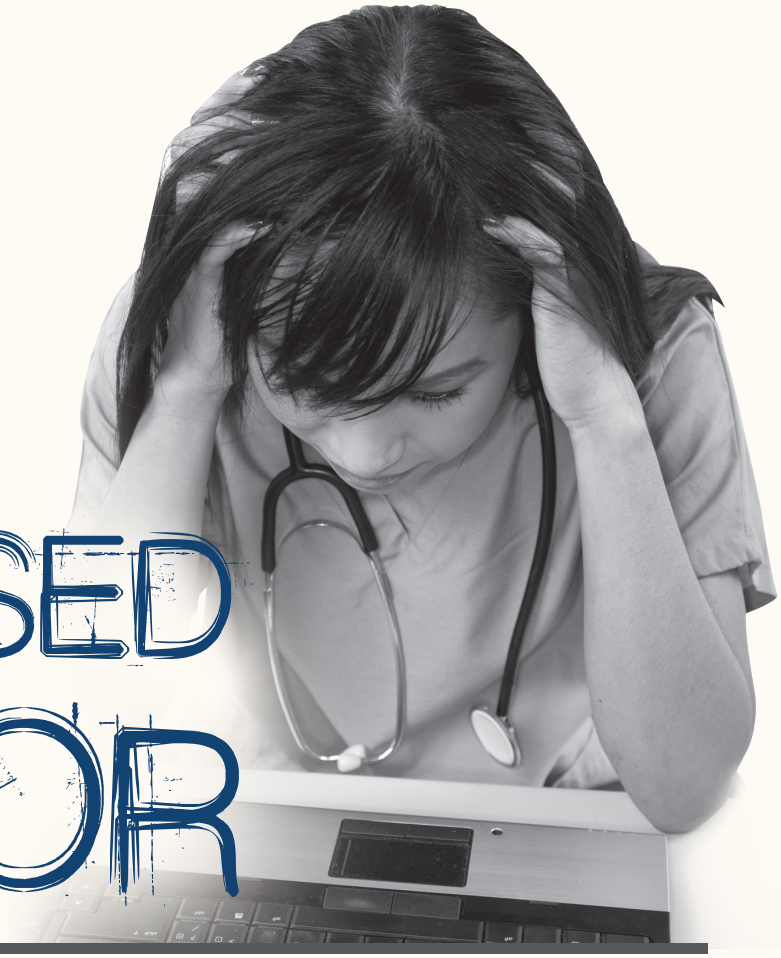

THE DEPRESSED DOCTOR

DEALING WITH DIFFICULT DECISIONS

"These are the duties of a physician: First… to heal his mind and to give help to himself before giving it to anyone else…"
— Monument to Serapion circa 220AD

ARE DOCTORS MORE LIKELY TO BE DEPRESSED?

Depression is a psychiatric condition that afflicts up to 5.8% of the Singapore population. It is a syndrome that includes abnormally low mood, anhedonia and somatic symptoms like insomnia and fatigue. Doctors appear to be at higher risk of having depression than the average person. A landmark Harvard study by Vaillant et al[1] prospectively followed Harvard sophomores for 30 years and found that doctors were consistently more likely to use drugs and alcohol heavily, have poor marriages and obtain psychotherapy. Doctors apparently endorse more depressive feelings in response to personal and professional stressors than even lawyers! Female doctors in particular appear to have a higher rate of depression in comparison to other females with similar educational levels and are far in excess of population levels of depression (39% vs 23.9%). Higher rates of depression are apparent, even for students, with up to 34% of medical students endorsing depressive symptoms that persist throughout training, showing little accommodation to the demands of training.

WHY ARE DOCTORS MORE DEPRESSED?

One explanation for the high rates of depression is the high stress nature of the job. This entails long working hours, regular rapid and high stake decision-making, while facing unpleasant and taxing illnesses with the constant requirement to keep up-to-date with increasing amounts of information. The typical personality of a doctor may be a predisposing factor as well. It is believed that the average doctor is smart, driven, competitive and has difficulty relaxing or acknowledging personal limits or vulnerabilities.

There is also some evidence that people with a predisposition to illnesses like depression, self-select into medicine. One study[2] showed that medical students, compared to controls, were more likely than law students to have experienced a serious medical illness in their family

of origin and the fear of death at a younger age. Selecting the medical profession may be an unconscious reflection of the desire to combat fears of powerlessness from close contact with serious illness or obtain the care that was lacking due to ill parents. Unfortunately, many doctors who enter the profession to "conquer illness" soon find that they are only human and have little power over many serious conditions.

WHAT IS THE PROBLEM WITH DEPRESSED DOCTORS?

The American Medical Association defines the impaired physician as one who is unable to fulfil professional or personal responsibilities due to psychiatric illness, alcoholism or drug dependency. Many depressed doctors are likely to initially have personal problems, such as marital or familial interactional problems, which can progress to the abuse of alcohol to "manage" these problems. Eventually, this can progress with difficulty in coping with clinical duties that can manifest in poor record-keeping, lapses in administrative duties, withdrawal from social activities and compensatory behaviour like rounding at odd hours. The most serious outcome of depressed doctors is suicide, which is four times more likely to occur in female doctors than the general population.

WHAT CAN OTHER DOCTORS DO TO HELP?

The first step is to recognise that something may be amiss. This is often reflected in problems related to the personal life of the doctor and if clinical performance is affected, the situation is often quite severe. A useful first step is corroboration with other colleagues to determine if your concerns about the doctor are shared. If confirmed, the next step could be a private chat with the affected doctor, to ask about the recent changes in mood, behaviour and general situation. However if there are issues of clinical competency, a more expeditious approach involving the programme director (for students) or head of department may be warranted. Referral to the hospital staff support programme or a certified mental health provider may be useful at this stage.

IS IT THAT SIMPLE?

Studies have shown that only one third of doctors who suspected a colleague to be impaired reported them. Common reasons include uncertainty about actual impairment or harm to patients, the general reluctance to criticise colleagues and the lack of protection of whistle-blowers. These are very real and practical issues when trying to get our colleagues the appropriate help.

A useful ethical framework should aim to prevent harm to patients, execute our professional obligation at self-regulation (as stated in the Singapore Medical Council [SMC] guidelines) and most importantly, help our impaired colleague. The best way to do this will vary from institution to institution but it is often wise to avoid treating a colleague, unless the relationship is purely clinical. The concerns about confidentiality and loss of licence to practice are very real for any impaired doctor. Locally, the SMC does not have a category of licensing that allows doctors to practise with restrictions, making fitness to practise an all-or-nothing situation. This could potentially make it more challenging to identify and treat impaired physicians.

ROUNDING UP

Medicine is a rapidly advancing field that has the potential to reduce suffering, extend life and improve our quality of life. The demands of this profession are high and take a toll on its members. We should be mindful of the first duty of doctors: to heal thyself. ◆

PROFILE

TEXT BY

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Dr Tor is a psychiatrist working in the Mood Disorder Unit in the Institute of Mental Health. He has a special interest in treating patients with electricity and magnetism. In a previous life, he spent his time treating stressed young men in uniform.

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