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MENTAL HEALTH

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GUEST EDITORIAL

JULY 2020

Dear healthcare worker: Now is the time to take a pause ...

Prof. Zuki Zingela

Healthcare workers across the globe have been the buffer between the onslaught of the coronavirus and their fellow countrymen and women. As the pandemic has continued relentlessly, it has left health systems reeling. Along with other essential workers, we have continued to ensure that our health systems and other essential systems remain functional despite the major shifts brought on by the pandemic. Maintaining the wellbeing of the healthcare worker in the face of all of this has never been more crucial – so much so that in the prioritisation of access to ventilators, some countries have classed healthcare workers up there with the "young and fit" to try and ensure that the chain of care remains unbroken should a healthcare worker be infected and require care.

Now is the time for each healthcare worker to ensure that in the quest to conquer the COVID-19 epidemic, we do not neglect an essential part of this equation – ourselves. If we are to triumph over this, we must look beyond the outbreak to the world we want to see after the last person with COVID-19 has been treated, when the dust has settled. In this, one of our darker hours in modern medicine, there is a chance to rewrite the script for ourselves and for our loved ones. We can change the story of this COVID-19 outbreak by marking it as a turning point, where we learn to care for ourselves as much as we care for others. We need to make this an ingrained habit, like brushing our teeth. We need to unlearn the bad habit of neglecting ourselves and our needs. This does not call for selfishness and self-absorption, but rather for self-acknowledgement, and balancing our own needs with the needs of others.

This mental health supplement has been compiled with this in mind. In it we unveil several pieces, written over the past couple of years, focusing on doctors' mental health. Some may seem like peripheral issues at first glance. Others may seem repetitive. When taken together, however, they represent a chance to reflect on our own wellbeing in a constructive and supportive way. They ask every one of us to take a pause and reflect on how we are caring for ourselves. They offer multiple voices on physician burnout, from different yet complementary perspectives. We get to revisit depression, anxiety, suicide, accommodation of those of us with mental illness in the workplace, maternal mental health issues and so much more. Lastly, we get a relook at tips and tricks for coping with stress, practising relaxation techniques and approaching sleeping problems. This is the one chance we get to ask, if we accept that we are essential to the country and indeed the whole world's triumph over this pandemic, who will take care of us while we take care of others? While some of us may say, not now, I cannot focus on myself because I am still dealing with helping others with this COVID-19 pandemic, to paraphrase Hillel, I ask, "if not you, then who? If not now, then when?"

Diane de Kock
Editor

During COVID-19, mental health among healthcare workers is paramount as we all reel under the pressure of this pandemic. When Prof. Zingela suggested we publish articles on mental health published in *SAMA Insider* over the past few years, we jumped at the chance. We hope this edition will assist our members during these challenging times.

Thank you to Prof. Zingela for her assistance in producing this supplement, and for always being so willing to write articles for *SAMA Insider*. To our copyeditor Kirsten Morreira, thank you for your attention to detail and invaluable help in compiling this edition, and to our talented layout artist Clinton Griffin, *Insiders* would not be the same without you!

Stay safe and look after yourselves.

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When the good doctor burns out

Prof. Zuki Zingela, *HOD, Psychiatry and Behavioural Sciences, Walter Sisulu University*

We fulfil many roles as doctors – besides saving life or limb – that require us to wear many hats and different faces, while never losing our core professionalism and dedication. We are mothers, fathers, wives, husbands, daughters, sons, siblings, cousins and friends. Some of us are also students and/or supervisors, mentors and guides. We give a lot of ourselves to everybody around us, leaving little space for personal needs and interests. By default, immediate family, extended family, friends and friends of friends often use us as Wikipedia or Google for any medical niggles, real or imagined. Other crises are also laid at our door, even if they have nothing to do with medicine, simply because we are seen as the "take charge" people who know what to do when others are at a loss. With all these wants and needs of others pulling us in different directions, we become neglectful of our own. We feel guilty about taking time off, even when sick. It is not unknown for a doctor to "forget" to take annual leave and to continue soldiering on in the midst of chaos. Our training primes us to carry on, and our profession compels us. Is it any wonder that the profession is buckling under the strain?

When burnout comes calling

In its 2018 physician lifestyle survey, Medscape found that 42% of the 15 000 doctors who responded, from 29 specialties, reported burnout, while 15% reported depression. Drummond, in an article on physician burnout, provides stats showing that one in every three doctors is experiencing burnout at any given time. So, what is burnout, and why are so many doctors experiencing it?

Burnout manifests as three core symptoms linked to work-related stress – stress that is unrelenting to the point of being overwhelming:

- emotional exhaustion
- lack of efficiency, or a reduced sense of personal accomplishment
- depersonalisation brought on by work related stress.

The emotional exhaustion can lead to feeling so run down that you have no energy or reserves to invest in most aspects of your job, with a loss of interest in and inability to engage fully with patients, colleagues or significant others. The depersonalisation aspect of burnout manifests as an emotional distancing from patients and others, and even pervasive cynicism and sarcasm that permeate various aspects of your life. Perceptions about lack of efficiency can introduce self-doubt, and affect your level of functioning and ability to be decisive at work.

Our training primes us to carry on, and our profession compels us

Christina Maslach and colleagues devised the Maslach Burnout Inventory, which is a standardised survey that screens for burnout. There may be delayed self-recognition of burnout, or a reluctance to act even when one has insight into its presence. Complicating things even further is the fact that burnout, although described by many researchers over the years, is not a well-delineated, fully fledged condition, and does not have clear treatment guidelines. It is also not listed as a diagnostic entity in the *DSM-5*, although there is overlap between the core symptoms described for burnout and depression. For example, loss of energy and the change in usual efficiency or sense of accomplishment are common to both conditions, while depersonalisation may be seen in a number of mental disorders, including depression, even though it is not a core diagnostic criterion. Some researchers propose that burnout should be taken as part of a continuum of depression, rather than a separate entity.

Irrespective of one's interpretation of the current literature on burnout, the fact that close to half of the 15 000 Medscape cohort described themselves as suffering from it implies that it exists as a recognised concept in the real world, away from textbooks and diagnostic criteria. Moreover, it can impact significantly and negatively on a doctor's productivity and work efficiency. A *JAMA International Medicine* meta-analysis refers to the profound physical and emotional consequences burnout can have for both doctors and patients. One of the consequences it describes is reduced efficiency of healthcare systems in delivering high-quality, safe care to patients. Examples of how this may manifest include preventable adverse events, such as prescribing improper medications, or failing to make appropriate and necessary referrals. The authors also describe a 1.96-fold increased risk of patient safety incidents, and a 2.28-times increased risk of reduced patient satisfaction reports.

Contributors to physician burnout include:

- medical training that demands that you give your all to your medical career, no matter what. Inherent to the classical style of medical training is a lack of acknowledgement of one's needs, and neglect of all aspects of self-care.
- a strenuous work environment with under-resourcing, short-staffing and general lack of appreciation. The result is overwork, with little say afforded to the individual doctor in the running of health systems or institutions. This can contribute to feelings of powerlessness and can fuel loss of emotional investment in all things to do with work.
- a profession that is intolerant of mistakes, due to the gravity and finality of the consequences when things go wrong, i.e. death.
- the nature of our work, which deals with people's pain, whether physical or emotional. It is our job to relieve their pain and distress. Most of the time we do this successfully, but due to the mortality of man, it cannot be done indefinitely. It therefore stands to reason that at times we will be unsuccessful. We are less accepting of this than those in other professions, however, due to our overactive sense of responsibility and perfectionism.

The conundrum of the injured healer healing themselves

To conquer the malaises of burnout, depression and other causes of mental distress that plague us, we must first acknowledge their existence. In understanding this reality, we also have to accept the part we play in perpetuating unrealistic expectations of ourselves as unbreakable superhumans. The caring nature of our profession that is nurtured

throughout our training has to include a caring approach towards ourselves and our own wellbeing. It does not mean compromising on quality and standards. Instead, it implies a recognition that on days when I am not functioning at my best, I should be able to acknowledge this to myself and colleagues around me, so that asking for help is not perceived as weakness but as an early indicator that they need to adapt and increase support until I can function at a higher level again. Many of us cope with our workload most of the time. But all of us have days when we are not firing on all cylinders. Such days are a realistic part of any profession. They should not be considered anathema to medicine. Our work systems should be geared to respond with contingency measures when such instances occur.

Prevention strategies that foster resilience, as a guard against burnout, should be encouraged. Self-care includes ensuring a more balanced work-life schedule, and maintaining social interconnectedness through positive relationships with family, friends or other support networks. Professional bodies and doctors' network groups can form an extension of this connectedness and encourage a sense of belonging which can counteract isolation and aloneness. Cultivating professional relationships with colleagues and seniors through mentorship, consulting with experts when faced with clinical or ethical dilemmas, and general collegial support may boost ability to copy with pressures at work. Healthy lifestyle habits such as getting enough sleep, exercise and proper nutrition are crucial in promoting and maintaining optimal energy levels. Psychological health also benefits from optimal physical health. Taking time out before exhaustion and despair set in about one's negative work circumstances is also crucial. Being aware of self-critical thoughts or self-talk, and learning to adjust one's thinking around these thoughts, is an important skill that some people may practise automatically, but if it does not come naturally, it assists to develop and hone the ability. Self-help books on mindfulness and cognitive behavioural techniques may also assist. Being able to vent to a sympathetic ear may assist in adjusting one's perspective when things feel overwhelming. A good mentor or guide can make an enormous difference to how the average doctor learns to deal with work problems, especially early on in one's career, which is the most vulnerable time for doctors. Taking sabbaticals where possible to focus on other areas of interest may also assist.

"Dr Burnout" does not always have to be at everyone's beck and call 24/7

For as long as doctors have not internalised the importance of wholistic self-care, the profession will continue to be predisposed to burnout. Equally important is for doctors to differentiate between being in the service of our fellow countrymen and women, and being in servitude to our sense of duty and dedication. Servitude implies enslavement to our profession, while being in service inherently includes a period when doctors should be able to put up an "out of service" sign, even if temporarily, to allow for rest and recuperation in times of need. "Dr Burnout" does not always have to be at everyone's beck and call 24/7. He or she also deserves a break.

SAMA Insider October 2019.

Doctor burnout: Resilience training isn't enough

Dr Maria Phalime, *author of the award-winning memoir,* Postmortem – The Doctor Who Walked Away

In a recent two-part article series published in the *Daily Maverick* titled "The canary and the coal mine – the state of public health", the SA Medical Research Council's Glenda Gray, Debbie Bradshaw and Leonard Gentle use the metaphor of the canary in the coal mine to highlight the dire state of public health in SA, and its relationship to the overall wellbeing of the nation.

In the early days of coal mining in Britain, miners would take caged canaries with them down the mine shaft. The yellow songbirds were more susceptible than the miners to the effects of noxious gases such as methane and carbon monoxide, and therefore served as an early warning system for the miners. When the birds stopped singing, the miners knew to quickly evacuate to safety above ground.

In their article, the authors liken the state of SA's health to the canary. "Today the canary giving us advance warning of a serious crisis if we do not respond appropriately, is the state of SA's health – both the social determinants of health, and the state of healthcare." They further assert that the state of the nation's health "is a direct measure of our existence, and frames whatever political and economic choices we may make. And yet current policies and economic orthodoxy are taking us in the opposite direction to that required to address what the reports are signalling."

I borrow this metaphor to illustrate the relationship between doctor burnout and the healthcare system. If the state of SA's health is a warning sign of a national crisis, doctor burnout is a warning sign of a healthcare system in crisis.

By now, many of us are aware of the scourge of burnout in the medical profession. Recent studies have shown a high prevalence of burnout among doctors in both rural and urban settings, and articles in the mainstream media have helped to draw attention to the challenges many face in our beleaguered system.

However, when we talk about burnout, the focus is often only on the syndrome, as described by Prof. Emerita at the University of California at Berkeley, Christina Maslach, and her colleagues, and characterises burnout as a syndrome consisting of the three dimensions of emotional exhaustion ("I've got nothing left to give"), depersonalisation ("I don't care anymore") and low sense of accomplishment ("What difference does it make?").

While this characterisation describes how burnout manifests in individuals, it only provides a partial understanding of what burnout is.

Burnout doesn't happen in a vacuum; it happens in workplaces that predispose doctors to burning out. Therefore, a fuller understanding of burnout must necessarily

include the workplace environment in which burnout develops and festers.

In addition to their work on defining workplace burnout, Prof. Maslach and her colleagues have also conducted extensive research into the workplace factors that drive and perpetuate it. They have identified what they term the six areas of work life that are most associated with burnout:

- **Workload**. In medicine, this factor is a given. It relates not only to the volume of work, but also the intensity. This area of work life is particularly important in the development of burnout. When job demands exceed human limits, emotional exhaustion begins to set in, and triggers the other manifestations of burnout.
- **Control**. Perceived control is an important predictor of wellbeing. To what extent do you feel you have control over where, when and how you work? Do you have the resources available to be effective in your work? And to what extent are you equipped to fulfil the level of responsibility you are given, and to make the kinds of decisions that you are required to make? A sense of control can act as a buffer against workload demands. However, if the workload is excessive and there is a low sense of control over it, burnout is a likely consequence.
- **Reward**. Reward doesn't only have to do with financial reward, though this can be an important factor when one's expectations aren't met. More significant than financial reward is acknowledgement and recognition of one's contribution, particularly from more senior doctors. This recognition has a reinforcing effect on behaviour, and if it doesn't happen, there is a sense of being out of sync with the values of the institution, which negatively impacts work engagement and performance. Reward also refers to intrinsic reward – the inner sense that what one is doing is meaningful.
- **Community**. As humans we are social beings, and the quality of our social interactions at work is important. What contributes to burnout in this area is low levels of support, toxic work relationships and poor teamwork dynamics. It's not only toxic relationships that are a problem. Even when we have good connections and positive relationships at work, the reality of rotating between different hospitals or working in remote locations may make it difficult to nurture these relationships, leading to feelings of isolation. Work also often affects our non-work relationships; being away from loved ones and our support network takes away a valuable support mechanism in times of strain.
- **Fairness**. How are decisions made in your place of work? Are policies and decision-making processes clear and equitable? To what extent do personalities play a role? When errors occur, are they dealt with openly and constructively, so that they become opportunities for learning and improvement, or are they dealt with from a position of blame and shaming? All of these factors contribute to the extent to which people feel that they are treated fairly at work.
- **Values**. When people feel that there is a mismatch between their values and the values of their organisation, engagement suffers. Also, when the organisation says "We care about you," but what actually occurs on a daily basis communicates the exact opposite, people become less engaged, and job performance is affected.

Doctor burnout is a warning sign of a healthcare system in crisis

These areas of work life are important contributors to burnout. Whenever there is a mismatch between people and their work environment, their energy, engagement and effectiveness are lowered, which correlates to the burnout dimensions of emotional exhaustion, depersonalisation and low sense of accomplishment.

Resilience training is often proposed as a solution for doctor burnout. It's understandable why this is the case, given the way our medical training teaches us to approach wellbeing issues. Through the process of history taking, clinical examination and special investigations, we arrive at diagnoses which inform the kinds of treatment we prescribe to alleviate symptoms and restore health.

Resilience training attempts to address doctor burnout in the same way – as a "disease entity" for which a definitive treatment can be prescribed.

This approach is problematic for a number of reasons:

- It focuses purely on the individual, and ignores the workplace context in which burnout occurs.
- It implies personal failing or weakness which must be "fixed" by toughening doctors up for the job. In this way, the approach contributes to the stigma associated with burnout.
- Resilience training also sends the wrong message – that employers bear no responsibility for addressing the drivers of burnout in the workplace; instead, doctors need to be equipped to better cope with that environment.
- Doctors are already resilient; it takes a lot to withstand the rigours of medical training, the long working hours and the often harsh conditions in which doctors work. They don't neeed to be toughened up any further.

Resilience training effectively says that doctors need to be "tougher canaries" in order to survive the mines of our healthcare system, which countless reports have shown to be toxic. It doesn't take much to see that this approach does little to address the wellbeing of the hardworking professionals who are at the coalface of patient care.

We need to acknowledge that burnout is the result of an interplay between individuals and their work environments; it is an ever-present risk of working in the high-pressure, high-stakes environments that characterise the practice of medicine. Therefore, if we are going to deal with it effectively, our approach needs to be:

- to reduce the risk, by addressing the drivers of burnout in the workplace,
- **and** to promote a culture of wellbeing, in order to enhance the capacity of individuals to perform effectively in these high-pressure environments.

There are no quick fixes. We need to adopt a long-term view that aims to fundamentally change the ways that workplaces are organised, medical students are trained and doctors work, and to create a culture that recognises the critical role that doctor wellbeing plays in patient wellbeing. For this to happen, leadership is key, both in terms of a commitment to a fundamental change in the way things are done, as well as in driving interventions forward.

SAMA Insider November 2018.

Tips and Tricks

On stress

We react in different ways when we are stressed. Get to know your "stress signature" – the different ways that it can manifest in you. This may include a conglomeration of nonspecific experiences, as described below:

- feeling unsettled, worried or restless
- thoughts going around in circles
- sleeplessness, or change in sleep pattern
- changes in appetite, eating pattern and even weight
- short temper
- problems with concentration, which can affect your ability to remember things
- decreased ability to take decisive decisions
- self-doubt
- increase in coping styles that may be damaging to your health and/or wellbeing, e.g. drinking, substance use, gambling
- physical symptoms such as tension headaches or other aches and pains, loose bowels, etc.

Are you suffering from occupational-specific dysphoria?

Prof. Stoffel Grobler, *associate professor, Walter Sisulu University*

In a recent article on burnout by, arguably, the world's leading expert, Christina Maslach, she referred to it as "occupational-specific dysphoria". While reading it, I thought back to the first time I gave a presentation on burnout, many years ago, while still in private practice as a psychiatrist.

As I stood there in front of the audience, I thought to myself, "You hypocrite! You're here in front of an audience of doctors, preaching about the prevention of burnout, yet you are suffering from it yourself!" That day, I made a decision to do something about it. Two years later, I left full-time private practice and went to work in Ireland, where I recovered from that sense of permanent emotional exhaustion.

Last year, after I presented on the topic of "Depression in doctors" at a SAMA CPD function, one colleague asked, "Is burnout a real thing?" The question was followed by laughter, and quips such as "We are all probably suffering from burnout." Well, as they say, there's many a true word spoken in jest: the sad fact is that most of them probably were. Doctors seem to have resigned themselves to the fact that they must live out their lives in a constant state of emotional exhaustion and detachment.

What is burnout?

The term "burnout" was coined in the 1970s by American psychologist Herbert Freudenberger. He used it to describe the consequences of severe stress and high ideals in the so-called helping professions.

Those in the helping professions, who sacrifice themselves for others, often end up being "burned out" – exhausted and struggling to cope with life's demands. It is also referred to as "compassion fatigue" or "the dark side of self-sacrifice". Burnout has been recognised for many years as an occupational hazard in professions such as human services, education and healthcare. The relationships that such providers develop with their patients or clients require an intense level of personal and emotional contact, and although this can be rewarding, it can also be emotionally draining. Within such occupations, the predominant habits are to be selfless and put others' needs first, to work long hours and to do whatever it takes to help a patient.

Defined as a "prolonged response to chronic emotional and interpersonal job stressors", Maslach and others describe burnout as "a point at which important, meaningful and challenging work becomes unpleasant, unfulfilling and meaningless". Energy turns to exhaustion, involvement (or engagement) becomes cynicism, and efficacy is replaced by ineffectiveness. The Maslach Burnout Inventory is one of the most commonly used instruments for assessing this psychological syndrome.

In order to better understand burnout in context, the conceptual models, causes and consequences need some consideration, as does burnout as a clinical diagnosis.

Conceptual models

There have been various conceptual models of the development of burnout, and its subsequent impact. The following are currently receiving attention:

- The transactional model refers to sequential stages and imbalances. Its three stages are: (*i*) job stressors (an imbalance between work demands and individual resources); (*ii*) individual strain (an emotional response of exhaustion and anxiety); and (*iii*) defensive coping (changes in attitudes and behaviour, such as greater cynicism).
- The job demands-resources model focuses on the notion that burnout arises when an individual experiences incessant job demands and has inadequate resources available to address and to reduce those demands.
- The conservation-of-resources model follows a basic motivational theory assuming that burnout arises as a result of persistent threats to available resources. When individuals perceive that the resources they value are threatened, they strive to maintain those resources.
- The areas-of-worklife model frames job stressors in terms of a person-job imbalance, or mismatch, and identifies six key areas in which these imbalances take place: workload, control, reward, community, fairness and values. The greater the mismatch between the person and the job, the greater the likelihood of burnout.

Causes

Work overload depletes the capacity of a person to meet the demands of the job. When overload is a chronic job condition, there is

little opportunity to rest, recover and restore balance.

There is also a clear link between a lack of **control** and burnout. When employees cannot exercise professional autonomy and do not have access to resources necessary to do an effective job, they are more likely to suffer from burnout.

Lack of recognition and **reward** (whether financial, institutional or social) increases people's vulnerability to burnout, because it devalues both the work and the workers, and is closely associated with feelings of inefficacy.

Community refers to the relationships that employees have with other people on the job. When these relationships are characterised by a lack of support and trust, and unresolved conflict, then there is a greater risk of burnout.

Fairness refers to the extent to which decisions at work are perceived as being fair and equitable. Cynicism, anger and hostility are likely to arise when people feel they are not being treated with the appropriate respect.

Finally, **values** are the ideals and motivations that originally attracted people to their job – the motivating connection between the worker and the workplace. When there is a values conflict or a gap between individual and organisational values, employees will find themselves making a trade-off between work they want to do and work they have to do, which can lead to burnout.

As in many other countries in the world, my personal experience is that healthcare resources are limited in SA, and the environment is unforgiving of mistakes. A recent publication by the WMA observed: "Physicians in many countries are experiencing great frustration in practising their profession, whether because of limited resources, government and/or corporate micromanagement of healthcare delivery, sensationalist media reports of medical errors and unethical physician conduct, or challenges to their authority and skills by patients and other healthcare providers".

Consequences

The consequences of burnout in doctors are absenteeism, decreased productivity, job dissatisfaction, lower quality of care, lowered retention of skilled staff and poor patient care, and greater patient dissatisfaction.

Interestingly, a Canadian study found that burnout may cause people to relocate, as more than half of the respondents in the study had considered relocating due to burnout. Moving to Ireland after private practice makes sense to me, in retrospect.

Burnout as a clinical diagnosis

There has been a drive to "medicalise" burnout by the medical profession, seemingly with the goal of establishing a clinical diagnosis, so that health professionals can receive reimbursement for treating individuals suffering from burnout.

This shift to diagnosing burnout as an individual disorder has mostly taken place in Northern Europe, primarily Sweden and the Netherlands. Sweden began using "work-related neurasthenia" as a burnout diagnosis in 1997, which soon became one of the five most common diagnoses. In 2005, the country revised the ICD-10 burnout diagnosis (Z73.0) to a difficulty in life management characterised by "vital exhaustion". The signs of vital exhaustion include 2 weeks of daily experiences of low energy, with difficulties in concentration, irritability, emotional instability, dizziness and sleep difficulties. Additionally, these symptoms must interfere with the patient's capacity to perform his or her work responsibilities.

In the Netherlands, the term *overspannenheid*, or "overstrain", is used to indicate burnout. This diagnostic approach estimates burnout prevalence at 3 - 7% across various occupations, with psychotherapists at 4%.

It is interesting that the USA has been reluctant to recognise burnout as a clinical diagnosis, partly due to concerns about a flood of requests for disability coverage. This absence of an official diagnosis of burnout limits access to treatment, disability coverage and workplace accommodations. An unfortunate consequence is that inaccurate diagnoses may reduce possibilities for successful recovery and return to work.

However, in the end, the medicalisation of burnout in this manner constitutes a one-dimensional approach. Current research has now begun focusing on all three dimensions of burnout, which allows for identification of multiple distinct patterns on the burnout-engagement continuum, having realised that exhaustion alone is not a proxy for burnout.

Treatment and prevention

Intervention strategies for burnout have to consider the high costs involved, both personal and organisational. Some attempt to treat burnout after it has occurred, while others focus on how to prevent it, by promoting engagement.

A Canadian study of physicians identified resilience as a dynamic, evolving process of positive attitudes and effective strategies that can prevent burnout. The study found four main aspects of physician resilience:

- attitudes and perspectives, which include valuing the physician role, maintaining interest, developing self-awareness and accepting personal limitations
- balance and prioritisation, which include setting limits, taking effective approaches to continuing professional development and honouring the self
- practice management style, which includes sound business management, having good staff and using effective practice arrangements
- supportive relations, which include positive personal relationships, effective professional relationships and good communication.

No measures to prevent burnout will be effective unless attention is paid to enhancing a positive work environment. Isolated strategies directed at individual doctors may prove of limited benefit. A positive work environment is defined as one that "attracts individuals into the health profession, encourages them to remain in the health workforce and enables them to perform effectively, to facilitate better adaptation to the work environment".

Key features of a positive work environment include achieving work-life balance by providing a family-friendly work environment and flexible working hours. Protection from exposure to occupational risks, enhancing job security, provision of childcare opportunities, compensation for reduced employment and maternity/parental leave were identified as attributes of the work environment that prevent burnout.

In as much as a positive work environment lowers the risk of burnout, the opposite is also true – the risk for burnout increases for doctors working in poorly functioning organisations.

Conclusion

In conclusion, if any of the following statements ring true for you, there is a chance that you might be suffering from burnout, or occupational-specific dysphoria:

- "I feel demoralised and emotionally exhausted all the time."
- "I have become cynical about my work environment, and I protect myself by being disengaged from patients, colleagues and my work."

- "My work has become meaningless and I don't enjoy what I'm doing anymore; I do not feel I'm making a difference anymore."

And if you just can't face another day of work, don't quit – at least not yet. Here are some practical suggestions:

- Talk to colleagues about it. This can be in the setting of a regularly scheduled group, or simply informal conversations about the stresses of work.
- Minimise administrative work. This may involve a financial investment in an assistant, but the cost can be minimal, especially if you hire a virtual assistant who can work a few hours a week from a remote location.
- Develop new professional skills, such as teaching, consultation or business management.
- Make a conscious effort to get re-engaged with your clinical work. Rediscover the idealism and intellectual curiosity that got you into medicine in the first place.
- Learn how to meditate, and schedule at least 5 - 10 minutes of meditation into your day.

At present, I can honestly say that I do not suffer from burnout. I ascribe it to the fact that I work in a hospital where the collegial support, ranging from medical colleagues to the other allied health professionals, and including management, is tangible. I feel privileged to work with such people, and it fills me with humility and thankfulness.

If you, the reader of this article, realise that you may be suffering from burnout, you have my fullest sympathy, and I implore you to do some introspection and make the necessary changes. For yourself, your family and, most importantly, your patients.

SAMA Insider May 2019.

Doctors under pressure: Let's support each other

Dr S Z Nzama, *JUDASA NEC vice-chairperson*

In recent years, the issue of medical practitioners and other healthcare providers' mental health, and their safety, has been highlighted. However, despite increased awareness of the fact that providing a service in any healthcare environment will take its mental toll at some point or another, very little has been done to address the issue on a grand scale.

Doctors and other healthcare professionals have become increasingly concerned about feeling unsafe in their working environment, and during one-on-one interactions with patients. Over the years, they have reported, on many occasions, events where they have been physically assaulted, verbally abused, threatened or even sexually harassed while executing their civil duties in SA. The number of such incidents witnessed in the past decade highlights the decline of healthcare services in the public sector, partly as a result of burnt-out healthcare professionals. However, while this issue has been in the spotlight, little has been said regarding the gruelling environment and the insurmountable pressures that doctors are forced to work under, resulting in what has been easily termed "poor service delivery". Little improvement has been seen in the workspace despite aims to provide noticeable change for the holistic betterment of healthcare professionals in their efforts to serve the citizens of the republic.

In 2010, a doctor was raped while on duty in a Bloemfontein hospital. In 2011, a junior doctor in Mpumalanga tragically lost his life at the hands of a patient, after being stabbed in the chest. In 2016, the safe-working-hours campaign was started by the Junior Doctors Association of SA (JUDASA) following the death of an exhausted "post-call" medical intern in the Western Cape. Yet to date, doctors across the country still report alarming working hours of up to 120 per week. Since the campaign began, ever-increasing numbers of dangerous and even life-threatening situations have been documented, incidents involving heinous crimes against doctors across the country. In 2018, three public-servant junior doctors were attacked at their off-site hospital residence in Limpopo, with a second series of attacks occurring just days afterwards in a different hospital in the same province.

[Are] doctors no longer valued in our society in the way they previously were?

The year 2019, regrettably, brings us back to the Free State, where a junior doctor had to defend herself against a vicious attack by a patient in an attempted rape. Less than 72 hours later, another doctor was the victim of an attempted hijacking in the hospital parking lot at the same facility. In other provinces, cases have been reported of armed gang-related violence in hospitals, where security service personnel have either fled the scene, leaving patients and healthcare professionals to fend for themselves, or else cowered together with the healthcare workers, leaving patients helpless. One question that comes to mind is whether doctors are no longer valued in our society in the way they previously were; or have economic circumstances become so dire that criminals merely see hospitals as easy targets?

Section 8 of the Occupational Health and Safety Amendment Act No. 181 of 1993 constitutionally compels employers to "provide and maintain, as far as reasonably practicable, a working environment that is safe and without risk to the health of his employees". Questions raised by the lack of staff safety in the vast majority of state facilities include:

Does the responsibility for security in government-owned facilities lie with the executive of each facility, the provincial government or the national authorities?

- Are the sourced security companies experienced in and capable of handling the multi-factored high-stress environment of a healthcare facility? Or is the safety of its employees not a priority for the Ministry of Health?

The mental health of medical professionals remains widely overlooked. Medical staff on the ground are continually subjected to various forms of abuse by patients and/or their families, and sometimes even by other members of staff, but physicians are expected

to "de-escalate" and "manage" each situation they encounter – and then to proceed with daily activities as though they are unaffected by the cases they have dealt with in their attempts to preserve human life. Comments from clients that they as tax contributors pay doctors' salaries, or that doctors should be grateful for their jobs, have been heard one too many times in public service. When asked to describe their working environment and their current outlook on their profession, junior doctors have described their experiences thus far as "demoralising, dangerous and exhausting". Unbeknownst to many in the field, medical professionals may act within their Constitutional rights by refusing to treat patients who are verbally or physically abusive, or who harass the professional in a sexual manner, with the exception of the *non compos mentis* patient (section 20, chapter 2 of the National Health Act No. 61 of 2003).

It should no longer be surprising that doctors are at high risk of a host of mental instabilities following years of practising their profession in what can be described as a hostile environment. Breaking bad news, counselling family members on the loss of loved ones and being viewed as a symbol of potentially devastating news are just some of the burdens that healthcare practitioners carry on their shoulders when entering their working environment daily. So far, there seems to be no national guideline or protocol that seeks to debrief healthcare practitioners on the traumatic situations they encounter during their practice. The expectation, it appears, is for healthcare workers to pick themselves up and carry on. Some facilities, as reported by a group of community service officers, do not have occupational health personnel on site, or policies/avenues for staff members to access

We can be more mindful of each other's wellbeing

these necessary services for their own mental healthcare benefit. Long working hours, with breaks viewed as luxuries one is lucky to have, constant criticism, without guidance, support or interest from senior staff, and snarky remarks when trying to refer patients to higher facilities of care are just some examples of the "minor" challenges the junior doctor must face in the arena. Does this then not explain the high substance abuse and other self-harm statistics reported in various journals and studies over the years? Is this not an indicator that doctors are not coping? Does this not also explain the blunted affects that doctors are repeatedly cautioned not to develop?

When asked, "How does it feel being a doctor?" one junior doctor replied: "It's not worth it! There is no amount of money that can bring back the pieces of myself that I lose every time I watch someone die, or the time I've lost with my loved ones in their times of celebration or mourning because I'm on call, or the sleep I've lost only for patients and their families to abuse me, even though I have been at work for over 24 hours and have had no time to eat, rest or even use the bathroom to relieve myself peacefully." This doctor further added, "My weekends are spent either working, or sleeping in an attempt to recover from the week past and ready myself for the week coming. Yes, I chose this, but I didn't think I would have to sacrifice the rest of my life to a career where my safety, mental and physical health is compromised and constantly under threat. Forgive me if I don't stay very long in clinical medicine."

We should notice that some, although not all, of the challenges mentioned above are those that we as healthcare professionals inflict on one other. Yes, it goes without saying that the nature of our work is stressful, and that cannot be corrected immediately, but the way we treat each other as colleagues can be. We can be more mindful of each other's wellbeing, supporting and acknowledging both the strengths and weaknesses each of us possesses.

It may not be a giant step, but a step forward we can take, in our attempts to improve our own mental health and that of our colleagues.

I would like to acknowledge Dr M Maseko and Dr I Bloemstein, community service medical officers, for their contributions to this article.

SAMA Insider September 2019.

Burnout: Are doctors immune to working long hours and stress?

Jolene Hattingh, *SAMA Knowledge Management, Research and Ethics Department*

Many people do not realise the extent to which doctors push themselves on a daily basis. The hours are long and the burden is heavy, and doctors too experience exhaustion and fatigue, and are not exempt from falling prey to the creeping side-effects of burnout.

But what exactly is it? "Burnout" is a psychological term used to describe the result of long-term exhaustion and occupational stress, with a diminished interest in work. Recognised in the *DSM-5*, burnout is closely related to disorders such as brain fag syndrome, chronic fatigue, anxiety and other depressive disorders, and should therefore not be taken lightly or simply brushed off. According to the WHO, workers in the health services have an increased risk of suicide.

Burnout, listed under life-management difficulty, falls within the ICD-10 codes (Z73) as a "state of vital exhaustion". The symptoms are similar to those of clinical depression, and include:

- **emotional exhaustion:** People suffering from burnout feel drained and exhausted, angry, overloaded, constantly tired and low in energy. You may feel like what you are doing does not matter that much anymore, or you may be disillusioned with everything. You might notice that you feel more generally pessimistic than you used to. While everybody experiences some negative emotions from time to time, it is important to notice when these become unusually common for you.
- **physical exhaustion:** Physical problems include stomach pains and digestion problems, insomnia, chronic fatigue and weight loss or gain.

- **reduced performance:** Burnout affects everyday tasks at work, at home or when caring for family members. People with burnout find it hard to concentrate, are listless and lack creativity. You may experience a lack of motivation, and find it difficult to drag yourself to work every day. You might even find yourself avoiding work-related activities.

Some risk factors that are specific to doctors include:

- occupational risk factors:
  - emotional demands that are part of the job, including patients' fears and frustrations, dealing with death and breaking the news of a loved one lost
  - extended working hours and staff shortages, leading to sleep deprivation
  - tension and lack of support among colleagues
  - easy access to prescription medications, which could lead to habitual use or misuse of these substances
- individual risk factors: Most doctors are strong, driven Type A personalities who strive for perfection. This personality can lead them to be obsessive-compulsive and overly controlling of their work environments. Type A individuals are described as being outgoing, ambitious, rigidly organised, highly status-conscious, sensitive, impatient, anxious, proactive, concerned with time management, high-achieving and "workaholics". They push themselves towards deadlines, and experience more job-related stress than satisfaction.

Friedman suggested that dangerous Type A behaviour is expressed through three major symptoms: (*i*) free-floating hostility, which can be triggered by even minor incidents; (*ii*) time urgency and impatience, which causes irritation and exasperation, usually described as being "short fused"; and (*iii*) a competitive drive, which causes stress and an achievement-driven mentality. The first of these symptoms is believed to be covert, and therefore less observable than the other two.

Stress and resulting burnout does not go away on its own – it will get worse unless you address the underlying issues causing it. If you ignore it, it will only cause you further harm as time goes by. It is important to know that the healing process takes time, and that it is not something that can be rushed. Not everyone will recover at the same pace, and not all strategies work equally well for everyone. The recovery strategies outlined below are all useful in different situations, so one should try to find a balance between them, and use those that work best and that feel right for you. If you believe that something is not working, do not be afraid to try something new.

Recovery strategies

Exercise. It is important to realise that your body may be in need of attention if you have experienced burnout. Studies have shown that exercise has both physical and mental benefits; not only does regular exercise help to reduce stress, but it also boosts your mood, improves your overall health and enhances your quality of life.

Rest and self-care. Make sure that you are getting enough sleep, eating well and drinking plenty of water throughout the day. These sound obvious, but busy professionals often ignore their most basic needs, while taking care of others. Often, call schedules result in erratic sleep patterns and busy doctors can go for many days without adequate sleep.

Take a vacation or leave of absence. Time away from work gives you the distance you need to relax and de-stress. Though your stress and problems at work may still be waiting for you when you return, taking time off is essential for getting the rest you need and coming up with long-term solutions to burnout. Taking time off to prepare for exams does not count as rest, unfortunately.

Reassess your goals. Take some time to reassess your personal goals. Burnout can occur when your work is out of alignment with your values, or when it is not contributing to your long-term goals. You may also experience frustration and burnout if you have no idea what your goals are. Self-analysis will give you a deeper understanding of what you find most important, and will show you which elements, if any, are missing from your life or work.

Avoid taking on any new responsibilities or commitments while you are recovering from burnout, if possible. Say "no" politely: doctors should be aware of their inherent sense of responsibility, which makes it really difficult to say no.

Practise positive thinking. Burnout can cause you to slip into a cycle of negative thinking. This negative thinking often worsens over time. Affirmations can also help you visualise and believe in what you are doing. It can be a challenge to develop the habit of positive thinking. This is why it is important to start small. Try thinking of something positive before you get out of bed each morning. Alternatively, at the end of the day, think back to one great thing that you did at work or at home.

Registrar burnout at Wits far exceeds international norms

More than that 80% of registrars at the University of the Witwatersrand's School of Clinical Medicine suffer from burnout, a response to prolonged stress, with "extremely high" levels of depersonalisation that affect professional response to patients, a survey published in the *South African Medical Journal* found.

In a 2014 US study, 60% of registrars were found to be suffering from burnout.

Researcher Cathelijn Zeijlemaker said in a *Times Select* report that she was particularly worried by the "extremely high" levels of depersonalisation felt that she uncovered among 170 registrars at Wits who completed an online questionnaire. This detachment from work, which resulted in unfeeling and impersonal responses to patients, "is associated with negative effects on professionalism", she said.

The report says the publication of Zeijlemaker's research, which she presented at the SA Association of Family Physicians conference in Midrand, coincides with a WHO bulletin in which a Cape Town doctor describes how he quit as an emergency physician after feeling an overwhelming sense of futility. Many of the responses indicated that registrars were suffering under both categories, but depersonalisation was the bigger problem area.

Richard Heron, co-chair of the International Occupational Medicine Society Collaborative, said that patients would ultimately suffer as a result. "The compassionate, caring environment is harder to maintain, and mistakes are more likely," he is quoted in the report as saying. "Burnout is not just linked to the health of the doctor: it also affects the safety of the patient."

Source: *Medical Brief*, 25 September 2019.

Celebrate small accomplishments. These celebrations can help you rediscover joy and meaning in your work again.

Random acts of kindness. You can also bring more positivity into your life by practising random acts of kindness at work. A basic part of our human nature is to help others. Being kind to others not only helps spread positivity in the workplace, but it also feels great.

Conclusion

Stress is a strong contributor to burnout. Stress can cause severe health problems and, in extreme cases, death. While stress management techniques have been shown to have a positive effect on reducing stress, they are for guidance only, and readers should take the advice of suitably qualified health professionals if they have any concerns over stress-related illnesses, or if stress is causing significant or persistent unhappiness. Health professionals should also be consulted before any major changes in diet or levels of exercise.

SAMA Insider November 2019.

Burnout is impacting patient care, says MPS

SAMA Communications Department

Over a third of both doctors and dentists suspect that emotional exhaustion has contributed to a clinical error, according to a Medical Protection Society (MPS) survey.

MPS's survey findings were revealed at its Ethics For All conference – one of the biggest events for healthcare professionals to explore the issues facing the profession. The survey of over 450 doctors and 147 dentists found:

- 60% of doctors, and 61% of dentists, experience a decreasing sense of personal wellbeing.
- 37% of doctors suspect that emotional exhaustion has at some point contributed to an irreversible clinical error, with 60% saying this was related to a lack of concentration.
- 31% of dentists suspect that emotional exhaustion has at some point contributed to an irreversible clinical error, with 43% saying this was related to a lack of concentration.
- 47% of doctors, and 44% of dentists, often or always start the working day feeling tired.

As the world's leading medical protection organisation, MPS sees first-hand the consequences when things have gone too far, and when its members can no longer cope – potentially leading to complaints or a negligence claim, leaving clinicians even more vulnerable to burnout.

To support healthcare professionals, MPS will be launching a burnout workshop across SA in 2020 for both doctors and dentists.

Members attending the workshop can enhance their understanding of resilience, burnout and associated risk, recognise the key signs of burnout and learn how to develop coping strategies to recover.

Dr Graham Howarth, head of medical services, SA, said: "Medicine is a brilliant career – there are few other professions with so many possibilities to improve people's lives. However, the increasing level of burnout I hear of from colleagues is particularly worrying. When doctors feel burnt out it is not only concerning for them, but for patients and the wider team. Doctors who are happy and engaged will find it easier to be compassionate, and provide safer patient care.

"As a mutual organisation, it is vital that we listen to and care for members – part of the solution is introducing the burnout workshop across SA in 2020 for both doctors and dentists. However, we recognise that more needs to be

About MPS

The Medical Protection Society Limited (MPS) is the world's leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 300 000 members around the world. Membership provides access to expert advice and support, and can also provide, depending on the type of membership required, the right to request indemnity for any complaints or claims arising from professional practice. Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. These can include clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our workshops, e-learning, clinical risk assessments, publications, conferences, lectures and presentations.

MPS is not an insurance company. All the benefits of membership of MPS are discretionary, as set out in the memorandum and articles of association.

done, and we want to go further by using our international insight and experience to call for concrete solutions to help improve the work environment of doctors and dentists."

Dr Alasdair McKelvie, head of dental services, SA, said: "A career in dentistry can be hugely rewarding, as dentists often have a strong sense of mission and purpose to help people have a better quality of life. But dentists can spend so much time and energy worrying about their patients that their own wellbeing can often be put on the back burner, which over time could affect patient care.

I am all too aware of the increasing levels of burnout dentists are facing – it is vital that action is taken to ensure that we do not let the environment we work in reduce the sense of value that we get from being a dentist.

"Our insight and international perspective allow for efforts to be directed towards practical solutions, such as rolling out our burnout workshop – but we must also work alongside other organisations and government to truly tackle the endemic problem of burnout in healthcare."

SAMA Insider December/January 2020.

Mental illness: The next pandemic?

Prof. Stoffel Grobler, *head of clinical unit, Elizabeth Donkin Hospital*

Recently, I wrote an article on LinkedIn about a new word I had thought of in light of the COVID-19 pandemic and subsequent lockdown measures, namely "burn-in", as opposed to burnout.

I thought of "burn-in" in the context of so-called "cabin fever", a common term used in especially northern-hemisphere countries to describe the emotional response to being cooped up in confined spaces during the long winter months. Cabin fever supposedly consists of feelings of restlessness, lethargy, sadness, poor concentration, irritability, decreased motivation and inability to cope with stress. All of which sounds very familiar, considering the ways people have been reacting to the lockdown measures. Cabin fever is, however, neither a scientific phenomenon nor a common behavioural science term.

Interestingly, the experience of astronauts regarding social isolation and its psychological effects was not a topic of much research until about 20 years ago. Since then, much research has been done on the psychological demands of isolation, which include interpersonal conflict, depression, dealing with confinement for extended times and problems in coping with separation. Now, many are turning to astronauts and submariners for advice as to how to deal with lockdown.

Burnout has also had a lot of airtime in the literature and, particularly in the medical profession, we are only too familiar with the concept – sadly, for many of us, from very personal experience.

In my LinkedIn article, I speculated about combining the symptoms of burnout with symptoms commonly associated with social isolation or, if you will, cabin fever, suggesting that the result would be a constellation of symptoms consisting of restlessness, depression, trouble concentrating, impatience, listlessness and decreased motivation, loss of a sense of meaning in life, disengagement and cynicism.

The point I am trying to make is that the COVID-19 pandemic has had an undeniable impact on our emotional state, on both us as healthcare providers and on our families who are not deemed essential workers and have to remain at home during the lockdown.

Research is already showing an increase in the prevalence of mental illness among healthcare providers. In many countries, including SA, the rate of domestic violence has also increased – glaring reminders that we are all suffering psychologically.

Studies from China show that mental health disorders are increasing in the context of COVID-19. One study looked into the frequency of anxiety, depression, phobias, cognitive change, compulsive behaviour, physical symptoms and social functioning using the COVID-19 Peritraumatic Distress Index, with scoring ranging from 0 to 100. A score between 28 and 51 indicated mild to moderate distress, and a score ≥52 indicated severe distress. Almost 35% of respondents experienced psychological distress (29.29% of scores were between 28 and 51, and 5.14% were ≥52).

In an article entitled "Mental health problems and social media exposure during COVID-19 outbreak", Gao *et al*. found the prevalence of depression to be 19.4%, anxiety 22.6% and a combination of depression and anxiety 48.3% during the COVID-19 outbreak in Wuhan, China. Using validated rating scales to assess anxiety, depression, insomnia and distress/post-traumatic stress symptoms, they found high rates of depression (50%), anxiety (45%), insomnia (34%) and distress (72%) among healthcare workers.

COVID-19 has had an undeniable impact on our emotional state

I am not aware of any current studies in SA estimating the increase in mental illness due to the COVID-19 pandemic, but the SA Stress and Health study (2008) found a lifetime prevalence of 30% for any mental health disorder, and 10% for major depression in the past.

Apart from the psychological distress caused by lockdown, the financial impact on

the average SA household will be devastating. Early forecasts suggest that the economic impact of lockdown costs the economy an estimated ZAR13 billion per day, and preliminary projections by the SA Reserve Bank indicate that the country could lose 370 000 jobs in 2020.

If I were to predict the risk of an increase in mental illness in SA, either new diagnoses or the exacerbation of existing mental illnesses, based on the evidence at my disposal, it seems logical to me that the prevalence of mental illness is about to increase exponentially. At the same time, the need for services to treat mental illness will increase considerably in the coming months.

We, as the medical profession, ought to be ready for this next pandemic, and put systems in place to meet the demand. Telepsychiatry and telepsychology are ways of expanding the availability of services. I sincerely hope the HPCSA will consider the risks v. the benefits when reviewing their guidelines on telemedicine after the COVID-19 pandemic is over.

Mental illness has always been a stigmatised domain. I hope that a positive outcome of this pandemic will be that, due to all the education available online regarding how to stay mentally well during the lockdown, as well as recognising the signs of mental illness, people will find it easier to ask for help in future.

SAMA Insider May 2020.

Tips and Tricks

Coping with stress

- Accept that some days will be better than others. That is normal.
- Try and identify what is the source of your stress.
- Ask yourself what you can do that is in your control about what is stressing you. If you can, identify something you can do to take the stress levels down – it is good to write out an action plan for yourself.
- Once your action plan is ready, you can break it down into smaller chunks and target one action per day, or every 2 days – whatever works for you.
- If you feel that what is stressing you is beyond your control, look at how you have been reacting to the stress to see if there are behaviours that you can change to minimise the effect it has on you.
- Look at your sleep pattern, eating habits, physical activity and exercise, and how much time you are spending worrying about what you cannot control. For every behaviour you have identified that is unhelpful to you, try and think of helpful behaviours you can replace it with.
- Make a list of 5 - 10 things that you know have brought you pleasure in the past, even if it does not feel like you are interested in doing them anymore (as long as they are not harmful to you or others). Add these activities to your day, even if it is one or two per day from your list.
- Schedule allowed "worry time" of no more than 5 minutes for every given 3 - 4-hour period, to enable yourself to take "breaks" outside of that worry time. You can do this by monitoring your thoughts and deliberately focusing your mind on doing more activities from your pleasure list every time you catch yourself worrying outside of your worry time.
- Remain connected to loved ones in various ways. Stay connected to your source of strength as well, whether this is spirituality, belonging to support groups, sports clubs, social clubs, etc.
- Remember to take it one day at a time. If everything feels like it is too much, then make an effort to focus on the task at hand, until it is complete.
- Good sleep, a balanced diet, exercise, relaxation techniques and meditation also help. So does building fun activities into your daily schedule, even if you are convinced you will not enjoy them at the time of planning.
- Spend time outside, on a walk, with a pet or with other people whose company brings you pleasure, to avoid being closeted indoors all day obsessing about your worries and your thoughts. This will give your mind a break, even if it is short-lived.
- Monitor your stress levels to make sure there is an improvement. If there is no improvement and the pattern continues for protracted periods, seek help from a professional.

Depression does not discriminate – even doctors suffer from it

SAMA Communications Department

Dr Sindisiwe van Zyl is a bubbly 41-year-old mother. A GP with a special interest in HIV treatment, this energetic doctor seems to have it all. But beneath the surface, Dr Sindi has a sad past, which she says she is slowly coming to terms with.

Four years ago, in April 2013, Dr Sindi was officially diagnosed with depression.

"I guess it was something I'd always lived with, but in that year a couple of different events culminated in me needing to be hospitalised, officially, for depression," she says.

Dr Sindi van Zyl

"Doctors and healthcare workers don't necessarily see the signs of depression in themselves"

In February that year, her boss was relieved of her duties, and Dr Sindi was promoted to a manager's position. In the same week she and her husband moved to a new house.

"Everything started unravelling, and it all just became too much for me to handle. Many patients with mental-health issues can trace back to a specific point where this happens. For me, these two events collided and I needed to go to hospital."

"It is vital to get outside help, and accept that we are sometimes also patients"

In a recent article in *HIV Nursing Matters*, she described her condition as being in a dark and helpless place.

"I felt as if I was standing at the bottom of the ocean on a sunny day. I could see the sunlight streaming into the ocean, I knew that light and life were up there, but I had no will to kick myself off the bottom. I wanted to, but I just couldn't do it," she relates.

But then Dr Sindi got help. She was in therapy for 3 years, which has helped her deal more effectively with her condition. Through cognitive behavioural therapy, she's been able to stop medication, and learnt to deal with problems through reasoning. There are still, she says, certain triggers, but she has learnt to cope with these more and more.

So, why is this important?

As a doctor, a healthcare worker, Dr Sindi says she hasn't experienced any stigma from colleagues or peers about her condition. This, she maintains, is because she's been brutally honest about her situation.

But, she says, other doctors and health-care workers don't necessarily see the signs of depression in themselves, which can have knock-on side-effects for their patients.

"A lot of doctors self-treat, which is fine for certain ailments and conditions. But, when it comes to mental-health issues, you cannot do this. It is vital to get outside help, and accept that we are sometimes also patients. We are human beings first, doctors second, and that realisation is extremely important to our own wellbeing."

And, unfortunately, she says, many doctors are in denial about their own mental health.

"There's this belief that doctors can't ever get sick, or have mental illnesses. We have to move away from this because it's a barrier that can cause damage to the doctor, and everyone he or she comes into contact with. I have crossed that barrier, but many of our colleagues have not," she asserts.

For Dr Sindi van Zyl, life at the moment is good. She says she is looking after herself first, and that this makes a difference for everyone in her life. She is rebuilding relationships neglected due to her illness, especially with her friends and family. "It's a long process, a slow process, but we are getting there. My message to other doctors and healthcare workers is simple – don't run away from mental-health issues. Instead, if you believe there is something wrong, get help, and get better."

SAMA Insider November 2017.

Depression: Don't wait until it's too late!

Dr Stoffel Grobler, *head of clinical unit, Elizabeth Donkin Hospital; associate professor, Walter Sisulu University*

The article in the *SAMA Insider* of November 2017 (page 15 of this issue) in which Dr Sindi van Zyl shared the story of her battle with depression refers. I would like to commend Dr van Zyl for her bravery, as she acknowledged something that far too many doctors are afraid to admit: that they too may be suffering from mental illness.

In recent years, I have personally made a point of sharing my own mental illnesses, namely generalised anxiety disorder and social anxiety disorder, when giving talks – something which elicits very different reactions from colleagues v. the general public, ranging from visible cringing to appreciation for my honesty.

My motive for making this disclosure is that, if we in the medical profession can't talk about our own mental illness, how can we expect our patients to not be ashamed of theirs, considering all the stigma surrounding the subject? If we don't do this, we are projecting our own shame onto our patients.

When I set out to read up on this topic, in looking at peer-reviewed articles over the last 10 years, I was shocked to find that there seemed to be far more articles on doctors' suicides than on the prevalence of mental illness among doctors. The reason for this, I found, was that doctors are reluctant to share their experience of mental illness for the reasons discussed below – hence the difficulty in finding published accounts of depression in doctors. Sadly, it would appear that doctors wait until it's too late, only reporting on mental illness among our peers when it ends in tragedy.

With this article, I would like to emphasise the importance of attending to our mental health, looking at rates of mental illness and suicide among doctors, as well as the risk factors for developing mental illness, and the barriers to care.

Mental illness among doctors

Research suggests that doctors generally have high rates of mental health problems, such as depression, anxiety, substance-use disorder and burnout. Furthermore, doctors have a higher risk of suicide than the general population.

Depression is at least as common in the medical profession as in the general population, affecting an estimated 12% of males, and up to 25% of females. It is estimated that between 10 and 20% of doctors become depressed at some point in their career, and that 10 - 12% develop a substance use disorder.

Female doctors are possibly at higher risk than the general population for developing depression and burnout as a result of role conflicts between their career and being a mother and/or a wife. In young doctors, for example, medical students and registrars, rates of depression range between 15 and 30%.

Globally, the following has been found:

- A survey of a UK-based doctors' support network found that 68% of 116 respondents had depression.
- A Canadian study found that 80% of doctors were suffering from burnout, and 23% of practitioners had significant depressive symptoms, with female doctors twice as likely to be depressed as males.
- In New Zealand, mental health problems are nearly three times as prevalent in GPs and surgeons than in the general population.
- In the USA, a prospective study found a significant increase in depressive symptoms during internship, with more than 25% of participants meeting the criteria for depression, compared with just 3.9% before the internship.
- Studies from Finland, Norway, Australia, Singapore, China, Taiwan, Sri Lanka and others have shown increased prevalence of anxiety, depression and suicidality among students and practitioners of medicine.

Risk factors for mental illness unique to doctors

Our job is a high-pressure one, with many stressors involved in our daily grind. Risk factors can generally be divided into two categories: occupational risk factors and individual risk factors (personality traits).

Occupational risk factors: There are numerous factors that can place doctors at higher risk of mental health problems than the general public. These include:

- the emotional demands of working with patients – breaking bad news, and being potentially confronted every day with patients' unrealistically high expectations, illness, anxiety, aggression, suffering and death
- the heavy workload, long shifts and unpredictable hours, and the associated sleep deprivation
- interpersonal relationship difficulties, for example, workplace bullying and poor relationships with colleagues
- lack of support and teamwork: it is not uncommon in SA to hear interns and community-service doctors complain about a lack of supervision and support from senior colleagues. A supportive team with a strong *esprit de corps* is protective against mental illness
- access to prescription drugs: the misuse of prescription drugs is common; doctors are in regular contact with a wide variety of drugs, and possess the knowledge of how these drugs work, what they do and how to administer them.

Individual risk factors: Our occupation self-selects driven, perfectionistic, type-A personalities – people who expect a lot from themselves. Unfortunately, these traits also contribute to controlling behaviour and an aversion to admitting to mental illness, which is still frequently seen as a "moral weakness".

These obsessive-compulsive traits also make us highly self-critical, and this predisposes us to excessive worrying, rumination and anxiety.

Other psychological traits common in doctors include an excessive sense of responsibility, a desire to please everyone, guilt for things outside of one's own control, and self-doubt.

Some practitioners may also have unhelpful coping strategies, for example, using emotional detachment, rather than actively dealing with stressors.

Barriers to care

Because of the stigma associated with mental illness, which seems to be greatly magnified among medical practitioners, doctors are reluctant to seek help. Although we seem to heed our own advice about avoiding medical risk factors for early mortality, we seem decidedly reluctant to address depression, a significant cause of morbidity and mortality that disproportionately affects us. Relative to the general population, doctors have a lower mortality risk from cancer and heart disease (doubtless related to knowledge about self-care, and access to early diagnosis), but they have an ominously higher risk of dying from suicide, the end stage of a treatable disease process.

Some reasons why doctors may not seek help for mental health problems are discussed below.

Professional implications: Doctors may have concerns about how their professional future might be affected by seeking help for mental health problems. For example, they may be worried about having to take time off work; they may feel guilty, and that they are letting people down by taking a day off sick and leaving their patients to someone else. Studies have suggested that doctors tend to take very little time off work, even when unwell; hence doctors are known to have high levels of "presenteeism", attending work even when not feeling well enough to do so.

They may fear that the medications prescribed for mental illness will affect their performance, putting their patients at risk. There may also be concerns about the implications of disclosing an illness, particularly when substance misuse is involved. It is important to note that medicine is a regulated profession, where doctors' health is of interest to the regulators. Doctors may hide illness to avoid potential disciplinary action or HPCSA involvement.

Difficulties with disclosure: It is common for doctors to self-diagnose, self-treat and self-prescribe. Although everyone knows that a doctor who treats him- or herself "has a fool for a patient", we also know that most doctors treat themselves anyway, at least on occasion. This is especially likely when the doctor believes that the consequences of seeking treatment may subject him or her to stigma, shame, or worse, making self-prescription look like the only option left.

Doctors tend to be secretive and reluctant to disclose mental health problems. They may be worried about confidentiality, and rather seek treatment from someone they know in a professional context. A study of doctors' attitudes to becoming mentally ill asked respondents who they would disclose to if they were to become mentally ill, and what factors might influence this; 73.4% said they would disclose a mental illness to a friend or family member rather than a professional, with most suggesting that career implications were their biggest concern regarding seeking help, as well as professional integrity and stigma. The researchers concluded the stigma surrounding mental health is prevalent among doctors.

Many doctors cite this issue of stigma, coupled with difficulties in ensuring privacy, fear of deregistration and the desire to continue helping patients, as major barriers in accessing care.

Psychological barriers: The perception among doctors that mental illness is a sign of weakness causes them to feel that they are letting down themselves, their patients and their colleagues by becoming ill, having to seek help and taking time away from work. This can lead to feelings of shame and embarrassment.

It seems to be hard for a doctor to become a patient, with many resisting the "role reversal" involved. Worth mentioning is the fact that doctors are notoriously difficult patients, and the doctor treating the "doctor-patient" should not over-identify with the patient, and should be cognisant of boundaries.

Lack of knowledge about where to find help: Many doctors do not know where to go to seek help. Should they go to see a GP, a psychiatrist or a psychologist? Very few even seem to have their own GP. A doctor whose thought processes are darkened by depression and the anticipated consequences of seeking treatment for it, may believe that self-treatment is the only safe option.

Once they do seek help, doctors sometimes find that the help they need is remarkably difficult to obtain.

Suicide

Year after year, doctors and dentists remain among the occupations with the highest suicide rates in the USA. The National Institute for Occupational Safety and Health (NIOSH) draws up a yearly list of the professions that are believed to have the highest suicide rates. Medical doctors top the list, evidence suggesting that doctors are approximately 1.87 times as likely to commit suicide as those in other occupations.

The top 11 professions with the highest suicide rates, according to NIOSH data (in descending order, with odds ratio in brackets), were medical doctors (1.87), dentists (1.67), police officers (1.54), veterinarians (1.54), people in financial services (1.51), real estate agents (1.38), electricians (1.36), lawyers (1.33), farmers (1.32), pharmacists (1.29) and chemists (1.28).

It was estimated in 1977 that on average, the USA loses the equivalent of at least one small medical school to suicide per year. Although it is impossible to estimate with accuracy, the number most often used is approximately 300 - 400 doctors/year, or "a doctor a day". Male and female doctors are equally as likely to commit suicide; however, in comparison with women in other occupations, female doctors are 2.78 times as likely to commit suicide.

Doctors are, obviously, knowledgeable regarding doses of medications and combinations that can be fatal. Evidence suggests that doctors are nearly 4× as more likely than the general population to use drugs as a suicide method, in an attempt to overdose.

Factors believed to contribute to doctors committing suicide include long working hours and sleep deprivation, demanding patients, bullying by colleagues, ease of access to medications and malpractice lawsuits.

Fast and efficient diagnosis and treatment benefit not only the sick doctor, but also those they treat; untreated mental health problems in doctors may lead to poor performance, professional misconduct and inadequate quality of care for their patients. In order to ensure patient safety, and sustain the public's confidence in doctors, it is essential to identify and treat mental health problems in doctors as quickly and efficiently as possible, so that their quality of care is not compromised.

The number of people potentially involved, for example, supervisors, occupational health teams, academic staff and regulating councils, may increase the doctor-patient's anxiety further. Therefore, interventions should be straightforward and efficient, to make the treatment process as effective as possible.

In many countries, specialist services have been set up where practitioners can get support and treatment in an environment designed specifically for doctors. I am not aware of any such service for doctors in SA, and I believe it is time that we seriously consider the creation of such a service, as a matter of urgency.

In the absence of such a service, though, I would like to make the following suggestions if you find yourself suffering psychologically and mentally:

- Find yourself a trusted GP who is not a friend, and make an appointment.
- Start seeing a clinical or counselling psychologist as well.
- Accept the sick role in this instance.
- Do not resist being referred to a psychiatrist.

In Australia, the #crazysocks4docs day campaign, where doctors wear crazy socks to raise awareness of mental illness in the medical profession once a year, has taken on a high profile, and sparked a lot of debate on social media and in other publications. The campaign was started by cardiologist Dr Geoff Toogood, who has championed mental health support for doctors since his own battle with mental illness. Incidentally, I am finishing this article today on 1 June, and I am about to put on my crazy socks. My therapist would call that synchronicity …

SAMA Insider July 2018.

Coping strategies for the distressed doctor

Prof. Zuki Zingela, *HOD, Department of Psychiatry and Behavioural Sciences, Walter Sisulu University*

Physician mental distress implies intangible pain or suffering in the distressed doctor. As intangible as it is, it still represents real and, at times, overwhelming suffering. This may be the result of overt mental disorders, such as anxiety disorders, depression or bipolar disorder, or covert psychological difficulties such as substance abuse or other addictions, behavioural problems, relationship difficulties or conflict in the workplace.

Physician distress may also have more permanent and tragic outcomes, such as suicide or even homicide. The heart-breaking end to a colleague's life, who died by suicide in early 2018, and also took the life of his son, is still fresh in the minds of colleagues who were at medical school with him. We are also well aware of the overwhelming evidence on physician suicides across the world. Very few of us are unfamiliar with Pamela Wible and her quest to highlight the distressed doctor's plight, and yet the carnage continues.

Physician mental distress

HPCSA statistics reveal various causes of doctor impairment in SA. The real numbers are probably much higher, if one considers doctors whose functioning may be impaired by mental distress but who do not necessarily attract HPCSA scrutiny. Most of the causes are linked to mental health issues or mental distress. On 1 October 2018, the HPCSA had 46 091 practitioners registered with its Medical and Dental Board. In May 2018, there were 345 practitioners (197 male, 143 female, 5 unlisted/unknown) who were under HPCSA health committee management. Of these, 225 were medical practitioners.

Up to 40% of medical practitioner impairment in the HPCSA database is due to substance abuse/dependence, and 31% is due to a mixture of different mental disorders, including bipolar disorder, anxiety disorders and unspecified mental disorders. This means that just over 70% of causes of impairment in medical practitioners can be linked to mental distress. It is worthwhile keeping in mind that anxiety disorders are the most common mental disorders, followed by depression. These conditions, and other causes of mental distress such as bipolar disorder, may all be associated with substance-use disorders. Distress in doctors may be linked to occupational, relationship or financial stressors, and may conversely manifest in the same life areas, i.e. with occupational, relationship and financial strife.

The greatest obstacle to accessing help is denial and lack of insight

The usual assumption is that doctors are supportive of each other, and yet lack of collegial behaviour and poor peer support can also be an integral part of what ails the profession. The HPCSA's ethical and professional rules provide a strict ethical code that prohibits a practitioner from casting reflections on the probity, professional reputation or skill of another person registered under the National Health Act No. 61 of 2003 or any other health Act. Despite this, instances of colleagues attacking colleagues, and going as far as committing actions tantamount to defamation, remain a persistent challenge, which adds to the distressed doctor's plight.

Destressing the distressed doctor

When mental distress manifests as a specific mental disorder, the greatest obstacle to accessing help is denial and lack of insight. This may be even more pronounced in doctors, possibly because of our perfectionistic outlook and reluctance to acknowledge problems when we are affected by human frailties. This leads to delayed help-seeking behaviour, and even to refusal to accept treatment. Although doctors are experts at diagnosing illness, we fail ourselves when it comes to recognition of our own distress, and even more so to taking corrective steps to get help.

Family, friends and peers can be invaluable in assisting a doctor with a mental disorder to seek help. In extreme cases, when the distressed doctor's behaviour places his or her life or the lives of others at risk, the family or close associates may have to turn to the Mental Health Care Act No. 17 of 2002 to empower him or her to seek help. Although not ideal, it has saved lives when applied judiciously. When a doctor is significantly impaired by mental illness or distress, then a submission also needs to be made to the HPCSA on the doctor's condition. This is often misunderstood by affected doctors as a punitive step, yet it seldom leads to such severe sanctions as to prevent the doctor from practising. The usual outcome is for the affected doctor to be enabled to practise medicine with guidance and supervision from peers while undergoing treatment.

Doctors know enough about healthy living strategies, and yet we fail to apply these successfully in our own lives. A healthy diet with a regular exercise routine and a healthy work-life balance go a long way towards destressing the pressured lives we lead. Good sleep is essential for the rejuvenation and revival of a stressed mind. Social interconnectedness complements this holistic approach. Harvest and develop other interests, where possible, to allow space for focusing on something pleasurable outside of your work. When such interests are balanced and consist of non-harmful or non-habit forming activities, they add to a balanced life.

During work days, short breaks are a must to boost waning energy levels. Missing meals is something we all do, even though we are well aware of the detrimental effects. If necessary, set an alarm for short breaks of up to 10 minutes, every 2 to 3 hours. In an 8-hour day, that equates to a period of up to 30 minutes taken for breaks during the work day, which may save your sanity, and possibly your life.

When the distressed doctor is overwhelmed

There may be times when our usual coping strategies fail. This may manifest as burnout, hopelessness, and giving in to previously checked unhealthy behaviours (e.g. binge drinking, bingeing on harmful illicit substances, going on gambling sprees, engaging in inappropriate sexual behaviours). In extreme cases, it may lead to decompensation with persistent and or intrusive ideas of self-harm or suicide. It is a good idea to have a "destress buddy", a go-to person whom you trust, be it a therapist, a formal or informal counsellor or a trusted friend. This person is someone you can contact at any time of the day or night, and who you trust to be there for you. Alternatively,

have the contact details for a helpline on your phone, and within easy access should you need them (see page 29).

Keep a confidential diary of your thoughts and feelings for retrospective analysis and reference, to help you learn from your mistakes. Use a hierarchy of positive behaviours or actions to help you battle the blues when they hit. This entails making a list of 5 - 10 non-harmful activities that you enjoy, and that usually help you feel better. On a bad day, you use the list by running through the activities from the first to the last, and repeating the cycle again if it becomes necessary, until the overwhelming feelings pass. And no matter how hopeless a situation feels at a given moment in time, the further time moves away from that point, the less overwhelming it may seem. One underused and underestimated tactic is distraction form the immediate problem. This serves to de-escalate the immediacy of the crisis, while allowing for space to consider alternative solutions.

Conclusion

As much as the plight of the distressed doctor is a real and sometimes unavoidable occupational hazard, a career in medicine has the potential to be fulfilling and life-affirming for those who choose this path. Peer support for the distressed doctor is crucial in ensuring that this noble profession of ours survives this surmountable challenge.

SAMA Insider March 2019.

Tips and Tricks

On sleep

A good night's sleep can be refreshing, and helps us to reset. Sleep patterns can change when we are under pressure, in pain (physical, psychological, etc.), stressed or when interrupted by disturbances such as too much noise or light. The pattern usually normalises again according to our body clock. But what if it does not? There are things you can do to help it along.

Sleep enhancers:

- A quiet, comfortable resting space with the ability to darken it when it is sleep time, even with a full moon outside – it may be better not to have a TV or radio in your room if you struggle to sleep
- A warm drink such as milk (with no caffeine) before bed
- A warm bath before bed
- Ensuring a temperature that is just right for your preference – an extra blanket if you prefer warmth, and light bed clothes if you prefer it cooler
- Light exercise in the early evening, but do not leave it too late as it could have the opposite effect of activating you rather than making you feel restful
- Meditation or other relaxation techniques.

Sleep interrupters:

Although the following may not disrupt sleep in everyone, when your sleep pattern is off, they can definitely contribute:

- Coffee or other high caffeine-content drinks in early evening
- Getting used to working in bed, e.g. being on your laptop or phone for prolonged period in bed sets up a pattern of behaviour that your mind gets so used to that it stops perceiving being in bed as sleep or rest time – this is like waking before the alarm goes off; your mind gets used to "waking" when getting into bed
- Too much noise and light (the obvious culprits)
- Stress, worry, anxiety or agitation of whatever cause – a couple of days here and there are okay, but when it establishes a pattern, you may need to take action
- Discomfort such as pain, heartburn, etc.
- Specific conditions such as depression, medical conditions, etc.

Other steps you can take:

- If you have been tossing and turning for 10 - 15 minutes, get out of bed, sit in an upright chair and do a boring task that you have been putting off for another 10 - 15 minutes. Try getting into bed after this. If it does not work, rewind and repeat.
- Remove the TV and radio from your bedroom. You can always bring them back when your sleep pattern normalises.
- Use any of the sleep-enhancer actions above.
- Identify any sleep interrupters above, and try to eliminate these from your evening routine.
- Sleeping tablets may be useful in the short term, if you have tried to enhance your sleep in non-harmful ways and this has still not helped. If used, this must be under the supervision of a health practitioner. If not managed well, dependency on these drugs may occur. Talk to your doctor should you feel that you need to. Health practitioners have a tendency to self-prescribe. Resist this tendency, because should you get into trouble with how much you are using, there is a possibility you may struggle to self-check.
- If you suffer from pain or have medical conditions that interrupt your sleep, talk to your doctor about help in managing these.
- Remember that a couple of nights of disturbed sleep when there are clear circumstances causing this are not harmful. It is only when they merge into a persistent pattern that you may need to take decisive action.

Addiction in the medical profession: When habits become destructive

Prof. Zuki Zingela, *HOD, Department of Psychiatry and Behavioural Sciences, Walter Sisulu University*

From use by priests in ancient times for religious ceremonies, to use by traditional and other types of healers across the ages, our ancestors across the world have devised ever-more potent compounds and faster ways to deliver psychoactive substances to our brains, in order to influence or change our perception of reality and our emotions.

One outcome of this gives rise to questions that we grapple with today, including: what makes some people more vulnerable to drug addiction than others? If a substance is potentially harmful, is it a perverse contradiction to talk about socially acceptable use, as seen with, for example, caffeine, nicotine and alcohol? What of addiction when it afflicts those in our profession, who are meant to help others?

The scale of the problem

In the March 2019 *SAMA Insider* article "Coping strategies for the distressed doctor" (page 18 in this supplement), I referred to the HPCSA 2018 statistics on impaired physicians. Up to 40% of medical practitioner impairment recorded in the HPCSA database is reported to be due to substance abuse or dependence. The stark reality of these figures means that in 4 out of every 10 doctors declared impaired by the HPCSA, the impairment is due to substance use.

The reasons for these sobering stats are likely similar to those leading to doctors struggling with their mental health, such as overwork, short staffing and being sandwiched between unrealistic demands and expectations from patients and managers, and being provided with very few resources to deliver quality services. Add to this financial pressures, societal and personal expectations of excellence, little room for failure, alongside perfectionistic traits, and the recipe is set for the catch-22 situation that doctors often find themselves trapped in: "Yes, I realise my job is destroying me, but I have invested too much in it to just walk away" – so, we stay. And if need be, we reach for whatever crutch we can find to keep us going. When the crutch turns into a destructive habit, however, this can make us vulnerable to mental distress and ill health.

Addiction is a challenge precisely because the fine line between socially acceptable use and pathological use can become blurred. It may be easier to demarcate the boundaries when the substance of abuse is illicit, but it poses a dilemma when the substance is seen as socially acceptable, for example, caffeine, alcohol, prescription drugs or specific types of addictive behaviours, such as gambling. An occasional drinker or gambler, for example, does not suffer from any disorder. Yet the same behaviours can become so entrenched as to become disabling and pathological.

Addiction in the medical profession

Without getting into technical detail about the effect of substances on the brain, and how a potentially addictive substance can fuel an escalation into the taking of larger amounts of that substance, it is worthwhile mentioning novelty-seeking as a factor that has been identified numerous times as associated with a vulnerability for addiction. This refers to the tendency to seek new stimuli and environments. It is influenced by both genetic and environmental factors, and may manifest as a personality trait. It has also been identified as a strong contributory factor – though not the only one – to the development of addiction.

The ease of access to substances of abuse is a realistic, easily accessible temptation to the average doctor

In general, we all have coping strategies, developed over time, which allow us to face stressors head on and continue to function. Such coping strategies play an important function, and enable us to keep going in the face of potentially overwhelming adversity. Balanced approaches or habits to destress allow us to regroup, and may buy us time and resilience while we try and figure out how to get ourselves out of troubling situations. The dilemma we face, however, is as described above. The idealist in us wants to deliver the best care possible to the patients we serve, but the realist in us recognises the near impossibility of this, whether due to limitations in the public sector or limitations to what medical aids will and will not pay for in the private sector.

Many of us may find something positive to keep us hanging on, whether it be the colleague who lightens the mood through effective use of humour as a defence, or the patient who bears their pain with a smile. Others find comfort and motivation in academic pursuits and/or research, volunteer work and similar activities. This is over and above the things we do in our spare time to try and cope.

The ease of access to substances (or behaviours) of abuse, however, is a realistic, easily accessible temptation to the average doctor. Your earning power means that you can get whatever your hard-earned salary can buy, be it expensive alcohol or more illicit substances of abuse. You can also raise enough capital to go toe-to-toe with serious gamblers. For a few hours, while in the grip of acute intoxication, your mind can escape the misfortune of your situation, and you feel good. The powerful illusion of being in control, though, lasts only as long as the high.

Practicalities

Am I addicted? This is often a hard question to ask, and an even harder one to answer honestly to oneself. The four-item CAGE questionnaire (https://psychology-tools.com/test/cage-alcohol-questionnaire) is good for assessing alcohol use, and it may assist in giving you insight into other addictive behaviours. If you answer yes to two or more of the four items, then, realistically, you have a problem.

What do I do about it?

- Tell a trusted friend, relative or colleague, so you can have someone in your corner who supports you.
- Examine what you gain from the substance use v. what you lose or stand to lose by continuing.
- Examine what (or who) supports you and makes you stronger in your attempts to quit. What (who) detracts you from progress? Change your social circle if need

be to minimise chances of relapsing into addictive behaviours.
- Reach out to a clinical psychologist to help you re-look at triggers for substance-taking behaviours and alternative coping strategies.
- You may be in a position to take your supervisor at work into your confidence. It is likely that they have observed a drop in your work performance already, so coming clean may assist in clearing the air, while providing space for you to address the issue.
- Consider self-reporting to the HPCSA as a means of assisting you to structure your path back to recovery.
- Consider checking into rehab if you have tried time and time again to come off the substance(s) without success. It may save your life.

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Anxiety – rattling the ''masculinity'' cage among men

South African Society of Psychiatrists

Anxiety disorders are ranked as the sixth largest contributor to life-long health concerns worldwide, with an estimated 3.6% of the global population (264 million people) living with anxiety. It affects nearly one in five adults in the USA, and in SA, the South African Stress and Health (SASH) study, which investigated the lifetime prevalence of common mental disorders, anxiety disorders were found to be the most prevalent class of lifetime mental disorders, at 15.8%.

On average, one in eight men will have depression, and one in five men will experience anxiety at some stage of their lives.

And even though statistics point towards women being twice as likely as men to suffer from anxiety disorders, the reason for this finding might be more social than scientific.

Dr Ian Westmore of the SA Society of Psychiatrists (SASOP) says that the stigma associated with anxiety disorders labels the condition as "unmanly" and a sign of weakness. He says that "this is the very reason that men are less likely to talk about their anxiety, and instead drown their anxiety with poor coping behaviours, increasing their risk of the anxiety or depression going unrecognised and untreated."

Dr Westmore says men are far less likely to seek support: this behaviour is more commonly seen in women, who are more eager to speak out and seek help, as opposed to the macho male social stereotype, which expects men to "man up" and adopt a "boys don't cry" mentality.

"It's this attitude of portraying men as brave and fearless that leads to men seeing themselves in a negative light if they suffer from anxiety. And for this very reason, they see seeking help as putting themselves in a vulnerable position."

Dr Westmore emphasises that it is a given that everyone feels anxious from time to time, and not every anxious episode should be seen as representing a disorder.

"It's okay to worry about things and life's many challenges. The difference is when that worry is difficult to control or shake long after a certain experience or event, and it starts interfering with your day-to-day activities or changes the way that you used to approach life – affecting aspects such as going out with your friends, being productive at work, taking part in team sports, bantering with colleagues and so forth. It severely affects relationships in that the coping mechanisms applied often affect those close to you, through alcohol, abusive behaviour and frequently depression."

"Society expects a lot from men. They're expected to be seen as confident, in control, decision-makers and decisive voices of reason and rationality. They are often portrayed as the rock with a steady hand and mind in times of trouble or uncertainty. They are stereotyped as the provider and protector, dependable, confident and fearless."

"However, these very traits that society has labelled men with could lead men to feel inadequate and emasculated. It's not realistic to expect men to be the stronger sex who always live by society's version of 'what makes a man,' and to simply find a way to 'pull yourself together.'"

Dr Westmore says that if left untreated, anxiety can present itself in many forms.

"Men who don't speak out find inappropriate coping strategies that might very well dull the anxiety temporarily, but could develop into a dependency that eventually spins out of control, aggravating the anxiety disorder."

"Abuse, gambling, drugs (including alcohol) and reckless behaviour are some of the confidence-gaining and coping mechanisms embraced by men. However, since they enable men to avoid their anxieties instead of facing them, these very coping mechanisms could aggravate the disorder."

"Anxiety can trigger anger in men, with violence, outbursts, bullying, abusiveness and explosive quick temper bursts as a result. Irritability – being edgy, touchy, cranky or impatient – becomes the normal reaction to everyday frustrations, large and small. In addition, anxiety drives avoidance, which in turn constricts lives. The result is a sense of having an empty life, which turns to depression, with feelings of hopelessness and helplessness."

Dr Westmore says a range of factors can contribute to, or even trigger the development of an anxiety disorder. These could be a genetic predisposition, as well as physical factors such as an imbalance of hormones and chemical messengers in the brain. But it can also be affected by environmental factors such as excessive stress in a relationship or a job/at school, financial predicaments and traumatic life events. Medical factors such as the side-effects of some medications, and symptoms or stress relating to an illness, may also lead to an anxiety disorder.

What are the tell-tale signs?

"Anxiety is more than just a bit of stress, sweaty palms or a sense of butterflies in the stomach. The symptoms are far more severe and include continuous feelings of worry, fear and impending doom that are so severe they interfere with your ability to work, to live a healthy life, to maintain relationships and to sleep."

Dr Westmore points out the following signs of anxiety:

Physical

- pounding or racing heart
- excessive sweating
- muscle tension or aches
- restlessness or agitation
- dizziness or vertigo
- shortness of breath or sensation of choking

- insomnia
- panic attacks
- fatigue
- nausea, diarrhoea or irritable bowel syndrome.

Emotional

- constant worry about what could go wrong
- perceiving situations and events as threatening when they are not
- indecisiveness and fear of making the wrong decision
- difficulty concentrating
- feelings of dread
- concentration problems
- avoidance
- catastrophic thinking
- irritability and edginess
- nightmares or intrusive thoughts in which traumatic scenes are replayed in the mind
- mood swings
- being overly vigilant towards danger
- absentmindedness
- fear of losing control.

In addition, persistent sadness, apathy, loss of hope or suicidal thoughts could show that the anxiety has morphed into depression, which is commonly seen together with anxiety disorders.

Dr Westmore says it is important to share your symptoms with someone you trust. Start with a family member or friend, but always find your way to a healthcare professional, who will be able to help you manage the symptoms. He says that treatments include cognitive behavioural therapy, counselling and, in some instances, medication, depending on the type of anxiety present.

"It is important to note that you need to develop your own action plan that includes lifestyle changes, which are as much a part of the recovery process as seeking medical attention. Engage in regular exercise to release your anxious energy and happy endorphins, get enough sleep, socialise with supportive friends and family, manage stress through meditation, music or art, follow a healthy diet, cut down on alcohol and avoid drugs and other stimulants."

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Tips and Tricks

An example of a relaxation technique

Learning a basic relaxation technique can help you to calm yourself when feeling overwhelmed. Have a look below, and use what you feel can help. One method is that of self-guided imagery, which you can learn and use when you need to. It takes 3 - 5 minutes in a quiet corner.

- Choose a quiet, private corner (at home, work etc.)
- If you have calming music (preferably instrumental), you can start playing it on your phone or other device. You can opt for quiet if you prefer.
- Sit or lie down comfortably. Put both feet on the ground, arms and hands relaxed by your sides, or resting on the arms of the chair if you are sitting. Alternatively, lie stretched out and facing up, arms relaxed by your sides.
- Close your eyes and take in the music, or the quiet.
- Allow your mind to wander to a favourite place. It may be a beautiful, calming space you have been to, somewhere you imagine in your head. Feel the ground under your feet.
- As you feel the ground under your feet, focus on breathing air in through your nose and exhaling through your mouth. With each breath you take, feel the calm of your quiet place in your body, your senses, your thoughts.
- Start to slow down your breathing. Count in your head if you have to: As you breathe in, "1 elephant, 2 elephant, 3 elephant, 4 elephant." Hold your breath a little, on "1 elephant, 2 elephant, 3 elephant, 4 elephant." Breathe out slowly, to "1 elephant, 2 elephant, 3 elephant, 4 elephant, 5 elephant, 6 elephant." Release all tension from your body by relaxing all the muscles you can as you breathe out. Do not worry if you cannot seem to slow your breath immediately. Focus on counting as you breathe in through your nose, hold your breath slightly and breathe out through your mouth. It will come. Repeat the cycle a few times, just focusing on your breathing (as you count in your head) and the ground under your feet.
- Once you feel ready, with your eyes still closed and your breathing now under control, you can start exploring your calming space – your private place – in your head.
- Look at what you can see. It can be anything that adds to your sense of calm (mine is a green park with green trees and beautiful flower beds in white and pink with a splash of yellow that go on endlessly around me). This is your private space, so allow your mind to add what you can imagine.
- Listen to what you can hear (I imagine the occasional bird song around me, a stream of water trickling in the distance, perhaps)
- Feel what you can touch (I feel the leaves of trees around me, the soft petals of flowers, the gentle breeze on my skin)
- Inhale what you can smell (I smell honeysuckle)
- Linger on what you can taste (I taste honeysuckle).
- Walk around your private place. Keep your breathing slow. Go back to counting if you get distracted. Enjoy the quiet and let it calm you. Let it wash over you.
- Repeat the cycle, starting anywhere from 7 to 10 if you need to.
- Once feeling calm, prepare to leave your quiet place. Take one last look around, remember the calm you feel at this moment and take that with you as you prepare to leave. Slowly open your eyes, focusing on your breathing once more. Continue for a few last moments just focusing on your breathing. Let go of all your tension by relaxing all the muscles you can in your body every time you breathe out through your mouth.

Reasonable accommodation rather than "light duty" for people with mental illness

Prof. Stoffel Grobler, *head of clinical unit, Elizabeth Donkin Hospital; associate professor, Walter Sisulu University*

Doctors are frequently faced with patients who are suffering from either a mental or physical illness that warrants some adjustment to their work responsibilities. They might be booked off for a short period, or are able to work but in need of some work adjustment while recovering from the illness.

In such circumstances, doctors tend to use the term "light duty" on the sick note, but what does it mean, exactly? Is there another term that could be used that is more appropriate and in line with current legislation in SA?

The term "light duty" generally refers to work that is physically or mentally less demanding than normal job duties, created for the purpose of providing alternative work for employees who are unable to perform some or all of their routine duties, until the person is healed or ready to resume all of their responsibilities.

In a 1996 article, "The light duty dilemma", it is argued that "when an employee sues for disability discrimination, the employer may discover that the light duty assignment was in fact a 'reasonable accommodation.'"

It stands to reason, then, that light duty is a vague term that can be widely interpreted, leading to confusion for both employer and employee, hence the need for a more appropriate term with a smaller likelihood of misinterpretation.

In order to understand reasonable accommodation in the SA context, with particular reference to mental illness, some understanding of the relevant legislation is needed. "Reasonable accommodation" is referred to in our legislation in the context of disability. However, not all patients to whom light duty is prescribed will necessarily be considered disabled according to the definition of disability in terms of the legislation. But that does not mean that the doctor cannot use the term, and be very specific as to what (s)he deems to be reasonable adjustments to the patient's working environment in order for them to recover fully.

Legislation

Our Bill of Rights (in the Constitution) is the principal source of legal rights for persons with disabilities, and supports the right to equality, dignity and freedom for all. This means that any discrimination, including discrimination based on a person's disability status, is a human rights issue.

Unfortunately, the law, in particular the Employment Equity Act (EEA) No. 55 of 1998, only gives general guidelines, and is not explicit enough when it comes to the definition of what constitutes disability, thereby failing to provide adequate protection for both employers and employees with disabilities.

The EEA is supported by two documents, the *Code of Good Practice* and the *Technical Assistance Guidelines on the Employment of Persons with Disabilities*, to further define the requirements of being declared disabled, be it temporarily or permanently. These two documents require employers to design and implement a workplace that eliminates unfair discrimination, and include guidelines on how to effect this purpose.

In order to qualify for reasonable accommodation, the employee will have to disclose their mental illness to the employer. Unfortunately, many employees are reluctant to disclose their disability status, especially when it is not "visible" – for example, mental illness. However, once an employee does disclose the disability, the employer has three duties placed upon them: (*i*) to investigate; (*ii*) to consult with the employee; and (*iii*) to implement reasonable accommodation.

Unfortunately, employees usually only disclose such a disability once a crisis has been reached, as for example when they are subjected to disciplinary action due to a drop in productivity. At this point, employers would typically start incapacity proceedings. Should an employer dismiss an employee on the grounds of their disability (if they have disclosed it), the dismissal is automatically unfair.

Important terminology

There are three terms that are not synonymous, and that lead to great confusion among doctors, employers and employees alike. These terms are impairment, incapacity and disability.

Impairment refers to "a significant deviation, loss or loss of use of any body structure or body function in an individual with a health condition, disorder or disease". In layman's terms, there has been a loss or decline in a person's ability to perform certain functions, either physically, mentally or both.

Disability, according to the EEA, is defined as (*i*) a long-term or recurring (*ii*) physical or mental impairment that (*iii*) substantially limits a person's prospect of entry into or advancement in employment. The EEA states that a person has to meet the third criterion (substantially limiting) in order to be classified as disabled. It is only within the scope of practice of occupational therapists to decide whether a condition is substantially limiting after a job analysis and a functional capacity assessment has been done.

Incapacity refers to a case in which an employee is unable to carry out or perform his/her contracted obligations due to inherent inability on the part of the employee. Incapacity is distinguished from misconduct and discipline in that fault or blame are not alleged.

Reasonable accommodation

The EEA states that employers should reasonably accommodate the needs of persons with disabilities. The aim of reasonable accommodation is to remove barriers affecting the person's ability to perform the essential functions of the job. It can also be described as making modifications or alterations to the way a job is normally performed.

For persons with mental illness, reasonable accommodations may be as straightforward as allowing the employee to take breaks in a private space, such as a small conference room or meeting room, or to work from home some days, to wear headphones to block out noise, to be seated in a space that is quiet, with little traffic, to not attend non-essential meetings or to indicate when they feel overwhelmed and need a break.

Conclusion

Equipped with this knowledge, I would like to encourage doctors to prescribe reasonable accommodation instead of light duty in cases with mental illness. And even though your patient may not fulfil the criteria for being considered temporarily disabled, using the term "reasonable accommodation", in conjunction with very specific recommendations, would go a long way towards protecting him or her, and avoiding confusion.

For some guidance regarding reasonable accommodative measures, the website https://askjan.org/a-to-z.cfm may be useful.

SAMA Insider October 2019.

Moms' maternal health is important for children too

South African Society of Psychiatrists

As many as one in five new mothers will experience depression just before or after giving birth, at risk to their own health and to the growth and development of their newborns.

And while it was previously thought that psychiatric medication was harmful to the unborn child, there is growing scientific evidence of the safety of antidepressants in pregnancy, and also showing that stopping medication may in fact cause more harm to both mother and baby.

"The risks posed to a fetus from antidepressants are consistently overestimated, while the risks of untreated depression are consistently underestimated because of the pervasive stigma against mental illness," warns specialist psychiatrist Dr Bavi Vythilingum, member of the South African Society of Psychiatrists.

Depression in pregnancy is often undiagnosed and goes untreated (as the focus is primarily on the physical health of mother and baby), but it can lead to premature labour, low birthweights and developmental delays, she says.

Postnatal mental illness, which mainly occurs as depression and anxiety, is second only to malnutrition as the greatest risk factor for poor development in newborns and young children, which in turn impacts on their own mental and physical health, intellectual abilities and future potential.

Dr Vythilingum said life changes around pregnancy make women vulnerable to mental illness, and women who have been diagnosed with depression before or during pregnancy are at higher risk of developing postnatal depression.

"Depression and anxiety cause significant suffering and disability – leading to a higher risk of substance abuse and suicide, hampering the mother's ability to bond with and care for her child, and disrupting family and partner relationships," she said.

Maternal mental health is considered a major public health challenge, both locally and globally. SA's National Department of Health has maternal and child health as one of its key priorities for the health of the nation, while reducing maternal and infant mortality are the leading targets of the UN Sustainable Development Goal 3: to "ensure healthy lives and promote wellbeing for all, at all ages".

As many as one in five new mothers will experience depression

Dr Vythilingum said virtually all women are at risk of developing mental disorders during pregnancy and in the first year after delivery, but pre-existing mental illness, alcohol or substance abuse, a lack of social support, poverty and unwanted pregnancies put them at greater risk, along with exposure to extreme stress or domestic, sexual or gender-based violence.

She said that pregnant women or new mothers experiencing symptoms of depression – including sleeping difficulties, feelings of inadequacy, helplessness or panic, lack of motivation, or feeling like crying for no reason – should consult their doctor, obstetrician or psychiatrist to develop an individual treatment plan.

"While these are all common symptoms of depression, women and their partners should also look out for [the mother's] feelings of detachment from the baby, feeling like she doesn't love the child as she should, and thoughts of harming herself or the baby," she said.

Regarding treatment, she said that psychotherapy was always the first line of treatment, along with mobilising family support, especially from the father or significant partner, and using community resources such as antenatal and baby clinics.

Medication such as antidepressants can be prescribed, depending on the nature and severity of the condition, and after weighing up the risks and benefits of medication for both mother and baby.

"Clinicians should weigh the growing evidence of detrimental and prolonged effects in children due to untreated antenatal depression and depressive symptoms during pregnancy, against the known and emerging studies on the safety of in-utero exposure to antidepressants," she said.

Dr Vythilingum advised women who fall pregnant while taking antidepressants not to stop taking the medication, but rather to consult with their doctor or psychiatrist, who can determine whether the specific medication should be continued, changed or stopped.

She said the selective serotonin reuptake inhibitors (SSRI) class of antidepressants were the most well-researched and safest for use in pregnancy, at relatively low risk to the unborn baby, but stressed that any decisions on medication should be made in consultation with the patient's psychiatrist and her obstetrician.

SAMA Insider March 2020.

Death by profession has a voice: "I am a doctor; I am human too"

Prof. Zuki Zingela, *HOD, Psychiatry and Behavioural Sciences, Walter Sisulu University*

From the heights of idealism to the depths of reality, the journey into medicine is never truly understood, even by those who travel it. Once on the frontline, the days of committing to becoming a healer, taking one's oath and graduating seem so perfect a memory that it almost feels like an alternate reality. How do we become so divorced from the ideal of the healing, nurturing profession, to find ourselves in this alienated existence that feeds on itself? Scores of physicians across the world are dying by suicide. Healers shoot themselves, hang themselves, jump from heights and take overdoses, while society around them continues with somnambulistic determination to pretend that all is well. How do we continue our journey in the shadow of this pessimism that stalks us, while holding onto hope that keeps our ideals alive?

Death by profession

Physician death by suicide is not unique to SA. Australia, the USA and the UK are grappling with this same challenge. On paper, the reality is bleak. The USA reports one completed physician suicide a day, one of the highest suicide rates of any profession in the modern world. Some factors thought to contribute to the silent suffering of medical doctors include stigma, perfectionism and the presenteeism that is often expected in the medical profession, i.e. the expectation that the doctor must be available to work 24/7. The default setting, instilled in any doctor, even during training, is that of neglecting their own needs for the sake of healing and helping others. This includes the neglect of one's own mental health needs. Garakani also argues that the societal stigma against mental illness is perpetuated by stigma within the profession itself, which often results in the marginalisation of psychiatry. This perpetuates the illusion that psychiatry is a fringe profession that is not real medicine. This may influence a doctor's help-seeking behaviour when mental illness or mental distress strikes.

The conundrum is not unique to qualified doctors. Medical students face similar challenges. Medical schools are like factories that mass-produce doctors to serve the health needs of humanity. The amount of knowledge that one must cram into the 6 years of medicine, in order to be judged safe enough to graduate, is immeasurable. There is a degree of inhumanness in the way such excellence is produced. Who can forget the humiliation of being cut down to size in front of fellow students and others by a consultant known for dishing out sadistic punishment to prove how little you know? The push for excellence and sacrificial service that is interwoven into the fabric of being a doctor is ingrained and sharpened on these factory floors. In a bid to produce tougher factory product, to serve the health needs of society, medical students are pushed to the limit and beyond, with no room to falter or deviate from the script. We lose some along the way, and we shrug it off. The cost of shrugging it off is measured in lives lost to suicide, substance abuse and other unmentionables that plague the profession. The resulting toughened factory product is inculcated with a self-sacrificing sense of duty. The cycle continues once the self-effacing medical student has qualified, to become a healer who is excellent at taking care of the needs of others but not at taking care of him/herself. Our sense of duty binds us to the people and communities we serve. It deserts us when it comes to ourselves.

Doctors can no longer be silent about the devastating effects of mental illness and suicide on the profession

Who heals the healer?

How does the profession heal itself? Who heals the healer? As much as we are dedicated to serve society, society also needs to be made more cognisant of the dire state of doctors' health. Yes, it is one's duty to look after one's health, but if the system one works in does not allow room for you to take on that responsibility fully, then by default, that system has failed you. Similarly, if the systems doctors work in are severely short-staffed and plagued with inhumane working conditions, then the resultant mental distress or mental disorders in doctors should be viewed as a form of employer negligence. Doctors deserve the same care that they give to patients when they too are sick.

What is the extent of the problem?

There has not been much research done to define the extent of mental disorders and suicide rates for doctors in SA. HPCSA Health Committee statistics provide a glimpse of impaired practitioners reported for different disorders, the majority of which are substance use and/or mental disorders. These do not include those who do not come to the attention of the council, despite experiencing significant problems that may affect patient care. Relatively high levels of poverty, the high burden of disease associated with HIV and TB, and violence, all add to the high-pressured environment that SA doctors work in. The expectation is that they will be just as affected, if not more so, by mental and substance-use disorders and suicide as their counterparts in countries like the USA. To devise effective intervention strategies, the extent of the problem needs to be researched and better defined, so that home-grown solutions can be found.

What should be done?

The doctor's corner. Doctors need to prioritise their health, both in and outside of work. The approach should be "When I am well, I can serve well," rather than this superhuman attempt to overstretch oneself beyond one's limit. Little things help:

Ensure that you have regular annual leave, to spend time with family and friends, and reinforce interconnectedness.

Remember to eat healthy food, exercise regularly, make time for hobbies, etc.

Take short time-out periods during a workday, e.g. a few minutes' tea break. Doctors who work in teams can tag each other, to make sure that the work on the floor is covered while allowing each other space for these time-out periods.

Consult with senior colleagues when a problem in clinical care is encountered. This can make a difference between feelings of guilt that eat at you when things go wrong, and an assurance that you did all you could to offer good care. The hardest lesson, which doctors find difficult to learn, is that even when you have done everything right, there are times when things go wrong and a life is lost. Self-blame is automatic in such instances, but does nothing to bring back the life lost. Instead, it weighs heavily on the doctor's mind, and can result in waning confidence in one's abilities, increasing self-doubt and other negative feelings that can predispose one to depression.

Mortality meetings may be helpful in instances where such meetings are driven by a need to address systemic failures, rather than to apportion blame.

Colleagues in the private sector should consider banding together to form peer support clubs, to allow space to discuss difficult cases, or just for peer contact, to avoid practising in isolation.

The NDoH and the private sector. It is in the interest of the SA public for the National Department of Health (NDoH) to invest resources in research into the extent of mental disorders and suicide in the medical profession, as well as the leading contributory factors in the SA setting. Such research should be prioritised before more lives are lost.

Addressing doctors' difficult working conditions in the public sector should also be a priority for the NDoH. The divorce between national health policies and implementation at provincial level needs equal attention, to ensure that all patients and doctors stand a chance of accessing a better health system at the point of service. Is national health insurance (NHI) the answer? Unless the ailing public health system is fixed urgently, it is unlikely to deliver the pressing answers we seek. If the growing need for doctors' mental healthcare is to be met, then a targeted and sustained investment must be made in growing the numbers of psychiatrists and multidisciplinary teams to meet this need.

Allegations about doctors struggling to make ends meet because of medical aid companies that drag their feet in paying for services rendered need to be fully investigated. This obviously adds to the stress of colleagues in private practice.

In addition, medical curricula need to be urgently revised, at both undergraduate and postgraduate level, to better equip doctors to look after themselves as well as they do their patients. Special attention must be paid to improving doctors' mental health service skills, starting with the amount of time allocated to the psychiatry rotation during medical internship training.

Conclusion

Doctors can no longer be silent about the devastating effects of mental illness and suicide on the profession. The death by suicide of an iconic healer, leader and role model such as Prof. Bongani Mayosi has given voice to this suffering.

SAMA Insider September 2018.

Suicide risk needs to be better managed in SA

SAMA Communications Department

Suicide is preventable, but gaps in SA's healthcare system, in both the public and private sectors, need to be closed if the country is to reduce the risk of self-harm, which kills an estimated 18 people every day.

Death by suicide has lasting effects on families, workplaces and communities, and the SA Society of Psychiatrists (SASOP) urges healthcare providers to better manage follow-up care for those at risk of suicide, rather than focusing only on one-off interventions at a crisis point.

SA's estimated suicide rate of 13.4 people per 100 000 is approximately four times the global rate of 3.6 per 100 000, but "if strategies are in place to identify and manage the risk in the early stages", most of these deaths could be averted, says Dr Kobus Roux, a psychiatrist and SASOP member.

Suicide prevention was the focus of this year's World Mental Health Day on 10 October, with the WHO estimating that one person in the world dies by suicide every 40 seconds, a tragic statistic that has led to their campaign for "40 seconds of action" to prevent suicide.

In SA, Dr Roux said, the private and public healthcare sectors "grossly fail" their users by not providing for follow-ups and ongoing treatment for high-risk patients who have attempted or threatened suicide, although this phase of treatment is considered critical in most healthcare systems for reducing suicide rates.

SA's suicide rate is approximately four times the global rate

"Ongoing therapeutic contact with high-risk patients is a very important strategy in suicide prevention. It needs to be implemented in the SA healthcare system and in the proposals for National Health Insurance (NHI)," Dr Roux said.

He highlighted Denmark and South Australia as regions that had achieved significant reductions in suicide rates by implementing strategies that included continuing outpatient treatment after episodes of suicidal behaviour. "People who have had a previous episode of serious suicidal ideation or behaviour are at greater risk of the events recurring, and they need follow-up and management for an extended period after the threat of suicide has been averted – but it is exactly that part which is neglected in SA," Dr Roux said.

Even more concerning, he said, was that the proposed NHI does not make provision for outpatient psychiatric care – psychiatric services are included only for inpatient care for chronic and severe mental disorders such as mania or psychotic disorders.

He said that the first phase of suicide prevention and treatment was "defusing and preventing acute suicidal behaviour", and that this was managed effectively by the healthcare system and volunteer organisations such as the SA Depression and Anxiety Group (SADAG) and LifeLine.

"The second phase, of follow-up on people with suicidal behaviour and depression – which is the leading cause of suicide – is where our system fails.

"Depression and suicidality are not included on the chronic disease list in private healthcare, and only acute treatment at the point of crisis,

in averting a suicide, is covered by medical aids. Ongoing outpatient treatment is not supported by most medical aids.

"In the public sector, once the suicidal crisis is averted, there is nowhere to refer a patient for follow-up care. Public sector psychiatric services have capacity to treat only those patients with chronic serious mental disorders, such as psychotic disorders, or after acute suicide attempts," Dr Roux said.

The third phase of managing suicide risk is for healthcare providers to be more vigilant in looking for signs of depression in patients with other long-standing chronic illnesses, both physical and mental, as there is a widely confirmed link between chronic illness and depression, and these patients are at higher risk of suicidal thoughts and behaviour.

"SASOP urges healthcare administrators and providers to make an effort to manage suicide risk and promote suicide prevention in their patients in all three of these distinct phases of risk, and particularly in urgently finding ways to provide ongoing care after a suicidal episode to prevent re-occurrence," Dr Roux said.

The SA Depression and Anxiety Group (SADAG) operates the country's only dedicated suicide helpline, open 24 hours every day of the year – call them on 0800 567 567 if you or someone you know needs help.

SAMA Insider November 2019.

All for one and one for all: Healthcare workers unite against COVID-19

Prof. Zuki Zingela, *HOD, Department of Psychiatry and Behavioural Sciences, Walter Sisulu University*

As we face the global challenge of COVID-19, countries are grappling with differing severities of the outbreak, but with no less devastating consequences. High death rates, debilitating lockdowns and strained or weakened economies have all pushed healthcare workers to the frontline of this global war whose end date is still undefined. Waking up to fight another day demands sustained stamina and an ethos steeped in the core values of medicine that cannot falter.

Mental health effects

Anxiety, fear and panic are normal reactions to any pandemic associated with high numbers of the sick and dying. The uniqueness of COVID-19 is that never has the human suffering been so well documented, down to the most minute detail. TB and HIV are prime examples of how devastating and disruptive outbreaks can be to health systems. But these were never instantaneously streamed to millions of homes across the world, as COVID-19 has been. The aftermath in health systems that are ill-prepared and overwhelmed by the outbreak has been beamed live into every health worker's immediate consciousness, revving up the expected reactions of fear, anxiety and panic to dizzying heights, accompanied by an overwhelming sense of doom.

In addition to post-traumatic stress disorder, depression and anxiety disorders described in frontline healthcare workers performing COVID-19 outbreak-related duties in China, there is an added increase in substance-use and related disorders. Add to this the normal reactions of loss and grief brought on by the sudden changes we have to contend with, the isolation associated with lockdowns and physical distancing and the economic hardships that come with the country's response to the outbreak, and one has the perfect storm for an increase in the burden of mental disorders that will follow. As the first and last line of defence, health workers represent the country's hope to resisting the potentially crippling effects of this outbreak.

Tips and tricks

Self-care and team care are paramount to our survival as individual healthcare workers, and that of the systems we work in. We all know the standard requirements of self-care, but our usual coping systems and networks have been dismantled due to lockdowns and social distancing requirements. The trick is to use what you have access to, despite the limitations.

Accept these unusual times as the new norm for now, and prepare your family and loved ones by conveying the seriousness of the situation, without being alarmist, to encourage co-operation in adjusting to this new norm. Ensure that you and your family have what you need available at home. Identify a designated shopper, who will be armed with a shopping list when necessary to keep the stock you have at home at a reasonable level. Have a rota for daily chores for everyone at home, so that everyone has a part to play while locked down. Ensure that you take breaks from news and updates about the outbreak, so that you are not overloaded with the morbid details of each death and negative consequence. At least an hour or two away from the news can give your mind a welcome break from the constant stress. Encourage activities such as cooking together, baking together, gardening, board games and exercise (e.g. using exercise apps). Maintain a regular sleep and exercise routine and a reasonably balanced diet. Eat and hydrate regularly at work too. Identifying a private "calming space" at home that can be used by everyone when they need it. Despite being stuck together at home during lockdown, you may end up with less physical contact with others due to the need for physical distancing

as an infection control measure. This may be confusing for children, who are used to more physical contact like hugs from family members. Have a designated non-shareable soft toy or pillow for each younger child (or anybody else for that matter) that they can cuddle for comfort.

Prioritise "me time" as a health worker, even if it is only 5 minutes for every 2 - 3 hours spent taking care of everybody else. Your survival and the survival of everybody else may depend on it! If you collapse due to exhaustion brought on by self-neglect, that takes one crucial person out of the chain of healthcare that we have to establish and maintain for those who will get seriously sick from the virus and need hospitalisation. Have a decontaminating area in your home, for example in the garage or behind your house, with a "contamination bin" where you throw away or store protective items or clothing.

Conclusion

This outbreak has brought on a sense of urgency and a demand for efficiency that was not evident before in our health institutions across the country. Never before have we seen such a co-ordinated, well-targeted response from our Minister of Health, National Department of Health and the whole executive of government, which has had to be synchronised across provinces and public and private services, as well as business and society at large.

"All for one and one for all, united we stand, divided we fall"

"All for one and one for all, united we stand, divided we fall". Alexandre Dumas immortalised these words in *The Three Musketeers*. For our health teams and systems to survive and remain functional in this time of corona, for our country to come out intact on the other side, we will all have to live by this motto.

SAMA Insider June 2020.

Where to get help and information

South African Depression and Anxiety Group (SADAG)

- For counselling queries, email: zane@sadag.org
- To contact a counsellor between 08h00 and 20h00, Monday to Sunday, call: **011 234 4837**
- For a suicidal emergency, contact us on **0800 567 567**
- 24-hour helpline: **0800 456 789**

Emergency lines

- Dr Reddy's helpline: **0800 21 22 23**
- Adcock Ingram depression and anxiety helpline: **0800 70 80 90**
- Department of Social Development substance abuse line 24-hour helpline: **0800 12 13 14** or SMS **32312**
- Suicide crisis line: **0800 567 567**
- Akeso Psychiatric Response Unit 24-hour: **0861 435 787**
- Cipla WhatsApp chat line (09h00 - 16h00): **076 882 2775**

Others

- Lifeline South Africa (any time day or night, every day of the year): **0861 322 322**
- National Institute for Communicable Diseases toll-free COVID-19 hotline: **0800 0299 299**
- Healthcare Workers Care Network 24-hour toll-free helpline: **080 021 2121**, SMS **43003** or visit healthcareworkerscarenetwork.org.za for immediate healthcare worker counselling and support.

Supporting doctors and medical students during COVID-19

Discovery appreciates your selfless commitment during this global pandemic and the contribution you make to the people of this country. We aim to assist you through this challenging period by providing you with relevant support, educational material and tools.

Supporting the doctors of the future 24/7 – medical students and young doctors. For 24/7 crisis and mental wellness support, call the Discovery Young Doctor Mental Health Helpline on 0800 323 323.

Supporting your comprehensive wellness through Discovery Healthy Company for Doctors. We understand that you are on the frontline, caring for patients with confirmed or possible cases of COVID-19, and thus have an increased risk of exposure to the virus. Many doctors are also facing long working hours, extreme work pressure, fatigue, occupational burnout and psychological distress.

To proactively support the personal and financial wellness of SA doctors during the COVID-19 outbreak, we are giving **all doctors** access to Discovery Healthy Company for Doctors – at no cost. This is for all doctors in **both the private and public sectors.** To view the benefits, click here.

Benefits available to doctors

- Proactive, relevant interventions from prevention and education to ongoing or episode management to assist in managing areas identified as at-risk across any of the four dimensions of wellbeing – physical, emotional and mental wellbeing, and legal support (personal and small business). You get access to:
  - legal and financial experts
  - trauma counsellors
  - registered psychologists and social workers.
- Support and advice from a Healthy Company counselling coach in a private and confidential setting. They provide this service telephonically or through the live-chat functionality on the Discovery app or Discovery website.
- Access to legal and financial experts, trauma counsellors, registered psychologists and social workers to assist with episodic or ongoing management for areas identified as at-risk, including emotional distress, anxiety or trauma.
- Online lifestyle management services, including a library of comprehensive educational material, assessments and tools to capture your mood and detect signs of emotional distress.

Confidentiality: Discovery Healthy Company treats all information totally confidentially. There is no data-sharing between us and any other subsidiaries within the Discovery Group.

How to access this service

All doctors on Vitality Active Rewards for Doctors have immediate access to Discovery Healthy Company for Doctors and can simply activate the benefit on the Discovery app. If you do not have Vitality Active Rewards for Doctors, you can follow the registration process below.

All other doctors should contact Healthy Company on 0800 320 420 or healthcompanyqueries@discovery.co.za to register and gain immediate access. For more information, visit the Discovery website.

We look forward to supporting your wellbeing.