormous time caring for populations affected by various ailments, paradoxically they are usually reluctant to seek help for their own problems. In the hustle and bustle of covering duties that span long hours, these hard-working women and men often neglect themselves even when they have obvious signs or symptoms and they may even continue to come to work when ill. This applies for the whole range of diseases, even easily treatable ones, but the situation is very serious indeed when it comes to mental health challenges.

In the past 12 months the African health fraternity has been devastated by deaths of prominent health-care providers, including a prominent cardiologist and an anesthesiologist who died by suicide in South Africa.[1] The news was numbing; everyone asked the questions as to why and how it could be, but no one could give answers at the time. Colleagues all over the continent were speaking only in whispers, the subject taboo – a clear sign of the stigma surrounding mental health that also manifests among health professionals. To an outsider these professionals look like high-achievers, who might be assumed to be happy. But often what is seen on the outside may not be the true reflection of the inside and what the public sees may not be what family members may know of the person. Indeed, it is often only after a death by suicide that an individual's long history of struggle and suffering is revealed. This contrasts grimly with other illnesses where diagnoses are made early on and support availed to individuals who have cancer, hypertension, diabetes or other chronic illnesses.

So why are health professional so at risk of suicide? The World Health Organization estimates that close to 800,000 people die from suicide each year.[2] When the focus is turned to the health professional, it was noted during the American Association meeting of 2018 that one doctor in the United States commits suicide every day. This extremely alarming estimate translates to a rate of 28 to 40 per 100,000 people, a figure that is more than twice that of the general population of 12.3 per 100,000.[3] The figures for health professionals who die by suicide in Africa are unknown. Furthermore, with the stigma attached to suicide the deaths may not be reported, especially in contexts where causes of death outside of hospitals are not rigorously monitored. It is noted from studies elsewhere however that among doctors the suicide mortality rate ('completion') is about the same for male and female doctors, while among the general population women are generally estimated to attempt suicide more often but the completion rate is higher for men.[3]

Suicide rates vary across regions of the world due to differences in cultural and life experiences.[4] For example, in the United States, factors that glaringly increase the risk of suicide include having a job that demands long-term investment in education and high natural ability, and which requires long working hours, depriving workers of time for leisure or interaction with family. Oddly enough, contrasting evidence has emerged in other countries like those on the African continent indicating the opposite trend to be true, where occupations requiring lower skills tend to carry increased rates of suicide.[3]

Numerous factors contribute to the choice of a suicide method that may be a result of what may be deemed as social acceptability of the method (i.e. culture and tradition) and its availability within the environment (i.e. opportunity).[5,6] The use of pesticides and poisons therefore tops the list in Africa owing to their abundancy in the African setting. Following this method in these low-income countries is suicide by hanging.[2] The suicide rate for health professionals in settings where there is ready access to prescription medications is higher than for those in health professions without such access or in non-health professional occupations. Hence, anesthesiologists and surgeons usually top the list when it comes to self-poisoning.

For reported cases of suicide, the cause is often untreated or undertreated depression or other mental illnesses which are usually chronic in nature, a fact that underscores the need for early diagnosis and treatment. In addition, there is the problem of alcoholism and substance abuse. The combination of the three further results in comorbidity and complications associated with its management. Depression remains the commonest disorder and the second highest contributor to disease disability-adjusted life years of the entire disease burden in the world.[5]

For health professionals, it is common to feel stress and even suffer 'burnout' resulting in inadequate work output and poor quality of life. They strive to help people but live with the knowledge that even in situations when all is done to help patients some eventually worsen and die. There is usually inadequate human resource infrastructure which contribute to work overload and stress. All this is extremely emotionally draining and without a system of ventilation and debriefing

Professor Noeline Nakasujja heads the Department of Psychiatry, College of Health Sciences, Makerere University and is President of the Uganda Society for Health Scientists.

eventually leads to catastrophic outcomes for the health professional.

While it may be perceived that suicides follow negative life events such as the loss of a loved one or professional disappointment, with high-achieving professionals like doctors, suicides can occur in the face of what others may perceive as success. The overwhelming demands and expectations of the job are sometimes difficult for the individual to juggle and maintain a healthy coping lifestyle.

During a recent annual conference for the Uganda Medical Association, a participant doctor approached me after I had been introduced and inquired whether there was a facility where medical doctors with mental health problems could seek care. It struck me that I had never known of a doctor asking such a question before, because of the stigma attached to mental health treatment and the fear of psychiatrists and the diagnoses they might make. I also started to wonder how long this particular doctor had suffered with the mental ailment before they mustered the courage to ask. Their suggestion was that there should be a designated place for health professionals to seek care.

We have to take care of our own, but how do we achieve this? Fighting stigma in mental health is key to ensuring increased seeking of care among health professionals.[1] There is a lot of cultural influence in the beliefs around the cause of mental illness in Africa, with even some professionals still believing that demons and spirits play a role in who becomes mentally ill.[6] The emphasis in understanding the biopsychosocial model in the path to mental illness needs to be underscored so that the role the disturbance of brain function plays is appreciated, requiring early diagnosis and treatment.[1] This scientific model helps to destigmatise the symptoms of mental illness, providing a platform for a public health approach for research and effective and early intervention. In addition, more information needs to be collected in the African setting to appreciate the means by which health professionals die by suicide in order to put into place means of limiting access as a component of prevention. Professionals should know how and where to seek help. Systems need to be put in place to enable this to happen so that we have a workforce that is fit to look after the health of others in society. There is a need to increase service and awareness about the dangers to the health professional and offer opportunities to access friendly services to improve quality of life and, most importantly, avoid unnecessary deaths.

References

1. Stein DJ. In the aftermath of a suicide: Any lessons from the sorrow? S Afr Med J. 2018 Aug 28;108(9):12412
2. WHO suicide data 2018. www.who.int/mental_health/prevention/suicide/suicideprevent/en
3. American Psychiatric Association 2018. Abstract 1–227, presented May 5, 2018
4. E Kinyanda, D Wamala, S Musisi,3 and H Hjelmeland. Suicide in urban Kampala, Uganda: a preliminary exploration. Afr Health Sci. 2011 Jun; 11(2): 219–227
5. Vladeta Ajdacic-Gross, Mitchell G Weiss, Mariann Ring, Urs Hepp, Matthias Bopp, Felix Gutzwiller, Wulf Rössle. Methods of suicide: international suicide patterns derived from the WHO mortality database. Bulletin of the World Health Organization. www.who.int/bulletin/volumes/86/9/07-043489/en
6. Hjelmeland H, Knizek BL, Kinyanda E, Musisi S, Nordvik H, Svarva K. Suicidal behavior as communication in a cultural context: a comparative study between Uganda and Norway. Crisis. 2008;29(3): 137-44