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Mental health and stigma in the medical profession

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Abstract

Until recently, much of the recent upsurge in interest in physician health has been motivated by concerns about improving patient care and patient safety and reducing medical errors. Increasingly, more attention has turned to examining how the management of mental illness among physicians might be improved within the medical profession and one key direction for change is the reduction of stigma associated with mental illness. I begin this article by presenting a brief overview of the stigma process from the general sociological literature. Next, I provide evidence that illustrates how the stigma of mental illness thrives in the medical profession as a result of the culture of medicine and medical training, perceptions of physicians and their colleagues, and expectations and responses of health care systems and organizations. Lastly, I discuss what needs to change by proposing ways of educating and raising awareness regarding mental illness among physicians, discussing approaches to assessing and identifying mental health concerns for physicians and by examining how safe and confidential support and treatment can be offered to physicians in need. I rely on strategically selected studies to effectively draw attention to and support the central themes of this article.

Keywords

mental illness, physicians, stigma

Introduction

> If my colleagues knew that I was bipolar, I fear that I would never again be taken seriously, that I would be viewed as the 'impaired physician' who, at a display of passion or emotion, would be seen as having an 'episode.' My hard-earned credibility would be gone. My right to express even normal anger or irritability, happiness or my effervescent sense of humor would be suspected as pathological. I would lose the right to just have a bad day.

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> If I had lost a breast to cancer or had Parkinson disease, I would have the concern and sympathy of my community. But this illness is perhaps harder to bear because it is yoked with shame and secrecy. I am not missing a body part nor do I have a resting tremor. Yet I still struggle with a chronic and debilitating illness associated with a high morbidity and mortality rate …
>
> If I continue to live pretending to be other than who and what I am, how can I hope the world will evolve and become a better place … It is time to give mental illness a name, a face, a story. Only in doing so will the stigma of this disease lose its power. (Fiala, 2004: 2925–2926)

This passage was recently published in the *Journal of the American Medical Association* by a physician who has lived with and been treated for manic depression for 30 years. Her words convey the power of stigma experienced by physicians with mental illness and her struggle with disclosure and secrecy. She proposes that only by making mental illness personal, by connecting the illness with someone we know, will the power of stigma among members of the medical profession be weakened.

Unfortunately, this physician is not alone in her struggle with the stigma of mental illness. Several recent studies report that depression among physicians is about the same as in the general population, around 12 to 13 percent, although it appears somewhat higher among women and medical students and residents (Dyrbye et al., 2006, 2008; King et al., 1992; Nuzzarello and Goldberg, 2004). In addition, it is estimated that approximately one in 10 physicians will develop a substance-related disorder at some point in their life (McCall, 2001; McLellan et al., 2008). Until recently, physicians' mental ill health was usually only a concern when a physician's behavior raised questions about their ability to treat patients or work with their colleagues (Hendin et al., 2007). Increasingly, it is recognized that the management of mental illness by physicians and the medical community might be improved and one key direction for change is the reduction of stigma associated with mental illness within the medical profession (Wallace et al., 2009).

The objectives of this article are threefold. First, I present a brief overview of the stigma process from the general sociological literature. Second, I provide evidence that illustrates how the stigma of mental illness among physicians thrives in the medical profession as a result of the culture of medicine and medical training, perceptions of physicians and their colleagues, and expectations and responses of health care systems and organizations. Lastly, I discuss what needs to change by proposing ways of educating and raising awareness regarding mental illness among physicians, discussing approaches to assessing and identifying mental health concerns for physicians and by examining how safe and confidential support and treatment can be offered to physicians in need. In meeting these objectives, I rely on strategically selected studies to effectively draw attention to and support the central themes of this article.

Stigmatization as a social process

Recently, there has been growing attention and initiatives designed to combat stigma and discrimination against mental illness, but in order to successfully reduce the negative

outcomes resulting from the stigmatization of mental illness, we must understand the contributing processes (Link and Phelan, 2001; Pescosolido et al., 2008). The concept of stigma is central to the sociological study of mental illness and how it impacts on individuals, treatment and policies, and the social outcomes related to mental illness (Pescosolido and Martin, 2007). While the definition of stigma has been criticized as exceptionally vague and highly variable (see Link and Phelan 2001), it often refers to an attribute that identifies an individual as possessing undesirable characteristics and is defined and enacted through social interaction (Goffman, 1963): 'Stigma is typically a social process, experienced or anticipated, characterized by exclusion, rejection, blame or devaluation that results from experience or reasonable anticipation of an adverse social judgment about a person or group' (Weiss and Ramakrishna, 2004: 536).

The sociological approach to stigma and mental illness has been largely influenced by the early works of Goffman (1963) and Scheff (1966). Goffman's (1963) book *Stigma: Notes on the Management of Spoiled Identity* offers a general perspective on the social consequences of difference, whether it applies to being an orphan, engaging in criminal behavior, or having a mental illness. The process of stigmatizing a devalued attribute occurs through social interaction where social relationships, rather than the attribute itself, are central to stigmatization. Those who are stigmatized are rejected and isolated from others although this may change over time where individuals shift from a stigmatized identity to a 'normal' one. Scheff's (1966) book *Being Mentally Ill: A Sociological Theory* complements Goffman's work by formalizing a labeling theory of mental illness that offers a detailed account of the influence of societal reactions to norm violations. His approach also emphasizes the centrality of the social construction of labels and stigma and the responses to them. The sociological literature has refined and elaborated these original formulations and extended their approaches to examine the impact that stigmatization can have on the lives of those who are affected by it. Based on current perspectives stemming from these two earlier approaches, the process of stigmatization may be described as follows.

The process of stigmatization usually begins with labeling someone with mental illness. Diagnostic labels are useful tools in medicine because they summarize information about a patient's illness permitting efficient and accurate communication among members of the profession (Sartorius, 2002). However, labeling someone with mental illness can lead to assigning certain negative stereotypes associated with undesirable characteristics that are attached to that label and distancing oneself from those with symptoms of mental illness (Corrigan et al., 2003; Pescosolido and Martin, 2007; Scheff, 1966). Common stereotypes about people with mental illness include the belief that they are responsible for their own illness and therefore blameworthy and that they are dangerous (Link and Phelan, 2001). Belief in these stereotypes may be endorsed by a negative evaluative component that triggers a negative emotional reaction or prejudicial response. In the medical profession, these stereotypes may generate the prejudicial response that physicians who are mentally ill are occupationally impaired (Carr, 2008; Myers, 1997; Harrison, 2008).

Stigma can also lead to discrimination including status loss, rejection, avoidance, exclusion, hostile behaviours, and withholding help (Link and Phelan, 2001). Discrimination is the behavioral response to stereotypes and prejudicial attitudes regarding persons with mental illness. Much of the general literature examines discrimination in terms of

unwillingness to help the stigmatized individual and active avoidance (e.g. Corrigan et al., 2003), which appear to be common responses among members of the medical profession in regards to their colleagues with mental illness (Center et al., 2003). Some suggest that the continued stigmatization of mental illness is a major factor contributing to individuals being reluctant to seek and maintain treatment (Phelan and Basow, 2007). Other studies report that the stigma of mental illness can be more debilitating and more difficult to overcome than the mental illness itself (Day et al., 2007; Pescosolido and Martin, 2007; Sartorious, 2002; Weiss et al., 2006).

How stigmatization of physicians with mental illness thrives in the medical profession

While stigma is said to involve social interactions at the individual level, these social interactions do not occur in a vacuum. Rather, they take place in broader social contexts in which organizations, institutions, and larger cultural structures shape and influence the notion of what is different and stigmatized (Goffman, 1963; Pescosolido et al., 2008). The stigmatization of physicians with mental illness is no different in this regard. Three contextual influences in the medical profession include: (1) the transmission of the culture of medicine in medical schools; (2) the attitudes of colleagues at work; and (3) the expectations and responses of health care systems' and organizations to physicians suffering from mental ill health or substance abuse.

The culture of medicine and medical training

Carr (2008: 300) describes how the culture of medicine teaches physicians to place a low priority on their own health:

> Sometimes we work exhausted, or, perhaps, more ill than our patients. Covertly, we get the message. We are to rise above any human frailty. It isn't a conscious process; it is, rather, who we have become. Resilience isn't taught but it is expected, and we come to expect it in ourselves and each other. Therefore, to admit a problem is to admit that we are, somehow, less than and not equal to our peers. We feel shame and we fear being judged and stigmatized so we tend to suffer in silence and carry on in a profession that prides itself on stoicism and bravado.

There is virtually no information on physicians' patterns of seeking help for mental health concerns or addictions and what does exist is outdated (Brewster, 1986; Center et al., 2003). There is more data on medical students that suggests that they have low rates of seeking help. Givens and Tjia (2002) report that of those medical students who screened positive for depression in their study, only 22 percent were using mental health services and only 42 percent of those with suicidal ideation were receiving treatment. According to their study participants, the most commonly cited barriers to using counseling services were lack of time (48%), lack of confidentiality (37%), stigma associated with using mental health services (30%), costs (28%), fear of documentation on their academic record (24%), and fear of an unwanted intervention (26%). Givens and Tjia (2002) conclude that students may be correct in thinking that using mental

health services is stigmatizing since other studies have found that medical students who received psychological counseling were less likely to secure residency positions.

Physicians report that they feel pressure to appear physically well even when they are not and that a physician's health is believed to reflect his or her medical competence (Thompson et al., 2001). As a result of their medical socialization and training, it appears that acknowledging psychological illness can be extremely difficult and viewed as a weakness or character flaw by physicians (Wallace et al., 2009). This may account for the stigmatization among physicians if they attribute the cause of illness to their personal frailty or responsibility.

Doctors who are mentally ill are not only unwilling to admit they have emotional problems, they are often reluctant to adopt the role of patient (Klitzman, 2008). The radical role reversal from the physician role to the patient role can seriously challenge and undermine the physician patient's personal and professional identity. This sometimes results in overwhelming conflict and tension for physicians in treatment and/or hospitalization and may contribute to premature termination of their treatment program (Rucinski and Cybulska, 1985).

Concerns about confidentiality as well as embarrassment in seeking psychiatric services are also deterrents to acknowledging a problem exists. As indicated above, the culture of medicine effectively discourages physicians from discussing their personal health or admitting vulnerability or illness to their colleagues. Both mental and physical illnesses are not well tolerated and self-care is usually not adequately taught or promoted in medical school. Most physicians do not pay particular attention to their own or their colleagues' health and downplay evidence that either may be unwell. For example, a recent study found that most doctors work when they are unwell and expect their colleagues to do so, even though they would not place the same expectations on their patients (Thompson et al., 2001).

Perceptions of physicians and their colleagues

> Despite the biological substrate of clinical depression or the genetic underpinnings of alcoholism, many physicians still believe these disorders are evidence of a lapse of will or moral failure, especially when they appear in other physicians. (Myers, 1994: 9)

The belief that the source of mental illness can be causally attributed to forces within the individual's control is consistent with the general theory of causal attributions where individuals are considered responsible for their situation (Corrigan et al., 2003; Pescosolido and Martin, 2007). Physicians' attitudes tend to discourage admission of health vulnerabilities, which is likely one of the driving forces behind their reluctance to seek mental health care (Center et al., 2003; Wallace and Lemaire, 2009). In addition, an important obstacle to successful coping with occupational stressors is 'the conspiracy of silence' where physicians are reluctant to recognize or talk openly about any psychological problems that might be due to their stressful working conditions (Arnetz, 2001; Wallace and Lemaire, 2007; Wallace et al., 2009).

The tendency among many impaired physicians and their colleagues is to believe that the physician will either work it out or the problem will somehow disappear. Out of

loyalty and respect, colleagues will often feel they owe one another the opportunity to resolve the situation on their own (McCall, 2001). This natural tendency to rationalize, devalue, or simply ignore the possibility of impairment supports the 'conspiracy of silence' and as a result nothing is done (Boisaubin and Levine, 2001; McCall, 2001; Wallace and Lemaire, 2009).

Colleagues may be reluctant to help a doctor in need because they worry about potentially victimizing the physician if there is insufficient evidence to take action. As well, many times action is delayed as either the individual or their colleagues are uncertain as to what steps to take and what support resources are available (Marshall, 2008). Colleagues may delay reporting to protect their at risk colleague from the adverse consequences of stigma, shame, income loss, and licensure actions. They may also be afraid of being wrong in their assessment of the situation and fear retaliation (McCall, 2001). In addition, many doctors find themselves facing the ethical dilemma of having to choose between protecting the privacy of their unwell colleagues versus the safety of patients. Roberts and colleagues (2005) found that preserving confidentiality among one's colleagues is a dominant value, even when the hypothetical doctors in need are at risk of suicide or patient care is compromised and the situation is further complicated when it involves concerns regarding mental ill health. Similarly, Farber and colleagues (2005) found that the majority of participants in their study are more likely to report a hypothetical physician involved in substance abuse than one who is emotionally or cognitively impaired.

Participants in Miller's (2009) study of 116 doctors seeking help for mental ill health reported being ostracized by their colleagues, being seen as weak, incapable or lazy or no longer being seen as a 'proper doctor'. In King et al.'s (1992) study, of the 133 doctors who reported previous emotional distress, 53 percent reported that their colleagues did not notice their distress, 17 percent reported that they felt some of their colleagues actively ignored them, and 11 percent reported they felt that their colleagues were irritated by it. However, 40 percent reported they received sympathy from some colleagues and 11 percent indicated that their colleagues had offered them help. It appears that while some physicians may be supportive and understanding of colleagues suffering from mental illness or seeking help, others may perpetuate the overwhelming stigma and shame that deters doctors from addressing their symptoms and seeking treatment.

Health care systems' and organizations' expectations

Concerns about physicians' mental ill health and substance abuse have traditionally been expressed in terms of disciplinary responses to ensure the safety of patients rather than in terms of treatment for the affected physician (Taub et al., 2006). Patient safety is obviously of paramount importance, but this approach has fostered a culture that tends to punish and stigmatize ill and/or impaired physicians rather than offering considerate and compassionate care that is typically offered to non-physicians suffering from similar conditions (Taub et al., 2006).

It is essential to highlight the critical distinction between being diagnosed with mental illness and being impaired. 'Illness' is not synonymous with 'impairment' (Carr, 2008): 'Physicians can be mentally ill and not occupationally impaired' (Myers, 1997: 12). Moreover, poor medical care is not only the result of mental illness, but in many cases

may be due to poor medical training, carelessness, or simply medical errors. Doctors may have one or more medical conditions or mental health problems that may not necessarily affect their fitness for work and their ability to provide safe and quality care to their patients (Harrison, 2008). This significant distinction between being diagnosed with a mental illness and being an impaired physician is not universally recognized however. For example, in a recent survey of executive directors of State Medical Boards in the USA, 37 percent of those surveyed indicated that the *diagnosis* of mental illness by itself was sufficient for sanctioning a physician (Hendin et al., 2007).

As Center and colleagues (2003: 3164) note: 'Practicing physicians with psychiatric disorders often encounter overt or covert discrimination in medical licensing, hospital privileges, health insurance, and/or malpractice insurance.' These discriminatory practices and policies often rely solely on the diagnosis of a psychiatric disorder, which may be entirely unrelated to a doctor's professional skills and abilities, particularly if they are receiving effective treatment. Center et al. (2003) argue impairment cannot be inferred from diagnosis alone and that we must shift our focus from the *diagnosed* professional to the *impaired* professional. Moreover, by concentrating on the diagnosis it may deter physicians from seeking help and being diagnosed and therefore pose even greater risks to patients and themselves if they go untreated.

Although the treatment options for ill and/or impaired physicians have never been better, the issue of professional, societal, and legal sanctions remains a strong deterrent to disclosing illnesses and seeking help (Harrison, 2008). Doctors with substance abuse problems are often discouraged from seeking help because of feelings of shame, seeing how badly other colleagues have been treated with similar experiences, and a lack of knowledge about available services (Marshall, 2008). The threat of disciplinary action can also be a powerful deterrent to physicians seeking help as well as to colleagues reporting suspected illness, addictions, or impairment (McCall, 2001). These worries are not unfounded. Miller's recent study of 116 doctors seeking help for mental ill health, as a result of their experience, reported losing their medical career, being less able to work, financial hardship, lack of energy, as well as the demoralizing 'anxiety, shame and despair of mental ill-health' (Miller, 2009: 54).

What needs to change?

Based on theories of prejudice and discrimination in other fields, particularly in regards to race and ethnicity, two common themes are prevalent in approaches to reducing the stigmatization of mental illness (Pescosolido and Martin, 2007). These include the role of interpersonal contact and the role of causal attributions. In regards to interpersonal contact, individuals who have more experiences, familiarity, and contact with people with mental health problems tend to have less negative reactions, display less discriminatory behaviors, and hold more tolerant attitudes (Kolodziej and Johnson, 1996). In regards to causal attributions, if individuals believe the causes of mental illness are attributable to flaws of the individual or their character, the individual is judged responsible for their situation. If an individual is viewed as responsible for causing their situation then they are more likely to be avoided, segregated, and experience discriminatory responses such as withholding help. In

contrast, if the illness is attributed to medical-genetic causes, stress, or accidents (e.g. a head injury suffered in an accident), then they are less likely to be judged responsible and more likely to be offered helped and less likely to experience stigmatization or discriminatory responses (Corrigan et al., 2003).

Research shows that, in order to be effective, anti-stigma programs must work on multiple levels by targeting individuals, structures, and systems and those involved must be motivated to change their strongly held stereotypes and discriminatory behaviors (Heijnders and van der Meij, 2006; Link and Phelan, 2001). Both contact and attribution themes are explored in relation to the different contextual influences examined above that may contribute to the stigma of mental illness among physicians. Is it important to note however, that very few studies have examined the effectiveness of specific stigma-reduction strategies in the general health-related stigma literature (Heijnders and van der Meij, 2006) and even fewer appear to exist in regards to physicians in particular. In the discussion that follows, three key proposals for change are examined that include: (1) educating and raising awareness regarding mental illness among physicians; (2) implementing assessment and identification of mental health concerns for physicians; and (3) providing safe and confidential support and help to physicians in need.

Educating and raising awareness about mental illness among physicians

Medical schools and organizations employing physicians need to assess how they influence and shape physicians' attitudes toward mental ill health and self-care. Physicians in training and practicing physicians need to be taught to recognize signs of distress in themselves and their colleagues, recognize when help is needed, and feel safe and supported in seeking or offering help (Pitt et al., 2004). Medical schools and the medical community need to be more committed to proactive health promotion among physicians where personal wellness needs to become part of the culture of medical schools and the medical profession that is recognized, modeled, and encouraged at each level of training and beyond (Carr, 2008; Wallace and Lemaire, 2009).

Two recent studies on medical student training provide concrete examples about how education and raising awareness are effective strategies in addressing both interpersonal contact and causal attributions. Schmetzer and Lafuze (2008) examined a psychiatry program that was developed to reduce stigmatizing attitudes among medical students and residents. It was designed to increase communication about psychiatric topics such as diagnosis, treatment, and stigma between physicians, patients with mental illness, and patients' families. The program involved presentations by patients' family members and representatives from the US organization known as the National Alliance on Mental Illness (NAMI) about issues of communication and stigma reduction. As well, the NAMI presenters also emphasized the importance of the biological basis of mental illness with the goal of shifting from a stigmatization or blame of the individual or their family dynamics as the etiologic basis for mental illness to a more medical focus on biologically based causes and treatments (Schmetzer and Lafuze, 2008). They assessed students' pre- and post-clerkship attitudes toward mental illness and the different ways professionals might interact with patients' families and mental health professionals. The program

shows promise for promoting communication among psychiatric patients and their families with medical students in regards to psychiatric disorders, treatment, and stigma issues. Similarly, a recent study by Nuzzarello and Goldberg (2004) found that one of the factors that affects medical students' diagnostic decision-making behavior for depression is their own personal experience with depression among close friends, family members, or themselves. They suggest that it may be helpful to have medical students who have struggled with and overcome depression to share their experiences with one another so as to communicate the importance of seeking treatment when needed.

The findings and recommendations of both of these studies are consistent with sociological theories that emphasize the 'binding power of common experiences' where familiarity, interpersonal contact, and interaction are vital to reducing discrimination and prejudice as well as the importance of understanding the biological basis of many mental illnesses (Pescosolido and Martin, 2007). Moreover, it appears that anti-stigma programs not only facilitate familiarity with mental illness but that they also raise awareness regarding the biological bases of certain mental health problems such that individuals are not believed responsible for their condition which contributes to prejudicial attitudes and stigmatization (Corrigan et al., 2003; Pescosolido and Martin, 2007).

Along related lines, doctors need to be taught and informed about the critical differences between 'illness' and 'impairment'. Rather than stigmatizing those who seek help, physicians must be supported and encouraged when they are bold enough to recognize they need help. This suggests a shift in the emphasis from physician impairment, which invokes ideas of disease and legalistic implications, toward an emphasis on overall physician health (Wallace et al., 2009). This movement away from a somewhat limited focus on mental health problems may also facilitate consideration of a wider range of physician health issues and possibly aid in the prevention of them (McGovern et al., 2000). The distinction between illness and impairment is consistent with the general literature on mental illness that emphasizes the need to clarify the risk of dangerous behavior among those with mental disorders. This literature suggests that perceptions of the mentally ill as being dangerous and subsequent emotional responses, such as fear or anger, affect the likelihood of others helping or rejecting those with mental illness (Corrigan et al., 2003). The unfounded notion that mentally ill physicians are inherently dangerous to themselves or their patients may rationalize the belief that they need to be segregated from the workplace through misinformed causal attributions.

Implementing assessment and identification of mental health concerns for physicians

The effectiveness of the medical profession in identifying and intervening on behalf of its members needs to change. There is usually a reluctance to confront colleagues and refer them to appropriate resources. As indicated above, this partly stems from concern about the potential for licensure actions, shame, or stigmatization that may result. Failure to intervene may also be due to inadequate standards by which to identify signs of need, difficulty determining whether a colleague is experiencing serious problems and in need of help, and lack of familiarity with available resources that offer supportive interventions (Taub et al., 2006).

One approach to facilitating change may involve developing anonymous self-evaluation screens for physicians that assess such issues as stress, burnout, anxiety, depression, and substance abuse. These may be offered by organizations employing physicians or through local or national professional associations (e.g. MedNet in the London area of southern England). The screening instruments may be used by physicians so that only they know their own results, which would allow them to monitor their wellness as well as help them identify early on any symptoms that warrant further attention. This could also be used to facilitate training medical students and physicians how to recognize depression and other symptoms in themselves, their colleagues and their patients, since studies show that physicians do not adequately detect or treat 40 to 60 percent of their patients with depression (Hampton, 2005). In addition, confidential assistance should be offered for physicians who have any questions or concerns about their screening results that is accompanied by a clear and supportive message in using such resources. This might offer a more proactive approach that might help physicians recognize the need for help before they become impaired (Carr, 2008).

In addition, occupational health assessments of physicians have been proposed as a method to evaluate whether doctors are fit to perform their professional activities. One approach is to rely on psychiatrists to evaluate physicians' mental health. A resource document recently developed by two councils of the American Psychiatric Association provides an initial source of information on guidelines for evaluating the psychiatric fitness-for-duty of physicians (Anfang et al., 2005).

Another approach for identifying physicians at risk may be incorporated into review programs similar to those used by the Colleges of Physicians and Surgeons of Alberta and Nova Scotia in Canada. Every five to seven years, they assesses all physicians in the province through the Physician Achievement Review (PAR) program (refer to www.par-program.org for information of the Alberta PAR process and www.nspar.ca for information on the Nova Scotia PAR process and copies of the survey instruments, sample physician reports, etc.). Patients, physician colleagues, and non-physician health care co-workers complete confidential questionnaires on topics ranging from the physician's management and communication skills to their medical competency, patient care and clinical knowledge and skills. Physicians are provided with the detailed aggregate results of their own practice in addition to a summary profile of all physicians in similar types of practice. A comparable strategy may be used to identify physicians with mental illness, alcohol or drug dependencies, or physical impairments (Leape and Fromson, 2006).

In addition to these assessment tools, there needs to be a more proactive approach to physician health and well-being that encourages and supports individual responsibility for wellness and that promotes and supports early intervention when health and performance deteriorates (Harrison, 2008). Current models of assessment are essentially reactive, often times being put into effect many years after a doctor may have initially required help. It often takes a crisis situation to initiate diagnosis and intervention by which time the problem may be longstanding or chronic (Marshall, 2008).

Several practical steps that may be taken to adopt a more positive and proactive approach have been proposed in the literature. For example, hospital and health care accrediting organizations need to have systems in place to detect and treat depression for all its health care providers in a safe and supportive way (Center et al., 2003). As suggested

above, one approach that hospital and medical centers could consider is conducting yearly anonymous screenings where staff obtain their own results and no one else (Hampton, 2005). In addition, medical schools and hospitals need to work with insurance companies to develop in-house consultation, referral, and treatment services for medical students and physicians with mental health problems (Hampton, 2005). Decisions about licensing and credentials should be based on evidence related to professional performance and not simply on psychiatric diagnosis or treatment. In some places, licensing boards conduct investigations if physicians seek treatment, which can lead to sanctioning regardless of whether there is any evidence of impaired functioning and this must change (Hampton, 2005). This leads to the next recommendation for change regarding the provision of safe and confidential support and assistance to physicians in need.

Providing safe and confidential support and help to physicians in need

In regards to the profession as a whole:

> The first step in responding to the high prevalence of mental illness among doctors … An overall change in attitude is needed so that the stigma may be removed from mentally ill doctors … Doctors who become ill merit as much vigilance and compassion from their colleagues as other patients. (Pilowski and O'Sullivan, 1989: 269)

The consensus in the current literature is that there needs to be a shift in the culture of medicine that encourages physicians to seek help for depression, other mental health problems, addictions, or suicidal risks (Wallace et al., 2009). The medical community must learn to better support its recovering colleagues. As Carr (2008: 302) notes 'Our compassion for the ill must extend to our fellow physicians.'

An example of promoting support among members of the medical community for colleagues at risk of substance abuse is the 'Dare to Care' campaign recently introduced by the Physician and Family Support Program in Alberta, Canada. This campaign is designed to educate physicians and medical residents about the issue of substance use disorders in the workplace with knowledge, care, and concern (Maier, 2006). The initiative seeks to raise awareness about the risk of substance abuse among physicians and residents, the signs of addiction and the issue of stigma, the resources available for physicians in need of help, as well as provide information on how to access resources for themselves or their colleagues. The guiding slogan 'Dare to care for a colleague. Dare to care for yourself' underscores the health promotion of self-care of this initiative rather than a more impairment oriented stance. Some of their education and awareness tactics have included strategic circulation of visually noticeable posters, conducting workshops and offering presentations, as well as communicating information and resources in print and electronically to stakeholders and medical workplaces.

In addition, doctors need to be informed about the availability of qualified resources that can be obtained promptly, confidentially, and without involving disciplinary bodies (Rucinski and Cybulska, 1985). Pitt et al. (2004) found that the residents in their study repeatedly told program psychiatrists that if not for the assurance of absolute confidentiality they would not have used the mental health services program. It is

imperative to foster a culture that is committed to taking remedial steps at the first signs of deterioration so that procedures are in place to identify which physicians are in need of assistance as well at the most effective and appropriate methods of intervention (Taub et al., 2006).

In addition, there needs to be a shift that eliminates the punitive, discriminatory responses associated with physician mental illness and physicians seeking help. It is important for health care organizations to implement processes that identify and manage physician impairment and ill-health that are separate from the disciplinary functions (Taub et al., 2006). Professional attitudes and institutional policies need to be sympathetic to physicians with mental health problems in need of help and support those who seek help.

For example, in North America, many doctors view their provincial or state physician health programs (PHP) as an extension of the regulatory authority and/or licensing body and they are fearful of their involvement. Others view the PHPs as involved with 'those physicians with problems' or 'impaired physicians' and they themselves do not want to be associated with that group of doctors. These barriers require clarification between the use of 'ill' and 'impaired' language and shift toward illness prevention and health maintenance (Carr, 2008). The shift away from emphasis on illness and impairment and toward promoting health and wellness mentioned above is an important cultural shift that may encourage physicians to recognize that it is acceptable to have vulnerabilities and seek professional help (Wallace et al., 2009). Farber et al. (2005) conclude that physicians' lack of knowledge about the guidelines, structure, and function of PHPs may explain why physicians delay in referring themselves or their colleagues. The medical profession is obligated to develop appropriate physician health programs that provide a supportive environment to maintain and restore health and wellness as well as promoting the effective and safe practice of medicine (Taub et al., 2006; Wallace et al., 2009).

Lastly, it is critical that doctors who do seek treatment are supported by their colleagues during the treatment process and upon their return to work. Supportive colleagues and a supportive work environment are critical to restoring and maintaining health and wellness (Taub et al., 2006), but this is often difficult to sustain when a physician is in treatment for an extended period of time. Miller (2009) found that certain workplace practices, such as working reduced hours or taking time off when necessary as well as having supportive peers, were important interventions that support physicians' return to work but more longitudinal studies are needed to better document the interventions and support systems that are most effective. She concludes from her recent study of physicians experiencing mental ill health who returned to work that 'research is needed to quantify and develop the concept of "capacity for work" particularly following mental ill-health' (Miller, 2009: 55). Others have also noted that all too often support systems are not put into place to ensure the physician is supported when they return to work and that their colleagues assist them when they resume patient care (Marshall, 2008; Taub et al., 2006).

It should be noted that several rigorous studies have assessed the extent to which doctors who receive appropriate treatment for substance abuse can return to work and be effective and safe health care providers (e.g. Brewster et al., 2008; Domino et al.,

2005; McLellan et al., 2008). Evidence shows that physicians with substance addictions, who enter intensive treatment followed by comprehensive long-term aftercare and monitoring, have long-term success rates in the 70 to 90 percent range (McCall, 2001). There are not as many data regarding the effectiveness of treatment or recovery rates for physicians suffering from depression or other forms of mental illness not related to substance addictions, even though the therapeutic options are generally plentiful and effective (Boisaubin and Levine, 2001; Pitt et al., 2004). Two recent studies have reported that most doctors who are treated for mental ill health successfully return to work (e.g. Bosch, 2000; Miller, 2009). More studies are needed to evaluate the effectiveness of treatment specifically in regards to mental health disorders that are purely psychological. Information and facts on how well physicians respond to treatment may counter false assumptions regarding the inevitability and permanent linkage between illness and impairment.

Conclusions

The stigmatization of mental illness in the medical profession is promoted and maintained in several different ways. Stigma is reinforced by teaching and encouraging physicians to place a low priority on their own health, to deny that they have any health problems, to keep any concerns about themselves or their colleagues to themselves, and to deal with it on their own. In addition, health care systems and organizations typically respond to mental illness and substance abuse by punishing and deterring physicians from seeking treatment.

Rather than stigmatizing those who seek help, physicians must be supported and encouraged when they recognize they need help. There needs to be a more proactive approach to physician health and wellness that offers information and strategies for early detection, that encourages and supports individual responsibility for wellness, and that promotes and supports early intervention when health and performance deteriorates. In addition, a more proactive approach is needed to not only teach and promote awareness but also to identify and teach effective practices and coping strategies in response to difficult or stressful situations. The medical profession and health care systems and organizations need to eliminate the punitive, discriminatory responses associated with physician mental illness and physicians seeking help and instead encourage and support individual responsibility and collegial support for physician wellness. In doing so, by eliminating the stigma and barriers associated with mental illness among physicians, it is more likely that physicians will acknowledge and confront mental health issues in themselves, their peers, medical students, and inevitably among their patients.

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